Contract for BadgerCare Plus

HMO Services

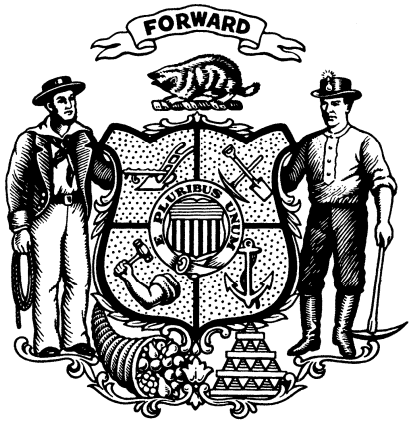
Between

The HMO

and

The Wisconsin Department of Health Services

September 1, 2010 through December 31, 2013



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CONTRACT FOR SERVICES

Between
The Wisconsin Department of Health Services
and
HMO

ARTICLE I

The Wisconsin Department of Health Services (the Department) and the HMO, an insurer with a certificate of authority to do business in Wisconsin, and an organization that makes available to enrolled participants, in consideration of periodic fixed payments, comprehensive health care services provided by providers selected by the organization and who are employees or partners of the organization or who have entered into a referral or contractual arrangement with the organization, for the purpose of providing and paying for BadgerCare Plus contract services to members enrolled in the HMO under the State of Wisconsin BadgerCare Plus program approved by the Secretary of the United States Department of Health and Human Services pursuant to the provisions of the Social Security Act and for the further specific purpose of promoting coordination and continuity of preventive health services and other medical care including prenatal care, emergency care, and HealthCheck services. The HMO does herewith agree:

I. DEFINITIONS

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to BadgerCare Plus, in reimbursement for services that are not medically necessary, or services that fail to meet professionally recognized standards for health. Abuse also includes member practices that result in unnecessary costs to the BadgerCare Plus program.

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service.

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

Appeal: A request for review of an action.

Assessment: An encounter where an appropriately qualified health care professional evaluates a member's special health care needs using evaluation, examination or diagnostic tools, review of past medical history, records such as laboratory reports, patient interview, to adequately address the member's health care and/or cultural needs in a multi-disciplinary treatment plan, plan of care or approach to delivery of care. The evaluation must include an encounter of care, not merely a telephone contact. Comprehensive physical examination is not required, unless it is necessary to fully assess the member's health care needs. For the purposes of an assessment,

qualified health care professional may include non-physician providers such as a psychologist for a member with an identified mental health care need, or advanced practice nurse, physician assistant, registered nurse or social worker, where physician intervention is not required.

Authorized Representative: For the purposes of filing a complaint, grievance, or appeal, an individual appointed by the member, including a provider or estate representative, may serve as an authorized representative.

BadgerCare Plus: The program that merges Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children, families, and childless adults. Coverage will include:

- All qualifying children (birth to age 19).
- All qualifying parents or caretaker relatives with incomes up to 200 percent of the federal poverty level (FPL).
- Pregnant women with incomes up to 300 percent of the FPL.
- Youth (ages 18 through 20) aging out of foster care.
- Farmers and other self-employed parents of children under 19, with incomes up to 200 percent of the FPL, contingent on depreciation calculations.
- Adults without Dependent Children (ages 19 to 64) with income levels below 200 percent of the FPL.

Balanced Workforce: An equitable representation of persons with disabilities, minorities and women available for jobs at each job category from the relevant labor market from which the members recruit job applicants.

Benchmark Plan: The BadgerCare Plus benefit plan available to children and pregnant women with incomes above 200 percent of the FPL, certain self-employed parents, and other caretaker relatives.

Business Associate: A person (or company) that provides a service to a covered program that requires their use of individually identifiable health information.

Capitation Payment: A payment the State agency makes monthly to a contractor on behalf of each member enrolled under a contract for the provision of medical services under the State Plan. The State agency makes the payment regardless of whether the particular member receives services during the period covered by the payment.

Care Coordination: The integration of all processes in response to a client's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services:

- Provided by a care coordinator for each member, and

- Supervised by individuals with the equivalent training and experience of a person with an RN nursing degree and experience with disabled members, or a certified social worker with medical background, or a nurse practitioner.

Care Coordination Includes:

Care Plan: As defined in this Article.

Service Coordination: The comprehensive organization of combined medical and social services across the continuum for the greatest benefit to the member and the most efficient use of resources. This includes arranging for service provision in the optimum combination and sequence, monitoring the provision of needed services and incurring an obligation to pay for BadgerCare Plus covered services.

Care Evaluation: Tracking the outcome of services and the attainment of care plan objectives. Care or service plans may be adjusted accordingly.

Service Management: Administering the provision of a few basic services. In addition to service authorization, this may include abbreviated planning, coordination and evaluation without formal case management (e.g., the isolated need for a ride or a meal).

Care Management System: Care management includes a comprehensive assessment and care plan, care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a person.

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

Case Management: The management of complex clinical services needed by the HMO members, ensuring appropriate resource utilization and facilitation of positive outcomes. For persons with serious mental illness, case management should be provided by and supervised by staff with mental health expertise.

CESA (Cooperative Educational Service Agencies): The unit serving as a connection between the state and school districts within its borders. There are 12 CESAs in Wisconsin. Cooperative Educational Service agencies coordinate and provide educational programs and services as requested by the school district.

CFR: Code of Federal Regulations.

Children With Special Health Care Needs: Children with or at increased risk for chronic physical, developmental, behavioral, or emotional conditions who also require health and related services of a type or amount beyond that required by children generally and who are enrolled in a Children with Special Health Care Needs program operated by a Local Health Department or a local Title V funded Maternal and Child Health Program.

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

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

Clinical Decision Support Tools: Tools that support informed clinical decision-making by presenting information in an integrated, interactive manner.

Cold Call Marketing: Any unsolicited personal contact by the HMO with a potential enrollee for the purpose of marketing.

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

Complaint: A general term used to describe a member's oral expression of dissatisfaction with the HMO. It can include access problems such as difficulty getting an appointment or receiving appropriate care; quality of care issues such as long waiting times in the reception area of a provider's office, rude providers or provider staff; or denial or reduction of a service. A complaint may become a grievance or appeal if it is subsequently submitted in writing.

Comprehensive Assessment: A detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, friends, peers or other significant people. In some instances, the assessment may be done in conjunction with care planning.

Comprehensive HealthCheck: Federal and state regulations establish certain requirements for comprehensive screenings. To be considered a comprehensive HealthCheck screen, the provider must assess and document the following components:

- A complete health and developmental history (including anticipatory guidance).
- A comprehensive unclothed physical examination.
- An age-appropriate vision screening exam.
- An age-appropriate hearing screening exam.
- An oral assessment plus referral to a dentist beginning at one year of age.

- The appropriate immunizations (according to age and health history).
- The appropriate laboratory tests (including blood lead level testing when appropriate for age).

Confidential Information: All tangible and intangible information and materials accessed or disclosed in connection with this Agreement, in any form or medium (and without regard to whether the information is owned by the State or by a third party), that satisfy at least one of the following criteria:

(i) Personally Identifiable Information;
(ii) Individually Identifiable Health Information;
(iii) Non-public information related to the State's employees, customers, technology (including databases, data processing, and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; or
(iv) Information designated as confidential in writing by the State.

Continuing Care Provider: A provider who has an agreement with the BadgerCare Plus program to provide:

A. Any reports that the Department may reasonably require, and

B. At least the following services to eligible HealthCheck members formally enrolled with the provider as enumerated in 42 CFR 441.60(a)(1)-(5):

1. Screening, diagnosis, treatment, and referrals for follow-up services,
2. Maintenance of the member's consolidated health history, including information received from other providers,
3. Physician's services as needed by the member for acute, episodic or chronic illnesses or conditions,
4. Provision or referral for dental services, and
5. Transportation and scheduling assistance.

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

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

Contractor: The HMO awarded a contract resulting from the HMO certification process to provide capitated managed care in accordance with this Contract.

Core Plan: The BadgerCare Plus benefit plan available to Adults without Dependent Children.

Corrective Action Plan: Plan communicated by the State to the HMO for the HMO to follow in the event of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Agreement, or in the event that any Confidential Information is lost or cannot be accounted for by the HMO. This also refers to the plan communicated to the State by the HMO to address a deficiency in contractual performance.

Covered Entity: A health plan (such as an HMO), a health care clearinghouse, or a health care provider that transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162.

Cultural Competency: A set of congruent behaviors, attitudes, practices and policies that are formed within an agency, and among professionals that enable the system, agency, and professionals to work respectfully, effectively and responsibly in diverse situations. Essential elements of cultural competence include understanding diversity issues at work, understanding the dynamic of difference, institutionalizing cultural knowledge, and adapting to and encouraging organizational diversity.

Days: Unless stated otherwise, "days" means calendar days.

Department: The Wisconsin Department of Health Services (formerly known as the Wisconsin Department of Health and Family Services).

Department Values: The Department's shared values include:

- An emphasis on a family centered approach.
- Member involvement throughout the process.
- Building resources on natural and community supports.
- A strength based approach.
- Providing unconditional care.
- Collaborating across systems.
- Using a team approach across agencies.
- Being gender, age and culturally responsive.
- Promoting a self-sufficiency focus on education and employment where appropriate.
- A belief in growth, learning and recovery.
- Being oriented to outcomes.

Emergency Medical Condition:

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

   1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

2. Serious impairment of bodily functions, or

3. Serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman who is in active labor:

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

2. Where transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

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

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title, and needed to evaluate or stabilize an emergency medical condition.

Encounter:

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

1. Office visits
2. Surgical procedures
3. Radiology (including professional and/or technical components)
4. Durable medical equipment
5. Emergency transportation to a hospital
6. Institutional stays (inpatient hospital, rehabilitation stays)
7. HealthCheck screens

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

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

1. HealthCheck Services
2. Lead Screening and Testing
3. Immunizations

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

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

Enrollment Area: The geographic area within which members must reside in order to enroll in the HMO under this Contract.

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

Enrollment Year: An enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12th calendar month. Further information is available in the BadgerCare Plus All-Provider Updates.

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

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

Formally Enrolled with a Continuing Care Provider (as cited in 42 CFR 441.60(d)): A member, member's guardian, or authorized representative agrees to use one continuing care provider as the regular source of a described set of services for a stated period of time.

ForwardHealth interChange: ForwardHealth interChange is a new system which replaces the Medicaid Management Information System (MMIS), which has been in place since 1977. It is based on a tested and federally certified system already operating in several other states. ForwardHealth interChange handles claims, prior authorizations, and other services for many of the state health care programs within a single system. Throughout this contract, the system is referred to as "interChange."

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

Grievance: An expression by a member or authorized representative of dissatisfaction or a complaint about any matter other than an action. The term is also used to refer to the overall system of complaints, grievances and appeals handled by the HMO. Possible grievance subjects include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

Health Care Professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health Needs Assessment (HNA): The HNA is a self-reported questionnaire designed to provide baseline health-status information for a population. The HNA is not intended to cover all medical conditions, but rather identify individuals considered to be at high risk of declining health status who would benefit from timely intervention.

HHS: The federal Department of Health and Human Services.

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

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

HMO: The Health Maintenance Organization or its parent corporation with a certificate of authority to do business in Wisconsin, that is obligated under this Contract.

HMO Technical Workgroup: A workgroup composed of HMO technical staff, contract administrators, claims processing, eligibility, and/or other HMO staff, who meet as necessary; with Department staff from the Division of Health Care Access and Accountability (DHCAA), and staff from the Department's Fiscal Agent.

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

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

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

Marketing: Any unsolicited contact by the HMO, its employees, affiliated providers, subcontractors, or agents to a potential member for the purpose of persuading such persons to enroll with the HMO or to disenroll from another HMO**.**

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

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

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

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

Member Communication: Materials designed to provide an HMO's members with clear and concise information about the HMO's program, the HMO's network, and the BadgerCare Plus program.

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

Members with Special Needs: Term used in clinical diagnostic and functional development to describe individuals who require additional assistance for conditions that may be medical, mental, developmental, physical or psychological.

Member, Participant and Consumer: A BadgerCare Plus member who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the HMO Enrollment Reports that the Department transmits to the HMO according to an established notification schedule. Children who are reported to the certifying agency within 100 days of birth shall be enrolled in the HMO their mother is enrolled in from their date of birth if the mother was a member on the date of birth. Children who are reported to the certifying agency after the 100th day, but before their first birthday are eligible for BadgerCare Plus on a fee-for-service (FFS) basis.

Newborn: A member less than 100 days old.

PCP: Primary care provider including, but not limited to FQHCs, RHCs, tribal health centers, and physicians, nurse practitioners, nurse midwives, physician assistants and physician clinics with specialties in general practice, family practice, internal medicine, obstetrics, gynecology, and pediatrics.

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

(a) the individual's Social Security number;
(b) the individual's driver's license number or state identification number;
(c) the individual's date of birth;
(d) the number of the individual's financial account, including a credit or debit card account number, or any security code, access code, or password that would permit access to the individual's financial account;
(e) the individual's DNA profile; or
(f) the individual's unique biometric data, including fingerprint, voice print, retina or iris image, or any other unique physical characteristic.

Post Stabilization Services: Medically necessary non-emergency services furnished to a member after he or she is stabilized following an emergency medical condition.

Potential member: A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an member of a specific HMO.

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

Provider: A person who has been certified by the Department to provide health care services to members and to be reimbursed by BadgerCare Plus for those services.

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

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

Rural Exception: The provision under 42 CFR 438.52 allowing states to require members in rural areas to enrollment into a single HMO.

Screening: The use of data-gathering techniques, tests, or tools to identify or quantify the health and/or cultural needs of a member. Screening methods may include telephonic contact, mailings, interactive web tools, or encounters in person with screeners or health care providers.

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

Service Area: An area of the State where the HMO has agreed to provide BadgerCare Plus services to members. The Department monitors enrollment levels of the HMO by the HMO's service area(s). The HMO indicates whether they will provide chiropractic services by service area. A service area may be as small as a zip code, may be a county, a number of counties, or the entire State.

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

Standard Plan: The BadgerCare Plus benefit plan available to children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes that meet specific thresholds.

State: The State of Wisconsin.

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

Supplemental Security Income (SSI): The program administered by the Social Security Administration under Title XVI of the Federal Social Security Act and 20 CFR Part 416 that provides a monthly stipend to elderly, blind, or disabled individuals as well as medical assistance through Title XIX of the Federal Social Security Act and Chapter 49 of Wisconsin statutes.

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

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

Voluntary: Refers to any service area where the Department cannot or does not require members to enroll in a HMO.

Wisconsin Tribal Health Directors Association (WTHDA): The coalition of all Wisconsin American Indian Tribal Health Departments.

Terms that are not defined above shall have their primary meaning identified in Wis. Adm. Code DHS 101-108.

ARTICLE II

II. DELEGATIONS OF AUTHORITY

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

- There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate, or out of compliance with HIPAA privacy or security requirements.

- Before any delegation, the HMO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

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

- If the HMO identifies deficiencies or areas for improvement, the HMO and the subcontractor shall take corrective action.

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

ARTICLE III

III. FUNCTIONS AND DUTIES OF THE HMO

A. Statutory Requirement

In consideration of the functions and duties of the Department contained in this Contract the HMO shall retain at all times during the period of this Contract a valid Certificate of Authority issued by the State of Wisconsin Office of the Commissioner of Insurance.

B. Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and rules and regulations that are in effect when the Contract is signed, or that come into effect during the term of the Contract. This includes, but is not limited to Title XIX of the Social Security Act, Title XXI, SCHIP, and Title 42 of the CFR.

Changes to BadgerCare Plus covered services mandated by federal or state law subsequent to the signing of this Contract will not affect the Contract services for the term of this Contract, unless agreed to by mutual consent, or the change is necessary to continue to receive federal funds or due to action of a court of law.

The Department may incorporate into the Contract any change in covered services mandated by federal or state law effective the date the law goes into effect, if it adjusts the capitation rate accordingly. The Department will give the HMO at least 30 days notice before the intended effective date of any such change that reflects service increases, and the HMO may elect to accept or reject the service increases for the remainder of that contract year. The Department will give the HMO 60 days notice of any such change that reflects service decreases, with a right of the HMO to dispute the amount of the decrease within 60 days. The HMO has the right to accept or reject service decreases for the remainder of the Contract year. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in the state budget.

The HMO is not endorsed by the federal or state government, CMS, or similar entity.

Federal funds must not be used for lobbying. Specifically and as applicable, the Contractor agrees to abide by the Copeland-Anti Kickback Act, the Davis-Bacon Act, federal contract work hours and safety standards requirements, the federal Clean Air Act and the federal Water Pollution Control Act.

C. Organizational Responsibilities and Duties

1. Ineligible Organizations

Upon obtaining information or receiving information from the Department or from another verifiable source, the HMO must exclude from participation in the HMO all organizations that could be included in any of the categories defined in a, 1), a) through e) of this section (references to the Act in this section refer to the Social Security Act).

a. Entities that could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has direct or indirect ownership or control interest of 5% or more in the entity has:

1) Been convicted of the following crimes:

a) Program related crimes (i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid). (Section 1128(a)(1) of the Act.)

b) Patient abuse (i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care). (Section 1128(a)(2) of the Act.)

c) Fraud (i.e., a state or federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government). (Section 1128(b)(1) of the Act.)

d) Obstruction of an investigation (i.e., conviction under state or federal law of interference or obstruction of any investigation into any criminal offense described in Subsections a), b), or c). (Section 1128(b)(2) of the Act.)

e) Offenses relating to controlled substances (i.e., conviction of a state or federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance. (Section 1128(b)(3) of the Act.)

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

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

b. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in Subsection 1. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

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

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

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

c. Entities that employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A, for the provision (directly or indirectly) of health care, utilization review, medical social work or administrative services. For the services listed, the HMO must refrain from contracting with any entity that employs, contracts with, or contracts through an entity that has been excluded from participation in Medicaid by the Secretary of Health and Human Services under the authority of Section 1128 or 1128A of the Act.

The HMO attests by signing this Contract, that it excludes from participation in the HMO all organizations that could be included in any of the above categories.

2. Contract Representative

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

3. Attestation

The HMO's Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or designee must attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department. This includes encounter data, ventilator dependent member data, provider and facility network submissions, and any other data regarding claims the HMO paid. The HMO must use the Department's attestation form in Addendum IV, I. The attestation form must be submitted quarterly to the HMO's Managed Care Analyst in the Bureau of Benefits Management (Article VII, K).

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

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

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

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

a. Affirmative Action Plan

1) For agreements where the HMO has 25 employees or more and will receive $25,000 or more, the HMO shall complete the AA plan. The HMO with an annual work force of less than 25 employees or less than $25,000 may be exempt from submitting the AA plan.

The AA Plan is written in detail and explains the HMO's program. To obtain instructions regarding the AA Plan

requirements go to
http://vendornet.state.wi.us/vendornet/contract/contcom.asp

2) The HMO must file its AA plan within 15 days after the award of a contract and includes all programs. The plan must be submitted to:

Karen Koehn
Bureau of Intergovernmental & Contract Management (BIRCM)
Department of Health Services
Division of Enterprise Services
1 West Wilson Street, Room 618
P.O. Box 7850
Madison, WI 53707
Phone: 608-266-7075
Karen.Koehn@wi.gov

Compliance with the requirements of the AA Plan will be monitored by the DHS Office of Affirmative Action and Civil Rights Compliance.

b. Civil Rights Compliance (CRC) Plan

(1) The HMO receiving federal and/or state funding to administer programs, services and activities through DHS must file a Civil Rights Compliance Letter of Assurance (CRC LOA) for the compliance period of 2010 – 2011 regardless of the number of employees and the amount of funding received. All HMOs with twenty-five (25) or more employees AND who receive over $25,000 in funding must complete a Civil Rights Compliance Plan (CRC Plan); however, **it is not required that HMOs submit a copy of their CRC Plan.** The CRC Plan is to be kept on file and made available upon request to any representative of the Department of Health Services. Specific guidance about the requirements for the CRC Plan can be found at http://dhs.wisconsin.gov/civilrights/Index.HTM.

For technical assistance on all aspects of the Civil Rights Compliance, the HMO is to contact the Department's AA/CRC Office at:

The Department of Health Services
1 W. Wilson Street, Room 555
P.O. Box 7850
Madison, WI 53707-7850

(608) 266-9372 (voice)
(888) 701-1251 TTY

(2) HMOs sub-contracting federal or state funding to other entities must obtain a CRC LOA from their sub-contractors. The CRC LOA must be kept on file and produced upon request or at the time that an on-site monitoring visit is conducted. Sub-contractors with twenty-five (25) or more employees AND who receive over $25,000 in funding must complete a CRC Plan. The CRC Plan is to be kept on file and produced upon request by the DHS AA/CRC Office, a representative of the DHS or at the time the HMO conducts an on-site monitoring visit.

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

(4) The HMO agrees not to exclude qualified persons from employment or otherwise.

(5) The HMO agrees to comply with all of the requirements in the revised Department CRC Plan and to ensure that their subcontractors comply during this Contract period. Specific guidance about the requirements for the CRC Plan can be found at http://dhs.wisconsin.gov/civilrights/Index.HTM.

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

(7) The HMO agrees to cooperate with the Department in developing, implementing and monitoring corrective action

plans that result from complaint investigations or monitoring efforts.

5. Non-Discrimination in Employment

The HMO must comply with all applicable federal and state laws relating to non-discrimination and equal employment opportunity including Wis. Stats., s.16.765, Federal Civil Rights Act of 1964, regulations issued pursuant to that Act and the provisions of Federal Executive Order 11246 dated September 26, 1985, and ensure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable Department regulations (45 CFR part 84) and all guidelines and interpretations issued pursuant thereto, and the provisions of the Age Discrimination and Employment Act of 1967 and Age Discrimination Act of 1975.

Wis. Stats., Chapter 16.765, requires that in connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the non-discrimination clause.

Contractor further agrees not to subject qualified persons to discrimination in employment in any manner or term or condition of employment on the basis of arrest record, conviction record, genetic testing, honesty testing, marital status, military service, pregnancy or childbirth, or use of legal products during non-work hours outside of the employer's premises, except as otherwise authorized by applicable statutes.

All HMO employees are expected to support goals and programmatic activities relating to non-discrimination and non retaliation in employment.

With respect to provider participation, reimbursement, or indemnification, the HMO will not discriminate against any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This shall not be construed to require the HMO to contract with providers beyond the

number necessary to meet the needs of the BadgerCare Plus and /or Medicaid SSI population. This shall not be construed to prohibit the HMO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities. If the HMO declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.

6. Provision of Services to the HMO Members

The HMO must provide contract services to BadgerCare Plus members under this Contract in the same manner as those services are provided to other members of the HMO.

The HMO must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

7. Access to Premises

The HMO must allow duly authorized agents or representatives of the state or federal government access to the HMO's or HMO subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the HMO's or subcontractor's contractual activities and shall produce all records requested as part of such review or audit within a reasonable time, but not more than 10 business days. Upon request for such right of access, the HMO or subcontractor must provide staff to assist in the audit or inspection effort, and adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits must be conducted in a manner as will not unduly interfere with the performance of HMO's or subcontractor's activities. The HMO will have 30 business days to respond to any findings of an audit before the Department finalizes it. All information obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

8. Liability for the Provision of Care

Remain liable for provision of care for that period for which capitation payment has been made in cases where medical status code changes occur subsequent to capitation payment.

9. Subcontracts

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

10. Coordination with Community-Based Health Organizations, Local Health Departments, Bureau of Milwaukee Child Welfare, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, County or Other Human Service Agencies, and School-based Mental Health Services

The HMO must make a good faith attempt to negotiate either an MOU or a contract with the organizations and agencies in its service area listed below. The MOU(s), contract(s) or written documentation of a good faith attempt must be available during the certification process and when requested by the Department. Failure of the HMO to have an MOU, contract or demonstrate a good faith effort, as specified by the Department, may result in the application by the Department of remedies specified under this Contract.
MOUs must be signed every three years as part of certification. If no changes have occurred, or the MOU automatically renews, then both the organization and the HMO must sign off that no changes have occurred and documentation to this effect must be submitted to the Bureau of Benefits Management upon request.

MOUs and contracts should clearly indicate guidelines for sharing clinical data between the HMO and the organization in order to ensure proper coordination of services; billing and payment procedures for services provided; and appeal rights for those organizations that are Medicaid-certified providers.

The Department will distribute and periodically update a list of known agencies and organizations referenced below in Milwaukee, Washington, Ozaukee, Waukesha, Racine and Kenosha counties to the HMO.

a. Community-Based Health Organizations

The Department encourages the HMO to contract with community-based health organizations for the provision of care to BadgerCare Plus members in order to ensure continuity and culturally appropriate care and services. Community-based organizations can provide HealthCheck outreach and screening, immunizations, family planning services, and other types of services.

The Department encourages the HMO to work closely with community-based health organizations. Community-based health organizations may also provide services, such as WIC services, that the HMO is required by federal law to coordinate with and refer to, as appropriate.

b. Local Health Departments

The Department encourages the HMO to contract with local health departments for the provision of care to BadgerCare Plus members in order to ensure continuity and culturally appropriate care and services. Local health departments can provide HealthCheck outreach and screening, immunizations, blood lead screening services, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases (e.g., tuberculosis, HIV/AIDS, sexually transmitted diseases, hepatitis and others). WIC projects provide nutrition services and supplemental foods, breast feeding promotion and support; and immunization screening. Many projects screen for blood lead poisoning during the WIC appointment. As indicated in Art. III, H, the HMO may enter into a contract or MOU with WIC projects that contract with the Department's Division of Public Health to be a certified provider for purposes of blood lead testing in order to receive direct reimbursement.

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

c. Child Welfare Coordination

HMOs must designate at least one staff member to serve as a contact with county child welfare agencies or BMCW. If the HMO chooses to designate more than one contact person the HMO should identify the service area for which each contract person is responsible. The Department encourages HMOs to designate a staff member with at least two years of experience working in a child welfare agency, or who has attended child welfare training through the Wisconsin Child Welfare Training Partnership.

In Milwaukee County, HMOs must provide all BadgerCare Plus covered mental health and substance abuse services to individuals identified as clients of BMCW. Disputes regarding the medical necessity of services identified in the Family Treatment Plan will be adjudicated using the dispute process, except that the HMO must provide court-ordered services.

Outside of Milwaukee County, HMOs shall coordinate with the appropriate county human services agency for the provision of services to members involved with the county.

d. Prenatal Care Coordination (PNCC) Agencies

The HMO must sign a Memorandum of Understanding (MOU) with all agencies in the HMO service area that are BadgerCare Plus-certified PNCC agencies. The purpose of the MOU is to ensure coordination of care between the HMO that provides medical services, and the PNCC agency that provides outreach, risk assessment, care planning, care coordination, and follow-up.

In addition, the HMO must assign the HMO medical representative to interface with the care coordinator from the PNCC agency. The HMO representative shall work with the care coordinator to identify what BadgerCare Plus covered services, in conjunction with other identified social services, are to be provided to the member. The HMO is not liable for medical services outside of their provider network by the care coordinator unless prior authorized by the HMO. In addition, the HMO is not required to pay for services provided directly to the PNCC provider. The Department pays such services on a FFS basis.

e. School-Based Services (SBS) Providers

The HMO must use its best effort and document attempts to sign a MOU with all SBS providers in the HMO service area to ensure continuity of care and to avoid duplication of services. School based services are paid FFS when provided by a BadgerCare Plus

certified SBS provider. However, in situations where a member's course of treatment is interrupted due to school breaks, after school hours or during the summer months, the HMO is responsible for providing and paying for all BadgerCare Plus covered services.

f. Targeted Case Management (TCM) Agencies

The HMO must interface with the case manager from the TCM agency to identify what BadgerCare Plus covered services or social services are to be provided to a member. The HMO is not required to pay for medical services directed outside of their provider network by the case manager unless prior authorized by the HMO. The Department will distribute a statewide list of certified TCM agencies to the HMO and periodically update the list.

The Department encourages the HMO to contract with community-based mental health agencies and/or school-based providers for the provision of mental health care to BadgerCare Plus children in a school setting. The HMO is encouraged to assist with the coordination of covered mental health services to its members (including those children without an IEP who may have mental health needs) with the school, mental health provider, and family as appropriate.

g. County and Other Human Service Agencies

The HMO must make a good faith attempt to negotiate either an MOU or contract with the counties and/or other human service agencies in their service area for the provision of services ordered by courts and for the provision of mental health and/or substance abuse services, as indicated in Add. I and Art. III, F. respectively.

h. School-based Mental Health Services

The Department encourages the HMO to contract with community-based mental health agencies and/or school-based providers for the provision of mental health care to BadgerCare Plus children in a school setting. The HMO is encouraged to assist with the coordination of covered mental health services to its members (including those children without an IEP who may have mental health needs) with the school, mental health provider, and family as appropriate.

11. Clinical Laboratory Improvement Amendments (CLIA)

The HMO must use only certain laboratories. All laboratory testing sites providing services under this Contract must have a valid CLIA certificate along with a CLIA identification number, and comply with CLIA regulations as specified by 42 CFR Part 493.1 "Laboratory Requirements and Basis and Scope." Those laboratories with certificates must provide only the types of tests permitted under the terms of their certification.

D. Payment Requirements/Procedures

The HMO is responsible for the payment of all contract services provided to all BadgerCare Plus members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the coverage period for BadgerCare Plus – Standard and Benchmark. The HMO is also responsible for the provision, or authorizing the provision of, services to all members with valid ForwardHealth ID cards indicating HMO enrollment, without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the enrollment reports must be reported to the Department for resolution. The HMO must continue to provide and authorize provision of all contract services until the discrepancy is resolved, including members who were PENDING on the Initial Report and held a valid ForwardHealth ID card indicating HMO enrollment, but did not appear as a CONTINUE on the Final Report. If a member shows on the Initial enrollment report as pending and later shows on the Final report as a disenroll, the HMO will not be liable for services after the date the disenrollment is effective. The payment for services to all newborns meeting the criteria described in the section "Capitation Payment for Newborns."

1. Claims Retrieval

   The HMO must maintain a claim retrieval system that can upon request identify date of receipt, action taken on all provider claims (i.e., paid, denied, other), and when action was taken. The HMO must have procedures in place that will show the date a claim was received whether the claim is a paper copy or an electronic submission. In addition, the HMO must maintain a claim retrieval system that can identify, within the individual claim, the services provided and the diagnoses of the members using nationally accepted coding systems: HCPCS including Level I CPT codes and Level II and Level III HCPCS codes with modifiers, ICD-9-CM diagnosis and procedure codes, and other national code sets such as place of service, type of service, and EOB codes. Finally, the claim retrieval system must be capable of identifying the provider of services by the appropriate BadgerCare Plus provider ID number and/or National Provider Identifier (NPI), if applicable, assigned to all in-plan providers.

2. Thirty Day Payment Requirement

The HMO must pay at least 90% of adjudicated clean claims from subcontractors for covered medically necessary services within 30 days of receipt of a clean claim, 99% within 90 days and 100% within 180 days of receipt, except to the extent subcontractors have agreed to later payment. HMO agrees not to delay payment to a subcontractor pending subcontractor collection of third party liability unless the HMO has an agreement with the subcontractor to collect third party liability.

3. Payment to a Non-HMO Provider for Services Provided to a Disabled Participant Less than Three or for Services Ordered by the Courts

The HMO must pay for covered services provided by a non-HMO provider to a disabled participant less than three years of age, or to any participant pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-HMO provider, and extending until the HMO issues a written denial or referral. This requirement does not apply if the HMO issues a written denial of referral within seven days of receiving the request for referral.

4. Payment of HMO Referrals to Non-Affiliated Providers

For HMO approved referrals to non-affiliated providers, the HMO must either establish payment arrangements in advance, or the HMO is liable for payment only to the extent that BadgerCare Plus pays, including Medicare deductibles, or would pay, its FFS providers for services.

5. Health Professional Shortage Area (HPSA) Payment Provision

The following provision refers to payments made by the HMO. HMO covered primary care and emergency care services provided to a member living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA must be paid at the HPSA enhanced rates as outlined under Medicaid FFS policy. Specified HMO-covered obstetric or gynecological services (see Wisconsin Health Care Programs Online Handbooks) provided to a member living in a HPSA or by a provider practicing in a HPSA must also be paid at the HPSA enhanced rates as outlined under Medicaid FFS policy. The specific enhanced payment amounts are available in the ForwardHealth Provider Updates.

However, this does not require the HMO to pay more than the enhanced FFS rate or the actual amount billed for these services. The HMO shall ensure that the money for HPSA payments is paid to the physicians and is not used to supplant funds that previously were used for payment to the physicians. The Department will supply a list of the services affected by this provision, the maximum FFS rates, and HPSAs. The HMO must develop written policies and procedures to ensure compliance with this

provision. These policies must be available for review by the Department, upon request.

6. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

   If the HMO contracts with a BadgerCare Plus certified FQHC or RHC for the provision of services to its members, the HMO must pay at a minimum the Medicaid FFS rate or the equivalent for services.

7. Immunization Program

   As a condition of certification as a BadgerCare Plus provider, the HMO must share member immunization status with the local health departments and other non-profit HealthCheck providers upon their request without the necessity of member authorization. The Department also requires that the local health departments and other non-profit HealthCheck providers share the same information with the HMO upon request. This provision ensures proper coordination of immunization services and prevents duplication of services.

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

8. Transplants

   Transplant coverage is as follows:

   a. Cornea and kidney transplants. These services are no longer considered experimental. Therefore, the HMO must also cover these services.

   b. The HMO is not required to cover procedures that are approved only at particular institutions, including bone marrow transplants, liver, heart, heart-lung, lung, pancreas-kidney, and pancreas transplants. There are no funds in the HMO capitation rates for these services.

   c. As a general principle, the BadgerCare Plus Program does not pay for transplants that it determines to be experimental in nature.

   Members who have had one or more of the transplant surgeries referenced in 8, b, above will be permanently exempted from HMO enrollment. Refer to Article VIII, F, 2, i. for the exemption criteria.

9. Hospitalization at the Time of Enrollment or Disenrollment

The HMO will not assume financial responsibility for members who are hospitalized at the time of enrollment (effective date of coverage) until an appropriate hospital discharge. The Department is responsible for paying on a FFS basis all BadgerCare Plus covered services for such hospitalized members during hospitalization (Article VIII, F).

Hospitalization in this section is defined as an inpatient stay at a certified hospital as defined in Wis. Adm. Code DHS 101.03(76). Discharge from one hospital and admission to another within 24 hours for continued treatment shall not be considered a discharge under this section. Discharge is defined here as it is in the UB-04 Manual.

Members, including newborn members, who are hospitalized at the time of disenrollment from the HMO shall remain the financial responsibility of the HMO. The financial liability of the HMO shall encompass all contract services. The HMO's financial liability shall continue for the duration of the hospitalization, except where:

a. Loss of BadgerCare Plus enrollment occurs.
b. Disenrollment occurs because there is a voluntary disenrollment from the HMO as a result of one of the conditions in Article VIII, F in which case the HMO's liability shall terminate upon disenrollment being effective.
c. Disenrollment is due to a medical status code change which includes:

    - SSI for BadgerCare Plus members only.
    - Institutionalized enrollment.

In these two exceptions, the HMO's liability shall not exceed the period for which it is capitated.

10. Members Living in a Public Institution

The HMO 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 a public institution after the last day of the month are no longer eligible for BadgerCare Plus and the HMO is not liable for providing care after the end of the first month.

Members who are living in a public institution and go directly from the public institution to a medical facility, court ordered or voluntarily, are no longer living in a public institution and remain eligible for BadgerCare Plus. The HMO shall be liable for the provision of medically necessary treatment if treatment is at the HMO's facilities, or if unable to itself provide for such treatment.

11. Payment to Provider Pending Credentialing Approval

The HMO must pay a Medicaid-certified provider for services provided to a member of the HMO while the provider's complete application for credentialing is pending approval by the HMO. If the provider's application is ultimately denied by the HMO, the HMO is not liable for the services provided.

E. Covered BadgerCare Plus Services

The HMO must provide BadgerCare Plus covered services to the extent as outlined below, but is not restricted to only providing BadgerCare Plus covered services. Sometimes the HMO finds that other treatment methods may be more appropriate than BadgerCare Plus covered services, or result in better outcomes.

None of the provisions of this Contract that are applicable to BadgerCare Plus covered services apply to other services that the HMO may choose to provide, except that abortions, hysterectomies and sterilizations must comply with 42 CFR 441 Subpart E and 42 CFR 441 Subpart F.

1. Provision of Contract Services

   The HMO must promptly provide or arrange for the provision of all services required under Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.43(23) and Wis. Adm. Code DHS 107 as applicable to the particular member and as further clarified in all Wisconsin Health Care Programs Online Handbook and HMO Contract Interpretation Bulletins, Provider Updates, through the interChange Portals, and as otherwise specified in this Contract except:

   a. Common Carrier Transportation, except in Milwaukee County where HMOs must provide this service (Art. III, E, 6). With implementation of a transportation management vendor contract beginning in CY 2011, HMOs in Washington, Ozaukee, Waukesha, Racine and Kenosha counties will be required to provide this service.

   b. Prenatal Care Coordination (PNCC), except the HMO must sign a Memorandum of Understanding (MOU).

   c. Targeted Case Management (TCM), except the HMO must work with the TCM case manager.

   d. School-Based Services (SBS), except the HMO must use its best efforts to sign a Memorandum of Understanding (MOU).

   e. Childcare Coordination.

   f. Certain Tuberculosis-related Services.

g. Crisis Intervention Benefit.

h. Community Support Program (CSP) services.

i. Comprehensive Community Services (CCS).

j. Pharmacy Coverage.

k. Chiropractic services, unless the HMO elects to provide chiropractic services.

Addendum V contains additional summary information on BadgerCare Plus covered services. Please refer to the ForwardHealth Provider Updates for the most current information regarding BadgerCare Plus covered services.

The HMO is not required to provide a counseling or referral service if the HMO objects to the service on moral or religious grounds. If the HMO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish prior notice to the Department and Enrollment Specialist about the service it will not cover. In addition, in accordance with 42 CFR 438.10 (other than paragraphs (e) and (f) as to how and where to receive the excluded service) the HMO must provide this information as follows:

a. To potential members before and during enrollment;
b. To members within ninety (90) calendar days after adopting the policy with respect to any particular service; and
c. In a written and prominent manner, the HMO shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus but which are not available through the HMO because of an objection on moral or religious grounds.

2. Medical Necessity

The actual provision of any service is subject to the professional judgment of the HMO providers as to the medical necessity of the service, except that the HMO must provide assessment, evaluation, and treatment services ordered by a court. Decisions to provide or not to provide or authorize medical services shall be based solely on medical necessity and appropriateness as defined in DHS 101.03(96m). Disputes between the HMO and members about medical necessity can be appealed through the HMO grievance system, and ultimately to the Department for a binding determination; the Department's determinations will be based on whether BadgerCare Plus would have covered the service on a FFS basis (except for certain experimental procedures).

3. Physician and Other Health Services

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

Note: Private duty nursing and personal care services are not covered for the Benchmark Plan members.

Provider-administered drugs (as defined by the Department in the maximum allowable fee schedule), will no longer be covered through the capitation rate.

4. Pre-Existing Medical Conditions

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

5. Ambulance Services

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

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

b. Pay for emergency ambulance services based on established BadgerCare Plus criteria for claims payment of these services.

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

d. Respond to appeals from ambulance providers within the time frame described. Failure will constitute the HMO agreement to pay the appealed claim in full.

6. Common Carrier Transportation

a. BadgerCare Plus – Standard Plan

The HMO must provide or arrange for common carrier transportation, including HealthCheck screenings, in accordance with the BadgerCare Plus transportation guidelines included in the Medicaid BadgerCare Plus Enrollment Handbook (online at http://emhandbooks.wi.gov/bcplus/policyfiles/5_Coverage/38_Covered_Services/38.3.htm.

Common carrier transportation includes, but is not limited to, taxi, van, or bus as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus covered services, including those not covered by the HMO such as chiropractic and family planning services. Common carrier transportation also includes coverage of meals and lodging in accordance with the Medicaid BadgerCare Plus Enrollment Handbook. The HMO must arrange for transportation for HealthCheck screenings.

1) Members Outside of Milwaukee County

Until the Department notifies the HMO that the transportation manager function is operational, the HMO must directly provide non-emergency transportation by common carrier or private motor vehicle for covered services to the member and the HMO will be reimbursed by the county; or

The HMO may refer a member directly to the local county human or social services agency for transportation services.

Beginning in CY 2011, HMOs will be required to submit common carrier reports according to the format in Addendum IV, J.

2) Members in Milwaukee County

Common carrier transportation is included in the capitation rate. HMOs are required to submit common carrier reports according to the format in Addendum IV, J.

b. BadgerCare Plus – Benchmark Plan

All non-emergency transportation, including common carrier transportation, is not a covered service under the Benchmark Plan.

7. Dental Services

a. Dental Services Covered by the HMO Contracted to Provide Dental Care for BadgerCare Plus – Standard Plan

1) All BadgerCare Plus covered dental services as required under DHS 107.07 and Wisconsin Health Care Programs Online Handbooks and Updates.

2) Diagnostic, preventive, and medically necessary follow-up care to treat a dental disease, illness, injury or disability of members while they are enrolled in the HMO, except as required in Subsection b) following.

3) Completion of orthodontic or prosthodontic treatment begun while a member was enrolled in the HMO if the member became ineligible for BadgerCare Plus or disenrolled from the HMO, no matter how long the treatment takes. The HMO will not be required to complete orthodontic or prosthodontic treatment on a member who began treatment as a FFS member and who subsequently was enrolled in the HMO.

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

b. Dental Services Covered by the HMO Contracted to Provide Dental Care for BadgerCare Plus – Benchmark Plan

Refer to Addendum V for dental covered services under the Benchmark Plan.

c. Reporting Requirements for Dental Services

HMOs that cover dental services must submit progress reports to the Department as part of its Annual Performance report documenting the outcomes or current status of activities intended to increase utilization among members and recruit and retain providers, specifically commenting on the requirements listed as part of Dental Services Quality Improvement in Art. IV, H and its strategy to meet the dental utilization performance benchmarks in Add. VI. These reports must include an assessment of the effectiveness of previous activities and any corrective action taken based on the assessment.

d. Right to Audit

The Department will conduct validity and completeness audits of dental claims. Upon request, the HMO must submit paid claims to the Department along with any other records the Department deems necessary for the completion of the audit. Payment of incomplete or inaccurate claims will subject the HMO to administrative sanctions outlined in Article XI.

e. Requirements to Dental Services Providers

If an HMO subcontracts with a dental benefits administrator, the dental benefits administrator has the right to appeal to both the HMO and Department, according to the Department's provider appeal requirements. This right to appeal is in addition to that of the provider’s.

HMOs must pay at a minimum the Medicaid fee-for-service rates for dental services. Providers rendering services must be paid at a minimum the Medicaid fee-for-service rates.

Responsibility for Payment of Orthodontic and Prosthodontic Treatment When There is an Eligibility Status Change During the Course of Treatment

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

* Orthodontic treatment is only covered by BadgerCare Plus for children under 21 as a result of a HealthCheck referral (DHS 107.07(3)).

8. Emergency and Post-Stabilization Services

a. 24-Hour Coverage

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

The HMO must:

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

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

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

3) Notify the Department and county human services department with which the HMO has a MOU or in which the HMO has enrollment of any changes to this toll-free telephone number for emergency calls within seven business days of the change.

b. Coverage and Payment of Emergency Services.

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

(2) The HMO may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

(3) The HMO may not deny payment for emergency services for a member with an emergency medical condition (even if the absence of immediate medical attention would not have had the outcomes specified in paragraphs 1., 2., and 3. of part A of the definition of Emergency Medical Condition) or for a member who had HMO approval to seek emergency services.

(4) The HMO may not deny payment based on the emergency room provider, hospital or fiscal agent not notifying the member's primary care provider or the HMO of the member's screening and treatment within ten (10) days the member's presentation for emergency services.

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

(6) The treating provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the HMO.

c. Coverage and Treatment of Post-Stabilization Care Services.

1) The HMO is financially responsible for post-stabilization care services consistent with the provisions in 42 CFR 422.113. The HMO is financially responsible for: .

a) services obtained within or outside the HMO's network that are pre-approved by the HMO or a network provider;

b) services obtained within or outside the HMO's network that are not pre-approved, but that are administered to maintain the member's stabilized condition within one (1) hour of a request for pre-approval to provide further post-stabilization care services;

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

- The HMO does not respond to a request for pre-approval of post-stabilization care services within one (1) hour;
- The HMO cannot be contacted; or,
- The HMO and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the HMO must give the treating physician the opportunity to consult with the HMO care team or medical director. The treating physician may continue with care of the member until the HMO care team or medical director is reached or one of the following occurs: a network physician assumes responsibility for the member's care at the treating hospital or through transfer; the treating physician and HMO reach agreement; or, the member is discharged.

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

3) The HMO must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the HMO

d. Additional Provisions

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

2) When emergency services are provided by non-affiliated providers, be liable for payment only to the extent that BadgerCare Plus pays, including Medicare deductibles, or would pay, FFS providers for services to the BadgerCare Plus populations. In no case will the HMO be required to pay more than billed charges. This condition does not apply to:

(1) Cases where prior payment arrangements were established; and

(2) Specific subcontract agreements.

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

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

9. Family Planning Services and Confidentiality of Family Planning Information

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

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

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

10. Fertility Drugs

The HMO must get prior authorization from the State Contracted Medical Representative through the Division of Health Care Access and Accountability before the HMO provider may treat a member with any of the following drug products: Chorionic Gonadotropin, Clomiphene, Gonadorelin, Menotropins, Urofollitropin and any other new fertility enhancing drugs. All prescribed fertility drugs are paid under FFS.

11. Pharmacy Coverage

Pharmacy coverage, including provider-administered drugs under Art. III, E, is carved out of the capitation rate for all BadgerCare Plus members and will be paid on a fee-for-service basis.

F. Mental Health and Substance Abuse Coverage Requirements/Coordination of Services with Community Agencies

The HMO must provide BadgerCare Plus covered services, but the HMO is not restricted to providing only those services. The HMO may provide additional or alternative treatments if the other treatment modalities are more appropriate and result in better outcomes than BadgerCare Plus covered services. Whether the service provided is a BadgerCare Plus covered service or an alternative or replacement to a BadgerCare Plus covered service, the HMO or HMO provider is not allowed to bill the member for the service, other than an allowable co-payment.

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

On the effective date of this Contract, the HMO must be in compliance with Wis. Stats., s.632.89;

a. Be certified according to DHS 105.21, 105.22, 105.23, 105.24, 105.25 and/or 105.255, to provide mental health and/or substance abuse services; or

b. Have contracted with facilities and/or providers certified according to DHS 105.21, 105.22, 105.23, 105.24, 105.25, and/or 105.255, to provide mental health and/or substance abuse services.

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

Regardless of whether a. or b., above, is chosen, such treatment facilities and/or providers must provide arrangements for covered transitional treatment in addition to other outpatient mental health and/or substance abuse services. Such transitional treatment arrangements may include but

are not limited to adult mental health day treatment, child/adolescent day treatment and substance abuse day treatment.

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

In compliance with said provisions, the HMO must further guarantee all enrolled BadgerCare Plus members access to all medically necessary outpatient mental health/substance abuse and covered transitional treatment.

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

2. BadgerCare Plus-Standard Plan:

No limit may be placed on the number of hours of outpatient treatment that the HMO must provide or reimburse where it has been determined that treatment for mental illness and/or substance abuse or covered transitional treatment is medically necessary. The HMO shall not establish any monetary limit or limit on the number of days of inpatient hospital treatment where it has been determined that this treatment is medically necessary.

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

3. BadgerCare Plus Benchmark Plan:

Information on mental health and substance abuse covered services under the BadgerCare Plus – Benchmark Plan can be found in Addendum V as well as in Provider Updates and through interChange.

4. Mental Health/Substance Abuse Assessment Requirements

The HMO must assure that authorization for mental health/substance abuse treatment for its members is governed by the findings of an assessment performed promptly by the HMO upon request of a client or referral from a primary care provider or physician in the HMO's network. Such assessments must be conducted by qualified staffs in a certified program who are experienced in mental health/substance abuse treatment. All denials of service and the selection of particular modalities of service shall be governed by the findings of this assessment, the effectiveness of the therapy for the condition (including best practice, evidence based practice), and the medical necessity of treatment. The lack of motivation of a member to participate in treatment shall not be considered a factor in determining medical necessity and may not be used as a rationale for withholding or limiting treatment of a client/member. The HMO will use the Wisconsin Uniform Placement Criteria (WI-UPC), or the placement criteria developed by the American Society of Addiction Medicine (ASAM) as mandated for substance abuse care providers in DHS 75. The requirement in no way obligates the HMO to provide care options included in the placement criteria that are not covered services under FFS.

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

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

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

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

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

6. Court-Related Children's Services

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

7. Court-Related Substance Abuse Services

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

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

8. Crisis Intervention Benefit (BadgerCare Plus Standard)

The HMO must assign a medical representative to coordinate with the designees of crisis intervention agencies certified under Wis. Adm. Code DHS 34 to provide services within the HMO's service area. The HMO must work with the certified Crisis Intervention Agency to coordinate the transition from crisis intervention care to ongoing BadgerCare Plus covered mental health and substance abuse care within the HMO's network. The HMO is not responsible for payment for services provided

to their members by certified Crisis Intervention Agencies. Those services are to be billed directly to FFS. In addition, the HMO is not required to pay for services directed by the certified Crisis Intervention Agency outside the HMO network, unless the HMO has authorized those services.

9. Emergency Detention and Court-Related Mental Health Services (BadgerCare Plus Standard)

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

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

b. The HMO 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 HMO to provide care to a member admitted to a non-HMO facility is accomplished if the county or treating facility notifies and advises the HMO of the admission within 72 hours, excluding weekends and/or holidays. The HMO may provide an alternative treatment plan for the county to submit at the probable cause hearing. The HMO 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.

c. If the county attempts to notify the person identified as the primary contact by the HMO to receive authorization for care, and does not succeed in reaching the HMO within 72 hours of admission excluding weekends and holidays, the HMO 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 HMO member by the non-HMO provider is deemed medically necessary, and coverage by the HMO is retroactive to the date of admission.

d. The HMO is financially liable for the member's court ordered evaluation and/or treatment when the HMO member is defending him/herself against a mental illness or substance abuse commitment:

1) If services are provided in the HMO facility; or

2) If the HMO approves provision in a non-contracted facility; or

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

4) If the HMO gives the county the name of an in-plan facility and the facility refuses to accept the member.

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

10. Institutionalized Individuals

a. Institutionalized Children

If inpatient or institutional services are provided in the HMO facility, or approved by the HMO for provision in a non-contracted facility, the HMO shall be financially liable for all children enrolled under this Contract for the entire period for which capitation is paid. The HMO 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.

b. Institutionalized Adults

The HMO is not liable for expenditures for any service to a person 21 to 64 years of age who is a resident of an institution for mental disease (IMD), except to the extent that expenditures for a service to an individual on convalescent leave from an IMD are reimbursed by FFS. If a person 21 to 64 years of age is in need of hospitalization for mental health or substance abuse issues, the HMO must make arrangements with a general acute care hospital to provide coverage.

11. Transportation Following Emergency Detention

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

12. Mental Health and/or Substance Abuse Exemptions

The BadgerCare Plus case head shall be given the option of disenrolling the member who meets one or more of the mental health and/or substance abuse criteria of this Contract, or applying to have the affected person remain in the FFS system. The same privilege applies to HMO members who are thought to meet one or more of the criteria defined in this Contract, at any point during the term of this Contract.

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

The HMO shall develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services to members. The HMO must work cooperatively with other community agencies, to treat mental health and/or substance abuse conditions as legitimate health care problems.

The HMO must make a good faith attempt to negotiate either an MOU or a contract with the counties in its service area. The MOU(s), contract(s) or written documentation of a good faith attempt must be available during the certification process and when requested by the Department. Failure of the HMO to have an MOU, contract or demonstrate a good faith effort, as specified by the Department, may result in the application by the Department of remedies as indicated in the Contract under Article XI.

MOUs must be signed every three years as part of certification. If no changes have occurred, or the MOU or contract automatically renew (is "evergreen"), then both the county and the HMO must sign off that no changes have occurred and documentation to this effect must be submitted to the Bureau of Benefits Management upon request.

MOUs and contracts should clearly indicate guidelines for sharing clinical data between the HMO and the organization in order to ensure proper coordination of services; billing and payment procedures for services provided; and appeal rights for those organizations that are Medicaid-certified providers.

G. Provider Appeals

1. The HMO must inform providers in writing (either electronically or hard copy) of the HMO's decision to pay or deny the original claim. HMOs who use the HIPAA 835 transaction set to notify providers of payment determination must include the below elements in their contract or MOU with providers or in their provider manual, or through written notification for non-contracted providers. Written notification of payment or denial must include the following information:

    a. A specific explanation of the payment amount or a specific reason for the nonpayment.

    b. A statement regarding the provider's rights to appeal to the HMO.

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

    d. An explanation of the process the provider should follow when appealing the HMO's decision to the HMO, which includes the following steps:

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

        2) Include the provider's name, date of service, date of billing, date of payment and/or nonpayment, member's name and Badger Care Plus ID number.

        3) Include the reason(s) the claim merits reconsideration.

        4) If the provider's complaint is medical (emergency, medical necessity and/or prior authorization), the HMO must indicate if medical records are required and need to be submitted with the appeal.

        5) Address the letter or form to the person and/or function at the HMO that handles provider appeals.

6) Send the appeal within 60 days of the initial denial or payment notice.

e. A statement advising the provider of the provider's right to appeal to the Department if the HMO fails to respond to the appeal within 45 days or if the provider is not satisfied with the HMO's response to the request for reconsideration. All BadgerCare Plus providers must appeal first to the HMO and then to the Department if they disagree with the HMO's payment or nonpayment of a claim. Appeals to the Department must be submitted in writing within 60 days of the HMO's final decision or, in the case of no response, within 60 days from the 45 day timeline allotted the HMO to respond. Providers must use the Department's form when submitting a provider appeal for State review and all elements of the form must be completed at the time the form is submitted (i.e. medical records for appeals regarding medical necessity).

The form is available at the following website:
http://dhs.wisconsin.gov/forms/F1/F12022.doc
Appeals to the Department must be sent to:

BadgerCare Plus
Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470
Fax Number: 608-224-6318

The HMO must include provider appeal procedures in their provider handbooks and incorporated into subcontracts with providers at the time of the next renewal.

2. The HMO must accept written appeals from providers submitted within 60 days of the HMO's initial payment and/or nonpayment notice. The HMO must respond in writing within 45 days from the date of receipt of the request for reconsideration. If the HMO fails to respond within 45 days, or if the provider is not satisfied with the HMO's response, the provider may seek a final determination from the Department.

3. In exceptional cases, the Department may override the HMO's time limit for the submission of claims and appeals. The Department will not exercise its authority in this regard unreasonably. The Department will accept written comments from all parties to the dispute prior to making a final decision. HMOs must return a copy of the Department's Request for Information letter with their response and any additional documentation to assist in the determination of the appeal.

The Department has 45 days from the date of receipt of all written comments to inform the provider and the HMO of the final decision. If

the Department's decision is in favor of the provider, the HMO will pay provider(s) within 45 days of receipt of the Department's final determination. The HMO must accept the Department's determinations regarding appeals of disputed claims.

4. The HMO must perform ongoing monitoring of provider appeals, and perform provider outreach and education on trends to prevent future denials/partial payments, thus reducing future provider appeals. The HMO must submit to the Department quarterly reports monitoring of provider appeals received and describe any interventions taken to address trends in appeal issues. HMOs are encouraged to resolve any informal appeals; however, the HMO must report on only those appeals received in writing. The Department will develop a report template for use by the HMOs to submit quarterly provider appeals monitoring reports.

   The Department will provide the HMO with data on provider appeals received by the Department and summarize trends in appeals, including data on numbers of appeals that were either overturned or upheld.

H. Provider Network and Access Requirements

The HMO must provide medical care to its BadgerCare Plus members that are as accessible to them, in terms of timeliness, amount, duration, and scope, as those services are to non-enrolled BadgerCare Plus members within the area served by the HMO.

1. Use of BadgerCare Plus Certified Providers

   Except in emergency situations, the HMO must use only providers who have been certified by the program for covered services. The Department reserves the right to withhold from the capitation payments the monies related to services provided by non-certified providers, at the FFS rate for those services, unless the HMO can demonstrate that it reasonably believed, based on the information provided by the Department, that the provider was certified by the program at the time the HMO reimbursed the provider for service provision. The Wis. Adm. Code, Ch. DHS 105, contains information regarding provider certification requirements. The HMO must require every physician providing services to members to have a Provider Number or National Provider Identifier (NPI).

2. Protocols/Standards to Ensure Access

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

The HMO's protocols must include training and information for providers in their network in order to promote and develop providers' skills in responding to the needs of persons with mental, physical and developmental disabilities. Training should include clinical and communication issues and the role of care coordinators.

For members, with special health care needs, where it has been determined to need a course of treatment or regular case monitoring, the HMO must have mechanisms in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.

The HMO must work collaboratively with the Department's patient navigator to support members who are pregnant in identifying an appropriate provider to meet their pregnancy needs.

3. Written Standards for Accessibility of Care

The HMO must have written standards for the accessibility of care and services. These standards must be communicated to providers and monitored by the HMO. The standards must include the following:

- Waiting times for care at facilities;
- Waiting times for appointments:
- Statement that providers' hours of operation do not discriminate against BadgerCare Plus members; and
- Whether or not provider(s) speak the member's language.

The HMO's standards for waiting times for appointments must be as follows for the indicated provider types:

- To be no longer than 14 days for an appointment with a PCP;
- To be no longer than 10 days for an appointment with a Mental Health provider to receive an initial assessment. The Department encourages the wait time for this type of appointment to be no longer than 5 days; and
- To be no longer than 7 days in CY 2010 and CY 2011, 5 days in CY 2012, and 3 days in CY 2013 for an appointment with a Mental Health provider for members who are discharged from an inpatient psychiatric hospital stay.

- To be no longer than 90 days for an appointment with a dental provider for a routine dental appointment.

The HMO must submit to the Department annually as part of its Annual Performance Report its minimum standards for waiting times for care and waiting time for appointments for PCPs, ob-care providers, pediatricians, mental health providers, and the following specialties. These minimum requirements shall not release the HMO from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members. These specialties are not meant to be a comprehensive list, and the HMO may submit additional standards for specialties not included in this list:

- Allergy & Immunology
- Cardiovascular Disease
- Dermatology
- Gastroenterology
- General Surgery
- Nephrology
- Neurological Surgery
- Neurology
- Nuclear Medicine
- OB/GYN
- Oncology and Hematology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Physical Medicine and Rehab
- Proctology
- Psychiatry
- Pulmonary Disease
- Thoracic and Cardiovascular Surgery
- Urology

4. Monitoring Compliance

The HMO must submit to the Department as part of its Annual Performance Report a template to be provided by the Department that will track actual waiting times for appointments and care. The HMO shall conduct surveys and site visits to monitor compliance with standards for waiting times for care and waiting time for appointments and shall include these findings in the report, as well as the corrective action it will take so that providers meet the HMO's standards and improve access for BadgerCare Plus members. The Department will investigate complaints received of HMOs that exceed standards for waiting times for care and waiting time for appointments.

5. Access to Selected BadgerCare Plus Providers and/or Covered Services

a. Dental Providers

The HMO must have a dental provider within a 20-mile distance from any member residing in the HMO service area or no further than the distance for non-enrolled members residing in the service area. If there is no certified provider within the specified distance, the travel distance shall be no more than for a non-enrolled member. The HMO must also consider whether the dentist accepts new patients, and whether full or part-time coverage is available.

b. Mental Health or Substance Abuse Providers

The HMO must have a mental health or substance abuse provider within a 35-mile distance from any member residing in the HMO service area or no further than the distance for non-enrolled members residing in the service area. If there is no certified provider within the specified distance, the travel distance shall be no more than for a non-enrolled member. The HMO must also consider whether the providers accept new patients, and whether full or part-time coverage is available.

c. High Risk Prenatal Care Services

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

d. HMO Referrals to Out-of-Network Providers for Services

The HMO must provide adequate and timely coverage of services provided out of network, when the required medical service is not available within the HMO network. The HMO must coordinate with out-of-network providers with respect to payment and ensure that cost to the member is no greater than it would be if the services were furnished within the network (42 CFR. §. 438.206(b) (v) (5)).

e. Primary Care Providers

The HMO may define other types of providers as primary care providers. If they do so, the HMO must define these other types of primary care providers and justify their inclusion as primary care providers during the pre-contract review phase of the HMO certification process.

The HMO must have a certified primary care provider within a 10-mile distance from any member residing in the HMO service area in the cities of Milwaukee, Racine, and Kenosha, and 20-mile distance for the remainder of the HMO's service area, unless there is no certified provider within the specified distance. In that case, the travel distance shall be no more than for a non-enrolled member. A service area for the HMO will be specified down to the zip code. Therefore, all portions of each zip code in the HMO service area in the cities of Milwaukee, Racine and Kenosha must be within 10 miles from a certified primary care provider, and all portions of each zip code in the remainder of the HMO's service area must be within 20 miles from a certified primary care provider

This access standard does not prevent a member from choosing an HMO when the member resides in a zip code that does not meet the above distance standard. However, the member will not be automatically assigned to that HMO. If the member has been assigned to the HMO or has chosen the HMO and becomes dissatisfied with the access to medical care, the member may disenroll from the HMO because of distance.

f. Second Medical Opinions

The HMO must, upon member request, provide members the opportunity to have a second opinion from a qualified network provider, subject to referral procedures approved by the Department. If an appropriately qualified provider is not available within the network, the HMO must arrange for a second opinion outside the network at no charge to the member.

g. Women's Health Specialists

In addition to a primary care provider a female member may have a women's health specialist. The HMO must provide female members with direct access to a women's health specialist within the network for covered women's routine and preventive health care services.

h. Urgent Care Centers or Walk-in Clinics

The HMO must include in its network urgent care centers, walk-in clinics, or other medical facilities. A hospital emergency department may not serve to meet this requirement. A physician's office may serve as such a facility as long as it meets all of the below criteria.

The HMO must include an urgent care center or walk-in clinic that are available to members no less than 11 hours each day Monday

through Friday, and no less than 5 hours each day on Saturday and Sunday. The centers or clinics must be within a 10-mile distance from any member residing in the HMO service area, unless there is no such clinic within the specified distance. In that case, the travel distance shall be no more than for a non-enrolled member. All urgent care centers and walk-in clinics do not have to be open for extended hours or weekends, but there shall be at least one such clinic that is open within 10 miles from each member for the specified amount of time each day.

All urgent care centers and walk-in clinics must meet the following requirements to be counted towards the geographic requirements:

- Facility must accept and advertise that walk-in appointments are accepted; and
- The following must be available during all hours the facility is open to see patients:
  - X-ray on site
  - Phlebotomy services on site
  - Appropriately licensed providers are on site with the resources to:
    - Obtain and read an EKG and X-ray on site
    - Administer PO, IM and IV medication/fluids on site
    - Perform minor procedures (ex. sutures, splinting) on site
  - The following equipment and staff trained in its use:
    - Automated external defibrillator (AED)
    - Oxygen, ambu-bag/oral airway
  - At least two exam rooms.

The HMO must include the hours for each urgent care or walk-in clinic listed in its network, and must include them in their Online Provider Directory.

i. Hospitals

The HMO must include a sufficient supply of hospitals in its network so that the following requirements are met:

1. The HMO must include a non-specialized hospital within a 20-mile distance from any member residing in the HMO service area. If there is no such hospital within the specified distance, the travel distance shall be no more than for a non-enrolled member.

2. The HMO must maintain a network so that the ratio of non-specialized hospital beds to Member Years (member months / 12) does not exceed a ratio of 1:50.

As it applies to this requirement, the Department defines a hospital specializing in Pediatrics as a *non-specialized* hospital. In all other instances, the Department defines a non-specialized hospital as one which is not exclusive to a single category of service or specialty including, but not limited to, behavioral health, cardiology or orthopedics.

The Department will calculate the number of hospital beds per hospital using the Department of Health Services Division of Quality Assurance Hospital Provider Directory: http://dhs.wisconsin.gov/bqaconsumer/HealthCare/HospitalCty.pdf .

6. Network Adequacy Requirements

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

a. The anticipated BadgerCare Plus enrollment.

b. The expected utilization of services, considering member characteristics and health care needs.

c. The number and types of providers (in terms of training experience and specialization) required to furnish the Contracted services.

d. The number of network providers not accepting new patients.

e. The geographic location of providers and members, distance, travel time, normal means of transportation used by members and whether provider locations are accessible to members with disabilities.

The HMO must provide written documentation supporting and assurance of the above network adequacy criteria as required by the Department for pre-contract certification and as part of the HMO's Annual Performance Report.

The HMO must also submit an updated provider network and facility file to the State's FTP server monthly, and notify the appropriate Managed Care Contract Compliance Analyst when there has been a significant change with respect to network adequacy, as defined by the Department, in the HMO's operations that would affect adequate capacity and services,

including changes in HMO benefits, geographic service areas, provider network, payments, or enrollment of a new population into the HMO. (42 CFR, §. 438.207(c)(2)(i-ii))

7. Provider to Member Ratio Requirements

The HMO must maintain a provider network so that the ratio of provider to Member Years (member months / 12) does not exceed the ratios for the corresponding provider types in the table following. For this purpose, primary care provider is defined as Physicians with Family Practice, General Practice, Internal Medicine, Ob/Gyn and Pediatric specialties, as well as Nurse Practitioners and Physician Assistants. If an HMO does not recognize one of the provider types listed in the previous sentence as a primary care provider, providers affiliated with that type will be excluded from the HMO's primary care provider to member ratio calculation.

Provider Type	Provider to Member Ratio
Primary Care Provider	1:100
Allergy	1:5,000
Cardiovascular Disease	1:1,000
Dentist	1:1,600
Dermatology	1:4,200
ENT – Otorhinolaryngology	1:1,800
Gastroenterology	1:1,400
General Surgery	1:1,000
Nephrology	1:3,000
Neurological Surgery	1:4,500
Neurology	1:1,500
Oncology & Hematology	1:1,600
Ophthalmology	1:1,400
Orthopedic Surgery	1:1,400
Physical Medicine & Rehab	1:2,200
Psychiatry	1:900
Pulmonary Disease	1:2,000
Thoracic and Cardiology Surgery	1:3,500
Urology	1:3,000

8. Provider Network Quality Assurance Monitoring

The HMO must describe in its annual report to the Department its strategy to ensure quality throughout its provider network in the HMO's effort to meet and exceed the Department's quality benchmarks indicated in Add. VI. The HMO must include data at the provider level on its network's performance demonstrating that members are receiving high-quality

services from providers. If the HMO is not reaching the Department's quality benchmarks, it must include the corrective action that it is taking.

9. Use of Non-Medicaid Providers

Effective February 1, 2008, the Department deems any WIC project that has a contract with the Department's Division of Public Health to be a certified provider for purposes of blood lead testing (and related services such as brief office visit, lab handling fee, etc.) only. The HMO may enter into a contract or MOU with such a WIC project and will directly reimburse the WIC project for those services.

10. Online Provider Directory

The HMO must post a provider directory on their website for members, network providers, and the Department to access. The information in the directory must be consistent with the information contained in the Extensible Markup Language (XML) provider file submitted to the Department on a monthly basis, and include, at a minimum, the following information:

- Provider name;
- Address;
- Specialty;
- If they provide services to children;
- Languages spoken; and
- If they are accepting new patients.

I. Responsibilities to Members

1. Advocate Requirements

The HMO must employ a BadgerCare Plus HMO Advocate(s) during the entire contract term. The HMO Advocate(s) must work with both members and providers to facilitate the provision of benefits to members. The advocate is responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. The advocate position must be in an organizational location within the HMO that provides the authority needed to carry out these tasks. The detailed requirements of the HMO Advocate are listed below:

a. Functions of the BadgerCare Plus HMO Advocate(s)

1) Investigate and resolve access and cultural sensitivity issues identified by HMO staff, State staff, providers, advocate organizations, and members.

2) Monitor formal and informal grievances with the grievance personnel for purposes of identification of trends or specific problem areas of access and care delivery. The monitoring function includes ongoing participation in the HMO grievance committee.

3) Recommend policy and procedural changes to HMO management including those needed to ensure and/or improve member access to and quality of care. The recommended changes can be for both internal administrative policies and subcontracted providers.

4) Act as the primary contact for member advocacy groups. Work with member advocacy groups on an ongoing basis to identify and correct member access barriers.

5) Act as the primary contact for local community based organizations (local governmental units, non-profit agencies, etc.). Work with the local community based organizations on an ongoing basis to acquire knowledge and insight regarding the special health care needs of members.

6) Participate in the Department's advocacy program for Managed Care. Such participation includes working with DHCAA Managed Care staff assigned to the HMO on issues of access to medical care, quality of medical care, and working with the enrollment specialist, ombudsmen, and the Department's approved external advocate on issues of access to medical care, quality of medical care, and enrollment and disenrollment.

7) Analyze on an ongoing basis internal HMO system functions that affect member access to medical care and quality of medical care.

8) Organize and provide ongoing training and educational materials for the HMO staff and providers to enhance their understanding of the values and practices of all cultures with which the HMO interacts.

9) Provide ongoing input to the HMO management on how changes in the HMO provider network will affect member access to medical care and member quality and continuity of care. Participate in the development and coordination of plans to minimize any potential problems that could be caused by provider network changes.

10) Review and approve the HMO's informing materials to be distributed to members to assess clarity and accuracy.

11) Assist members and their authorized representatives for the purpose of obtaining their medical records.

12) The lead advocate position is responsible for overall evaluation of the HMO's internal advocacy plan and is required to monitor any contracts the HMO may enter into for external advocacy with culturally diverse associations or agencies. The lead advocate is responsible for training the associations or agencies and ensuring their input into the HMO's advocacy plan.

b. Staff Requirements and Authority of the BadgerCare Plus HMO Advocate

At a minimum, the HMO must have one HMO Advocate for every 10,000 members. The advocate(s) must be located in the organizational structure so that they have the authority to perform the functions and duties listed in Section 1, a, 1)-12) above.

The HMO certification application requires the HMO to state the staffing levels to perform the functions and duties listed in Subsection 1, a, 1)-12) above in terms of number of full and part time staff and total full time equivalents (FTEs) assigned to these tasks. The Department assumes that an HMO acting as an Administrative Service Organization (ASO) for another HMO will have at least one advocate or FTE position for each ASO contract as well as maintain their own internal advocate(s). The HMO must consider and monitor current enrollment levels when evaluating the number of advocates necessary to meet the needs of members. The HMO may employ less than a FTE advocate position, but must justify to the satisfaction of the Department why less than one FTE position will suffice for the HMO's member population. The HMO must also regularly evaluate the advocate position, work plan(s), and job duties and allocate an additional FTE advocate position or positions to meet the duties listed in Subsection 1, a, 1)-12) above if there is significant increase in the HMO's member population or in the HMO service area. The HMO is required to report out to the Department annually as part of its Annual Performance Report the results of the evaluation conducted and any corrective action taken in response. The Department reserves the right to require the HMO to employ an FTE advocate position if the HMO does not demonstrate the adequacy of a part-time advocate position.

In order to meet the requirement for the advocate position statewide, the Department encourages the HMO to contract or have a formal memorandum of understanding for advocacy and/or translation services with associations or organizations that have culturally diverse populations within the HMO service area. However, the overall or lead responsibility for the advocate position must be within each HMO. The HMO must monitor the effectiveness of the associations and agencies under contract and may alter the Contract(s) with written notification to the Department.

2. Advance Directives

The HMO must maintain written policies and procedures related to advance directives. (Written information provided must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.) An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated. The HMO must:

a. Provide written information at the time of HMO enrollment to all adults receiving medical care through the HMO regarding:

1) The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and

2) The individual's right to file a grievance with the Department of Health Services, Division of Quality Assurance, regarding noncompliance with advance directive requirements. If requested, assist the member in filing a grievance with the Division of Quality Assurance regarding noncompliance with advance directive requirements; and

3) The HMO's written policies respecting the implementation of such rights.

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

c. Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be

construed as requiring the provision of care which conflicts with an advance directive.

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

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

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

3. Primary Care Provider Assignment

The HMO must have a process in place to assign each BadgerCare Plus member to a PCP, including a defined method to notify the member of such an assignment.

a. HMO PCP assignment strategy

The strategy the HMO uses to assign members to a PCP must take into account the health care needs of the member. In particular, for those members with chronic conditions including but not limited to those listed below, HMOs are to take additional steps to ensure these members are assigned a primary care provider that can appropriately address their condition as well as ensure the member receives coordinated care to help manage the condition. Depending on the condition, the primary care provider may be a specialist. The specific chronic conditions for adults include, but are not limited to:

- Diabetes
- Asthma
- COPD
- Congestive heart failure
- Behavioral health/mental illness

And for children include, but are not limited to:

- Diabetes
- Asthma
- Behavioral health/mental illness

HMOs must ensure members are assigned a PCP that provides culturally appropriate care. Specifically, the provider must be able

to relate to the member and provide care with sensitivity, understanding, and respect for the member's culture.

As part of the PCP assignment strategy, HMOs must include the following:

i. A process for assigning all members to a PCP, including a step in which members are given the opportunity to choose their PCP.

ii. A plan to identify members with the above chronic conditions, as well as multiple chronic conditions. The plan for identifying these members should include the use of specific clinical guidelines and decision making tools.

iii. For members with chronic conditions:

1. Process for assigning members to an appropriate primary care provider (or specialist) and ensuring care will be coordinated between primary care provider and specialists.
2. A plan to ensure members have at least 2 visits with their primary care provider per year related to their condition.
3. A process for ensuring a patient-centered and comprehensive treatment plan is developed between a member and their assigned primary care physician. The plan must include a self-care component, a plan to treat co-morbidities if present, a process of coordinating care among multiple providers if needed, and a strategy to ensure that the member complies with that plan.

iv. Communication methods that notify members of their PCP, ensure the member utilizes their primary care provider, and encourages members to keep their scheduled appointments.

v. How the HMO will evaluate the effectiveness of their primary care provider assignment strategy. The HMO must include in their evaluation of how the strategies affected:

1. The quality of care members received
2. Members compliance with their primary care provider assignment
3. Members who do not show up for their scheduled appointments
4. Members who receive care through their primary care provider versus through the emergency department.

b. Changing and lock-in PCP assignments

The HMO must permit members to change primary providers at least twice in any year, and to change primary providers more often than that for just cause, just cause being defined as lack of access to quality, culturally appropriate, health care. Such just cause will be handled as a formal grievance. If the HMO has reason to lock in a member to one primary provider in cases of difficult case management, the HMO must submit a written request in advance of such lock-in to the Department's Bureau of Enrollment Management.

c. Data sharing with PCP

The HMO must provide information on members to their assigned primary care provider on a monthly basis. The information must include, but is not limited to, utilization data and prescription drug data such as from the pharmacy extract provided by the Department.

The HMO must submit to the Department by September 15, 2010 a plan for how it plans to fulfill this requirement including when the HMO will disseminate this information to PCPs, how the PCPs will access this information, and what will be included in the information given. The HMO must solicit feedback from PCPs periodically on this plan and incorporate their feedback.

d. PCP assignment reporting

The HMO must submit a data file monthly according to the schedule listed in Art. VII, K to the Department that documents which PCP each member is assigned to for the proceeding month. The file must be submitted in the format designated by DHS. If the member was assigned to a certain PCP because of their chronic disease, it must be noted in the file. The file must include:

- Provider Medicaid ID number
- Provider name
- Provider address
- Provider county
- Provider specialty
- Member ID
- Member county
- Chronic disease that assignment was based on (if applicable)

e. Department review

The Department will review the HMO's PCP assignment strategy as part of its assessment of the HMO's Annual Performance Report. If the HMO fails to meet the quality performance measures outlined in Add. VI, the Department may modify the HMO's PCP assignment strategy which the HMO must implement within three months.

4. Member Appointment Compliance

The HMO must have a strategy in place to reduce the number of members who do not show up for scheduled appointments. This strategy must include outreach and education components to both members and providers. The HMO must report annually to the Department on the effectiveness of this strategy and any corrective action taken.

5. Coordination and Continuation of Care

Have a system in place for the HMO to ensure well-managed patient care, including at a minimum:

a. Management and integration of health care through primary provider/gatekeeper/other means.

b. Systems to ensure referrals for medically necessary, specialty, secondary and tertiary care.

c. Systems to ensure provision of care in emergency situations, including an education process to ensure that members know where and how to obtain medically necessary care in emergency situations.

d. Systems that clearly specify referral requirements to providers and subcontractors. The HMO must keep copies of referrals (approved and denied) in a central file or the patient's medical records.

e. Systems to ensure the provision of a clinical determination of the medical necessity and appropriateness of the member to continue with mental health and substance abuse providers who are not subcontracted with the HMO. The determination must be made within 10 business days of the member's request. If the HMO determines that the member does not need to continue with the non-contracted provider, it must ensure an orderly transition of care.

f. Coordinate the services the HMO furnishes to the member with the services the member receives from any other provider of health care or insurance plan.

g. Share with other HMOs serving the member, results of its identification and assessment of any member with special health care needs so that those activities need not be duplicated.

6. Conversion Privileges

The HMO must offer any member covered under this Contract, whose enrollment is subsequently terminated due to loss of BadgerCare Plus eligibility, the opportunity to convert to private insurance without underwriting. The time period for conversion following BadgerCare Plus termination notice must comply with Wis. Stats. 632.897 regarding conversion rights.

7. Cultural Competency

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

a. Recognizing members' beliefs,

b. Addressing cultural differences in a competent manner, and

c. Fostering in its staff and providers behaviors that effectively address interpersonal communication styles that are sensitive, understanding, and respectful of members' cultural backgrounds.

The HMO must have specific policy statements on these topics and communicate them to subcontractors. The HMO must have a process in place for evaluating the effectiveness of its strategy for addressing the special health needs of members needing specific culturally competent services. The HMO must report to the Department annually as part of its Annual Performance Report on the results of the evaluation and any corrective action taken in response to the results.

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

care, and the Department may, pursuant to such a grievance, permit a member to disenroll from that HMO and enroll into another HMO.

8. Member Handbook, Education and Outreach for Newly Enrolled Members

a. Within 10 days of initial enrollment notification to the HMO, annually thereafter and whenever requested by member, guardians or authorized representatives, provide a member handbook written at a sixth grade reading comprehension level and which at a minimum will include information about:

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

2) Information on contract services offered by the HMO.

3) Location of facilities.

4) Hours of service.

5) Informal and formal grievance procedures, including notification of the member's right to a fair hearing.

6) Grievance appeal procedures.

7) HealthCheck.

8) Family planning policies.

9) Policies on the use of emergency and urgent care facilities.

10) Providers and whether the provider is accepting new "members." Additionally, include languages spoken by the provider. Members must be informed of the HMO's online provider directory.

11) Changing HMOs.

Handbooks must be mailed to each case head, but HMOs may choose to mail to each individual member. HMOs must post their current BadgerCare Plus member handbooks and provider directories on their website; however, the HMO must mail a hard copy to the case head or member annually or provide an electronic copy of the handbook and directory to members who have requested this option.

b. As needed the HMO must provide periodic updates to the handbook and explain changes to the information listed above. Such changes must be approved by the Department prior to printing.

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

d. Member handbooks (or other substitute member information approved by the Department that explains the HMO's services and how to use the HMO) must be made available upon request within a reasonable timeframe in at least: Spanish, Russian, and Hmong if the HMO has members who are conversant only in those languages. The handbook must tell members how to obtain a copy of the handbook in those languages. The Department will translate the standard handbook language into the three specified languages. The HMO may use the translated standard handbook language as appropriate to its service area. However, the HMO must have local resources review the final handbook language to ensure that the appropriate dialect(s) is/are used in the standard translation. The HMO must also arrange for translation into any other dialects appropriate for its members. The HMO also must arrange for the member handbook to be provided in Braille, larger fonts, or orally translated for its visually limited members.

e. The HMO may create member handbook language that is simpler than the standard language, but the language must be approved by the Department. The HMO must also independently arrange for the translation of any non-standard language.

f. The HMO must submit their member handbook for review and approval as part of the certification process and no more than 60 days of signing the Contract for 2010-2013.

g. Standard language on several subjects, including HealthCheck, family planning, grievance and appeal rights, conversion rights, and emergency and urgent care, must appear in all handbooks. Any exceptions to the standard must be approved in advance by the Department, and will be approved only for exceptional reasons. If the standard language changes during the course of the Contract period, due to changes in federal or state laws, rules or regulations, the HMO must insert the new language into the member handbooks as of the effective date of any such change.

h. In addition to the above requirements for the member handbook, the HMO must perform other education and outreach activities for newly enrolled members. The HMO must submit to the

Department for prior written approval an education and outreach plan targeted towards newly enrolled members. The outreach plan will be examined by the Department during pre-contract review and on an annual basis. Newly enrolled members are listed as "ADD-New" on the enrollment reports. The plan must identify at least two educational/outreach activities the HMO will undertake to tell new members how to access services within the HMO network. The plan must include the frequency (i.e., weekly, monthly, etc.) of the activities, the person within the HMO responsible for the activities, and how the activities will be documented and evaluated for effectiveness.

i. With Department approval, HMOs may send member handbooks, provider directories, newsletters, and other new member information (which does not contain PHI) electronically to members that provide an e-mail address to the HMO, provided the HMO meets the timeframes above regarding distribution of member handbooks. HMOs may also choose to send the annual materials electronically to members that have provided an e-mail address. HMOs must document these plans in the Member Outreach and Communication Plan submitted to the Department for approval.

9. Provider Directory

The HMO must post the provider directory on their website for members to access. The information in the directory must be consistent with the information contained in the XML file submitted to the Department on a monthly basis, and include the following information:

- Provider name;
- Address;
- Specialty;
- If they provide services to children;
- Languages spoken; and
- If they are accepting new patients.

10. Health Education and Disease Prevention

The HMO must inform all members of ways they can maintain their own health and properly use health care services.

The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The program must include:

a. An individual responsible for the coordination and delivery of services.

b. Information on how to obtain these services (locations, hours, telephone numbers, etc.).

c. Health-related educational materials in the form of printed, audiovisual, and/or personal communication.

Health-related educational materials produced by the HMO must be at a sixth grade reading comprehension level and reflect sensitivity to the diverse cultures served. Also, if the HMO uses material produced by other entities, the HMO must review these materials for grade level comprehension and sensitivity to the diverse cultures served. Finally, the HMO must make all reasonable efforts to locate and use culturally appropriate health-related material.

d. Information on recommended check ups and screenings, and prevention and management of disease states that affect the general population. This includes specific information for persons who have or who are at risk of developing such health problems as hypertension, diabetes, STD, asthma, breast and cervical cancer, osteoporosis and postpartum depression.

e. Health education and disease prevention programs, including injury control, family planning, teen pregnancy, sexually transmitted disease prevention, prenatal care, nutrition, childhood immunization, substance abuse prevention, child abuse prevention, parenting skills, stress control, postpartum depression, exercise, smoking cessation, weight gain and healthy birth, postpartum weight loss, and breast feeding promotion and support. (Note: Any education and prevention programs for family planning and substance abuse would supplement the required family planning and substance abuse health care services covered by BadgerCare Plus.)

f. Promotion of the health education and disease prevention programs, including use of languages understood by the population served, and use of facilities accessible to the population served.

g. Information on and promotion of other available prevention services offered outside of the HMO, including child nutrition programs, parenting classes, programs offered by local health departments and other programs.

h. Systematic referrals of potentially eligible women, infants, and children to the Special Supplemental Nutrition Program for

Women, Infants, and Children (WIC) and relevant medical information to the WIC program. More information about the WIC program as well a list of the local WIC agencies can be found on the WIC website (http://www.dhs.wi.gov/wic/).

11. Interpreter Services

The HMO must provide interpreter and sign language services free of charge for members as necessary to ensure availability of effective communication regarding treatment, medical history or health education and/or any other component of this Contract. The HMO must:

a. Offer an interpreter, including a sign language interpreter, in all crucial situations requiring language assistance as soon as it is determined that the member is of limited English proficiency.

b. Provide 24-hour a day, seven days a week access to interpreter and sign language services in languages spoken by those individuals eligible to receive the services provided by the HMO or its providers.

c. Provide an interpreter in time to assist adequately with all necessary care, including urgent and emergency care, when a member or provider requests interpreter services in a specific situation where care is needed. The HMO must clearly document all such actions and results. This documentation must be available to the Department upon request.

d. Use professional interpreters, as needed, where technical, medical, or treatment information or other matters, where impartiality is critical, are to be discussed or where use of a family member or friend, as interpreter is otherwise inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

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

f. Designate a staff person to be responsible for the administration of interpreter/translation services.

g. Receive Department approval of written policies and procedures for the provision of interpreter services.

As part of the certification application, the HMO must submit the policies and procedures for interpreters, a list of interpreters the HMO uses, and

the language spoken by each interpreter. The HMO must also submit, as part of certification, its policy on provision of auxiliary aids to hearing-impaired members. The policy must include a description of the HMO's process for assessing the preferred method of communication of each hearing-impaired member. The HMO must offer each hearing-impaired member the type of auxiliary aid(s) s/he prefers in order to access program services and benefits. Once the hearing-impaired member identifies the type of auxiliary aid(s) s/he prefers, a less effective form of communication may not be used. For example, a person who can most effectively communicate in sign language may not be required to communicate using hand written notes.

J. Billing Members

For BadgerCare Plus any provider who knowingly and willfully bills a BadgerCare Plus member for a covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1) [42 U.S.C. 1320a-7b] of the Social Security Act and Wis. Stats. 49.49(3m). This provision shall continue to be in effect even if the HMO becomes insolvent.

However, if a member agrees in advance in writing to pay for a service not covered by BadgerCare Plus, then the HMO, HMO provider, or HMO subcontractor may bill the member. The standard release form signed by the member at the time of services does not relieve the HMO and its providers and subcontractors from the prohibition against billing a member in the absence of a knowing assumption of liability for a non-BadgerCare Plus covered service. The form or other type of acknowledgment relevant to a member's liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus.

The HMO and its providers and subcontractors must not bill a BadgerCare Plus member for medically necessary covered services provided during the member's period of HMO enrollment, except for allowable co-payments and premiums established by the Division of Health Care Access and Accountability (DHCAA) for covered services provided during the member's period of enrollment in BadgerCare Plus.

K. HealthCheck

1. HMO Responsibilities

   a. Provide Comprehensive HealthCheck services as a continuing care provider, and according to policies and procedures in Wisconsin Health Care Programs Online Handbook related to covered services.

   b. Provide Comprehensive HealthCheck screens upon request. The HMO must provide a HealthCheck screen within 60 days (if a screen is due according to the periodicity schedule) for members over one year of age for which a parent or guardian of a member requests a Comprehensive HealthCheck screen. If the screen is not due within 30 days, then the HMO must schedule the appointment in accordance with the periodicity schedule.

      The HMO must provide a Comprehensive HealthCheck screen within 30 days (if a screen is due according to the periodicity schedule) for members up to one year of age for which a parent or guardian of a member requests a Comprehensive HealthCheck screen. If the screen is not due within 30 days, then the HMO must schedule the appointment in accordance with the periodicity schedule.

   c. Provide Comprehensive HealthCheck screens at a rate equal to or greater than 80% of the expected number of screens. Comprehensive HealthCheck screen for children through two years of age generally include both Blood Lead Toxicity testing and age appropriate immunizations.

   d. The rate of Comprehensive HealthCheck screens will continue to be determined by the calculation in the HealthCheck Worksheet (Addendum IV, G). Comprehensive HealthCheck data provided by the HMO must agree with its medical record documentation. For the purpose of the HealthCheck recoupment process, the Department will not include any additional HealthCheck encounter records that are received after January 16 for the year under consideration. (Please note: This date marks the end of the twelve and one half month period of time from the end of the year under consideration. For example, for dates of service in 2010 the cut-off date will be January 16, 2012).

2. Department Responsibilities

a. The Department will pay HMOs in its capitation rates assuming 80% of screens are complete, and recoup funds if HMO does not meet 80% goal.

b. The HealthCheck worksheet is provided in Addendum IV, G.

L. Marketing Plans and Informing Materials

1. Approval of Member Communication Plans and Outreach Plans

The HMO is required to submit a member communication plan and an outreach plan to the Department. The member communication plan and the outreach plan must describe the HMO's timeline and process for distributing outreach and member communication materials, including materials posted to the HMO's website or distributed electronically. The HMO must also specify the format of its member communication and outreach materials (mailings, radio, TV, billboards, etc.) and its target population or intended audience. All member communication and outreach plans must be prior approved by the Department. The HMO shall submit a description of its member communication plan and outreach plan it or its subcontractors plan to implement to the Department for review as part of its pre-contract review and then annually as part of its Annual Performance Report. The Department will review/approve the plans within 30 days. The HMO may make changes to its member communication and outreach plan throughout the year. Any significant changes to previously approved member communication or outreach plans must be submitted to the Department for review.

2. Review of Member Communication and Outreach Materials

The Department will review all member communication and outreach materials that are part of the HMO's plan as follows:

a. The Department will review and either approves, approve with modifications, or disapprove all member communication materials and outreach materials within ten business days, except Member Handbooks, which will be reviewed within 30 days. If the HMO does not receive a response from the Department within the prescribed time frame, the HMO should contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within two business days of this contact.

b. Time-sensitive member communication materials and outreach materials must be clearly marked time-sensitive by the HMO and

will be approved, approved with modifications, or disapproved by the Department within three business days. The Department reserves the right to determine whether the materials are indeed time-sensitive. If the HMO does not receive a response from the Department within three business days, the HMO must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within one business day of this contact.

c. The Department will not approve any materials that are confusing, fraudulent or misleading, or that do not accurately reflect the scope, philosophy, or covered benefits of the BadgerCare Plus programs.

d. The HMO must correct any problems and errors the Department identifies. The HMO agrees to comply with Ins. 6.07 and 3.27, Wis. Adm. Code, and practices consistent with the Balanced Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [42 U.S.C. 1396v(d)(2)].

Educational materials prepared by the HMO or by their contracted providers and sent to the HMO's entire membership (i.e. Medicare, BadgerCare Plus, Medicaid SSI, and commercial members) do not require the Department's approval, unless there is specific mention of BadgerCare Plus. Educational material prepared by outside entities (i.e., the American Cancer Society, the Diabetic Association, etc.) does not require the Department's approval.

3. Allowable Member Communication and Outreach Practices

HMOs are required to distribute member communication materials to BadgerCare Plus managed care members. Member communication requirements are detailed in Article III, Section I "Responsibilities to Members."

Member communication materials should be designed to provide the members with clear and concise information about the HMO's program, the HMO's network, and the BadgerCare Plus program. All member communication materials must be written at a sixth-grade comprehension level. Member communication materials must be made available in at least Spanish, Russian, and Hmong if the HMO has members that are conversant only in those languages. The HMO must also arrange for translation into any other dialects appropriate for its members.

The HMO shall also be allowed to perform the following outreach and member communication activities and distribute the following materials:

a. Make available brochures and display posters at provider offices and clinics that inform patients that the clinic or provider is part of the plan's provider network, provided that all plans in which the provider participates have an equal opportunity to be represented. Examples include posters/brochures that read "BadgerCare Plus Members Accepted Here" or "BadgerCare Plus Participating Health Plan."

b. Inform the public with a general health message which may utilize the BadgerCare Plus program's logo or the HMO's logo.

c. Attend activities that benefit the entire community, such as health fairs or other health education and promotion activities.

d. Offer nominal gifts (less than $5 value) for potential members at health fairs.

e. Offer gifts (valued $5-$25) to current members as incentives for a quality improvement strategy.

f. Make telephone calls, mailings, and home visits only to members currently enrolled in the HMO, for the sole purpose of educating them about services offered by or available through the HMO.

g. Include a 1-page flyer approved by the Department in the HMO enrollment materials sent by the Department to newly enrolled BadgerCare Plus members.

h. Anything else approved by the Department.

Should the HMO distribute outreach materials, it shall distribute the materials to its entire service area.

4. Prohibited Activities

HMOs are prohibited from marketing to potential BadgerCare Plus managed care members and BadgerCare Plus members who are not the HMO's members, except in regards to 1-page flyer included in HMO enrollment materials as indicated above. The Department defines "marketing" as any unsolicited contact by the HMO, its employees, affiliated providers, subcontractors, or agents with a potential member, other than as permitted in 3., above, for the purpose of persuading such persons to enroll with the health plan or to disenroll from another health plan.

HMOs are prohibited from:

a. Direct and indirect cold calls, either door-to-door or via telephone with potential members.

b. Practices that seek to influence enrollment in conjunction with the sale of any other insurance product.

c. Offer of material or financial gain to potential members as an inducement to enroll.

d. Advertising of non-mandated services (e.g. waiving co-pays).

e. Materials which contain the assertion that the client must enroll in the HMO in order to obtain benefits or avoid losing benefits.

f. Practices that are discriminatory.

g. Activities and materials that could mislead, confuse, or defraud members or potential members or otherwise misrepresent the HMO, its marketing representatives, the Department, or CMS..

h. Materials that contain false information.

i. Practices that are reasonably expected to have the effect of denying or discouraging enrollment.

5. The HMO Agreement to Abide by Member Communication/Informing Criteria

The HMO agrees to engage only in member communication and outreach activities and distribute only those materials that are pre-approved in writing. The HMO that fails to abide by these requirements may be subject to sanctions. In determining any sanctions, the Department will take into consideration any past unfair member communication, or marketing practices, the nature of the current problem, and the specific implications on the health and well being of members. In the event that the HMO's affiliated provider fails to abide by these requirements, the Department will evaluate if it was reasonable for the HMO to have had knowledge of the member communication or marketing issue and the HMO's ability to adequately monitor ongoing future member communication or marketing activities of the subcontractors.

Any HMO that engages in marketing or that distributes materials without prior approval by the DHS may be subject to:

a. Immediate retraction of materials

b. Sanctions detailed in Article XI.

M. Reproduction/Distribution of Materials

Reproduce and distribute at the HMO's expense, according to a reasonable Department timetable, information or documents sent to the HMO from the Department that contains information the HMO-affiliated providers must have in order to fully implement this Contract.

N. HMO ID Cards

The HMO may issue its own HMO ID cards. The HMO may not deny services to a member solely for failure to present the HMO issued ID card. The ForwardHealth cards will always determine the HMO enrollment, even where the HMO issues HMO ID cards.

O. Open Enrollment

During the continuous open enrollment period the HMO shall accept members eligible for coverage under this Contract, in the order in which they are enrolled. The HMO will not discriminate against individuals eligible to enroll on the basis of race, color, national origin or health status and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin or health status.

P. Selective Reporting Requirements

1. Communicable Disease Reporting

   As required by Wis. Stats. 252.05, 252.15(5)(a)6 and 252.17(7)(9b), physicians, physician assistants, podiatrists, nurses, nurse midwives, physical therapists, and dietitians affiliated with a BadgerCare Plus HMO shall report the appearance, suspicion or diagnosis of a communicable disease or death resulting from a communicable disease to the local health department for any member treated or visited by the provider. Reports of human immunodeficiency virus (HIV) infection shall be made directly to the State Epidemiologist. Such reports shall include the name, sex, age, residence, communicable disease, and any other facts required by the local health department and Wisconsin Division of Public Health. Such reporting shall be made within 24 hours of learning about the communicable disease or death or as specified in Wis. Adm. Code DHS 145. Charts and reporting forms on communicable diseases are available from the local health department. Each laboratory subcontracted or otherwise affiliated with the HMO shall report to the local health department the identification or suspected identification of any communicable disease listed in Wis. Adm. Code DHS 145. Reports of HIV infections shall be made directly to the State Epidemiologist.

2. Fraud and Abuse Investigations

   The HMO agrees to cooperate with the Department on fraud and abuse investigations. In addition, the HMO agrees to report allegations of fraud

and abuse (both provider and member) to the Department within 15 days of the suspected fraud or abuse coming to the attention of the HMO. Failure on the part of the HMO to cooperate or report fraud and/or abuse may result in any applicable sanctions under Article XI.

The HMO must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. The HMO arrangements or procedures must include the following:

- Written policies, procedures, and standards of conduct that articulates the organization's commitment to comply with all applicable Federal and State standards.
- The designation of a compliance officer and a compliance committee that is accountable to senior management.
- Effective lines of communication between the compliance officer and the organization's employees.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Provision for internal monitoring and auditing.
- Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the HMO's contract.

The HMO must report the following to the state:

- Number of complaints of fraud and abuse that warrant preliminary investigation
- For each that warrants investigation, supply the:
    - Name.
    - ID number
    - Source of complaint
    - Type of provider
    - Nature of complaint
    - Approximate dollars involved
    - Legal & administrative disposition of the case

3. Physician Incentive Plans

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

The HMO shall fully comply with the physician incentive plan requirements specified in 42 CFR s. 417.479(d) through (g) and the requirements relating to subcontracts set forth in 42 CFR s. 417.479(i), as

those provisions may be amended from time to time. HMO will comply with the requirements set forth in 42 CFR 422.208 and.210.

The HMO may operate a physician incentive plan only if no specific payment can be made directly or indirectly under such a plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

If physician/group is put at substantial financial risk for services not provided by the physician/group, the HMO must ensure that the physician/group has adequate stop-loss protection.
The HMO must provide adequate and timely information on its physician incentive plan to any member upon request.

If required to conduct a member survey, survey results must be disclosed to the State, and, upon request, disclosed to members.

The disclosure to the State includes the following:

- The HMO must report whether services not furnished by a physician/group are covered by the incentive plan. No further disclosure is required if the PIP does not cover services not furnished by physician/group.
- The HMO must report type of incentive arrangement, e.g. withhold, bonus, capitation.
- The HMO must report percent of withhold or bonus (if applicable)
- The HMO must report panel size, and if patients are pooled, the approved method used.

Q. Abortions, Hysterectomies and Sterilization Requirements

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

1. Abortions must comply with the requirements of Wis. Stats., Ch. 20.927, and with 42 CFR 441 Subpart E--Abortions.

2. Hysterectomies and sterilizations must comply with 42 CFR 441 Subpart F--Sterilizations.

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

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

R. Medical Home Pilot for High-Risk Pregnant Women

The HMO must implement a Medical Home pilot by January 1, 2011 that targets high-risk pregnant women. The Medical Home must function based on four core principles:

- Having a personal OB-Care provider who provides first contact care or a point of entry for new problems. The OB-Care provider is defined as a physician, nurse midwife, nurse practitioner or physician assistant with specialty in obstetrics, OR a PCP who performs deliveries;
- Ongoing care over time;
- Comprehensive care; and
- Coordination of care across a person's conditions, providers and settings.

1. Target Population

The Medical Home must recruit members that meet criteria 'A'; either 1, 2, or 3 in criteria 'B'; and either 1 or 2 in criteria 'C':

a. Criteria A:
   1) Are currently pregnant

b. Criteria B:

   1) Are listed on the HBO high-risk registry;
   2) identified by a provider to be eligible to be on the HBO high-risk registry, OR
   3) are under 18 years of age,

c. Criteria C;

   1) Live within the following zip-codes in Racine, Kenosha, or Milwaukee counties:

53140	53143	53144	53204
53205	53206	53208	53209
53210	53212	53215	53216
53218	53224	53233	53402
53403	53404		

   2) OR have one of the following chronic conditions:

:

- Asthma
- Cardiac disease
- Diabetes mellitus
- Hypertension
- Pulmonary disease
- Behavioral health/mental health issues

The Medical Home must enroll a minimum of 100 members for CY 2011, 200 members for CY 2012, and 300 members for CY 2013 at some point of each calendar year. Each member must be enrolled within the first 16 weeks of her pregnancy, must have attended a minimum of 10 appointments with the Ob-care provider, and must continue to be enrolled through 60 days post-partum for the member to count towards the requirement. These criteria will be used to determine the enhanced payment amount in Article III, R, 7.

The HMO must coordinate its enrollment efforts with those of other programs in the community targeting high-risk pregnant women.

2. Basic Requirements

The Medical Home must be a single clinic or network of clinics that is accountable for the total care of the member and must:

a. Include an OB-care provider that serves as the first contact care or a point of entry for new problems during the member's pregnancy. The OB-care provider, the care coordinator, and the member's primary care physician (who may or may not be the OB-care provider) will work together to identify the medical needs of the member to ensure that she will have a healthy birth outcome. This effort shall be led by the Ob-care provider.

b. Adopt written standards for patient access and communication to the member as determined by the HMO and approved by the Department. These written standards must, at a minimum, meet appointment and waiting times according to Art. III, H of the contract. In addition, treatment and/or medical advice must be available 24 hours a day, seven days a week.

c. Use an electronic health record system or registry to manage patient data in order to:

- organize clinical information,
- identify diagnoses and conditions among the provider's patients that fit one of the chronic conditions listed in (d) or have a lasting detrimental effect on health,
- track patient test results,
- identify abnormal patient results, and
- systematically track referrals.

d. Adopt and implement evidence-based guidelines that are based on, but not limited to, treatment and management of the following chronic medical conditions:

- Asthma
- Cardiac disease
- Diabetes mellitus
- Hypertension
- Pulmonary disease
- Behavioral health/mental health

The HMO must have in place clear procedures for addressing the complex needs of women with these conditions, including, but not limited to, referrals to appropriate specialists.

e. Actively support and promote patient self-management.

f. Measure the quality of the performance of the physician practice and of the individual physicians within the practice, including with respect to the provision of clinical services, patient outcomes, and patient safety, using at least the following measures:

- Prenatal and Postpartum Care HEDIS measures
- Frequency of Ongoing Prenatal Care HEDIS measure
- CAHPS or other comparable member satisfaction survey

g. Report to members of the physician practice and to other persons on the quality of the performance of the physician practice and of individual physicians.

h. Demonstrate cultural competency among provider and office staff.

3. Care Coordinator

A key component of the Medical Home pilot is the coordination of care for the member. Therefore, the Medical Home must have a care coordinator on-site (located where the member's OB-Care provider is located) that can assist the member in making and keeping appointments, contacting other providers and public services when needed, coordinating services from community programs, providing patient education, and any other duties that will assist the member in having a healthy pregnancy. The care coordinator may be an employee of the HMO or of the clinic.

To ensure continuity of care, the Care Coordinator shall contact the office of any PCP (and PNCC if applicable) that the participating member had/has an ongoing relationship with, in order to learn about the member's medical history, current conditions, and concerns that the PCP may have regarding the member's health during the pregnancy.

The Ob-Care provider should develop a care management plan for the member in conjunction with the Care Coordinator, the PCP (if not the Ob-Care provider) and member. The care management plan must have an initial intake process where all needs of the member are identified to ensure that the Medical Home will provide comprehensive care. The care management plan must include a patient self-care component and monthly home visits by a nurse or social worker. The Care Coordinator should establish regular communication with the Ob-Care provider and PCP to track progress with the care management plan. The Care Coordinator should also assist in any on-site implementation-related duties for the Medical Home pilot.

4. Discharge Plan

All members shall remain enrolled and receiving services as needed within the Medical Home for 60 days post-partum.

If the member had a healthy birth outcome, the following activities shall take place within the member's 60 days post-partum in the Medical Home:

a. The member shall have no fewer than one post-partum follow-up appointment with the medical Home that shall meet any ACOG and other post-partum guidelines that apply;
b. The Care Coordinator shall contact the member's PCP to inform her or him of the birth outcome and any concerns that the OB-care provider has regarding the member or child's health post-partum;
c. The Care Coordinator shall educate the member on inter-conception care specific to her needs.

If the member had a poor birth-outcome, as defined by the Department, she will continue to be enrolled in the Medical Home pilot and the following activities will take place within 60 days post-partum:

a. Parts a, b, and c for members with a healthy birth outcome shall remain the same for members with a poor birth outcome.
b. The Care Coordinator shall develop a treatment plan for the infant and the mother with input from the mother and the OB-care provider. The treatment plan shall include the coordination of appointments with other providers (which may be within the Medical Home) who are appropriate to provide ongoing services for the mother and infant's specific needs.
c. The Care Coordinator shall maintain contact with the mother to ensure that the initial appointments with other providers have taken place. If these appointments have not occurred within 60 days post-partum, the Care Coordinator will continue to maintain contact until the appointments have taken place. After the initial appointments have taken place and the 60 days post-partum has been completed, the mother's enrollment in the Medical Home will cease.

Regardless of the birth outcome, the Care Coordinator will follow-up with the mother at least twice a year for two years following the birth to ensure the mother and child are receiving appropriate care.

5. Reporting

The HMO must submit to the Department by September 15, 2010 a detailed plan on how the HMO will implement the medical home pilot by January 1, 2011. The plan should address all of the required elements laid out above, as well as reflect the proposal submitted as part of the RFP bidding process.

The HMO must submit a report to the Department semi-annually evaluating its medical home pilot—one December 1 and one as part of the HMO's Annual Performance Report due June 1. The report shall include:

- A list of OB-Care providers participating and which members are assigned to each OB-Care provider;
- A narrative describing how the Medical Home satisfies criteria (a) through (h);
- A narrative that includes specific examples of processes and outcomes detailing how the Medical Home, in conjunction with the care coordinator, provides comprehensive and patient-centered care, and correctly identifies the needs of the member;
- Quality data findings from (f);
- Status report on patient access standards from (b);
- The number of new members recruited to the Medical Home for that year as of the time of the report, and;
- Any corrective action that is being taken to meet the requirements of the Medical Home pilot.

Following CY 2013, the Department will perform an evaluation of the overall outcomes and effectiveness of the Medical Home pilot.

6. Evaluation

The HMO must assure that appropriate members of the organizations participating in the Medical Home Pilot will work with the Department and authorized representatives of the Department to evaluate the Medical Home pilot. This may include, but is not limited to, the following:

a) Assuring that staff will be available to participate in evaluation design and other meetings related to the evaluation.

b) Collecting and reporting needed data, as identified by the evaluator.

c) Reviewing findings and offering comments/suggestions.

d) Sharing information with relevant stakeholders and distributing reports following approval by the Department.

The evaluation will assess individual HMO performance and overall outcomes and effectiveness of the Medical Home pilot.

7. Payment Structure

Participating providers are to receive the following enhanced payments beginning July 1, 2011 for women that meet the eligibility criteria in Article III, R, 1:

- DHS will pay $1,000 in addition to the kick payment the Department makes to the HMO upon a delivery for every birth to an eligible member enrolled in the medical home pilot. The amount will increase to $2,000 if the birth has a good outcome as defined by the Department.

- These payments will be paid to the HMOs and the HMOs will be required to pass the payments on to the provider.

Participating members in the Medical Home pilot will be excluded from the Healthy Birth Outcomes incentive in section Add. VI.

8. HMO representative

The HMO must designate a staff person to oversee the execution of the medical home pilot. The HMO representative will be responsible for representing the HMO regarding inquiries pertaining to the medical home pilot and will be available during normal business hours. The HMO representative will be responsible for ensuring the medical home pilot is implemented in accordance with the contract.

S. Enhanced Physician Reimbursement for Medical Home Practice Design

The HMO may provide enhanced reimbursement to primary care provider practices that function as a medical home. The HMO must report to the Department annually as part of its Annual Performance Report:

- Whether the HMO provides such a reimbursement and if so which practices are recipients.
- The criteria the HMO uses to identify practices that function as a medical home and are eligible for this reimbursement.

- The HMO's process for evaluating practices annually as to whether they meet the criteria.
- How this reimbursement process is implemented.
- Evidence that they are supplying their in-network providers with materials that explain in detail what their medical home criteria are, and how a clinic would be reimbursed for functioning as a medical home.

T. Participation in DHS Health IT Workgroup

The HMO must participate in a Health IT Workgroup established by the Department to coordinate activities and develop cohesive systems strategies among the Department and the HMOs. The Health IT Workgroup will meet on a designated schedule as agreed to by the Department and the HMOs.

ARTICLE IV

IV. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT (QAPI)

The HMO QAPI program must conform to the requirements of 42 CFR, Part 438, Medicaid Managed Care Requirements, Subpart D, QAPI. The program must also comply with 42 CFR 434.34 which states that the HMO must have a QAPI system that:

- Is consistent with the utilization control requirement of 42 CFR 456.
- Provides for review by appropriate health professionals of the process followed in providing health services.
- Provides for systematic data collection of performance and patient results.
- Provides for interpretation of this data to the practitioners.
- Provides for making needed changes.

A. QAPI Program

The HMO must have a comprehensive QAPI program that protects, maintains, and improves the quality of care provided to BadgerCare Plus program members.

1. The HMO must evaluate the overall effectiveness of its QAPI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its BadgerCare Plus population.

2. The HMO must have documentation of all aspects of the QAPI program available for Department review upon request. The Department may perform off-site and on-site QAPI audits to ensure that the HMO is in compliance with contract requirements. The review and audit may include:

    - On-site visits;
    - Staff and member interviews;
    - Medical record reviews;
    - Review of all QAPI procedures, reports, committee activities, including credentialing and recredentialing activities;
    - Corrective actions and follow-up plans;
    - Peer review process;
    - Review of the results of the member satisfaction surveys; and
    - Review of staff and provider qualifications.

3. The HMO must have a written QAPI work plan that is ratified by the board of directors and outlines the scope of activity and the goals, objectives, and time lines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies and results member satisfaction surveys and the performance measures.

4. The HMO governing body is ultimately accountable to the Department for the quality of care provided to HMO members. Oversight responsibilities of the governing body include, at a minimum:

   - Approval of the overall QAPI program;
   - An annual QAPI plan, designating an accountable entity or entities within the organization to provide oversight of QAPI;
   - Review of written reports from the designated entity on a periodic basis, which include a description of QAPI activities;
   - Progress on objectives, and improvements made;
   - Formal review on an annual basis of a written report on the QAPI program; and
   - Directing modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the HMO.

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

   - A variety of health professions (e.g., physical therapy, nursing, etc.).
   - Qualified professionals specializing in mental health or substance abuse and dental care on a consulting basis when an issue related to these areas arises.
   - A variety of medical disciplines (e.g., medicine, surgery, radiology, etc.).
   - A psychiatrist and an individual with specialized knowledge and experience with persons with disabilities.
   - HMO management or governing body.

6. Members of the HMO must be able to contribute input to the QAPI Committee. The HMO must have a system to receive member input on quality improvement, document the input received, document the HMO's response to the input, including a description of any changes or studies it implemented as the result of the input and document feedback to members in response to input received. The HMO response must be timely.

7. The committee must meet on a regular basis, but not less frequently than quarterly. The activities of the QAPI Committee must be documented in the form of minutes and reports. The QAPI Committee must be accountable to the governing body. Documentation of Committee minutes and activities must be available to the Department upon request.

   A minimum of one QAPI Committee meeting per calendar year must include a briefing on and review of the HMO's Annual Performance Report prior to its submission to the Department. In addition to the QAPI members, this meeting must also include the following representatives:

   - At least three BadgerCare Plus members
   - At least three community advocates from different organizations who work directly with the HMO's BadgerCare Plus members

8. QAPI activities of the HMO's providers and subcontractors, if separate from HMO QAPI activities, must be integrated into the overall HMO/QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter data, are incorporated into all provider and subcontractor contracts and employment agreements. The HMO QAPI program shall provide feedback to the providers and subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QAPI efforts. Other management activities (utilization management, risk management, customer service, complaints and grievances, etc.) must be integrated with the QAPI program. Physicians and other health care practitioners and institutional providers must actively cooperate and participate in the HMO's quality activities.

   The HMO remains accountable for all QAPI functions, even if certain functions are delegated to other entities. If the HMO delegates any activities to contractors, the conditions listed in Article II "Delegations of Authority" must be met.

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

10. The HMO must designate a senior executive to be responsible for the operation and success of the QAPI program. If this individual is not the HMO Medical Director, the Medical Director must have substantial involvement in the QAPI program. The designated individual shall be accountable for the QAPI activities of the HMO's own providers, as well as the HMO's subcontracted providers.

11. The qualifications, staffing level and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of important aspects of care and services, facilitating appropriate use of preventive services, monitoring provider performance, provider credentialing, involving members in QAPI initiatives and conducting performance improvement projects.

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

B. Monitoring and Evaluation

1. The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Important aspects of care (i.e., acute, chronic conditions, high volume, high-risk preventive care and services) are studied and prioritized for performance improvement and/or development of practice guidelines. Standardized quality indicators must be used to assess improvement, ensure achievement of minimum performance levels, monitor adherence to guidelines, and identify patterns of over and under utilization. The Department will report HEDIS in CY 2012, CY 2013, and CY 2014 using CY 2011, CY 2012, and CY 2013 clinical services data, respectively. For clinical services where no HEDIS measure exists or until HEDIS is fully implemented, the Department will use the existing MEDDIC-MS performance measures for the remaining areas of measurement.

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

3. The HMO must also monitor and evaluate care and services in certain priority clinical and non-clinical areas.

4. The HMO must have a specific program in place to monitor and evaluate the utilization of behavioral health services. The HMO must be able to provide utilization reports to the Department on request.

5. The HMO must make documentation available to the Department upon request regarding quality improvement and assessment studies on plan performance, which relate to the enrolled population. See reporting requirements in "Performance Improvement Priority Areas and Projects."

6. The HMO must develop or adopt best practice guidelines or standards that are disseminated through clinical decision support tools to providers and to members as appropriate or upon request. The guidelines are based on valid and reliable medical evidence or consensus of health professionals; consider the needs of the members; developed or adopted in consultation with the contracting health professionals, and reviewed and updated periodically.

   Decisions with respect to utilization management, member education, coverage of services, and other areas to which the practice guidelines apply are consistent with the guidelines. Variations from the guidelines must be based on the clinical situation.

C. Health Promotion and Disease Prevention Services

1. The HMO must identify at-risk populations for preventive services and develop strategies for reaching BadgerCare Plus members included in this population. Public health resources can be used to enhance the HMO's health promotion and preventive care programs.

2. The HMO must have mechanisms for facilitating appropriate use of preventive services and educating members on health promotion. At a minimum, an effective health promotion and prevention program includes HMO outreach to and education of its members, tracking preventive services, practice guidelines for preventive services, yearly measurement of performance in the delivery of such services, and communication of this information to providers and members.

   The Department encourages the HMO to develop and implement disease management programs and systems to enhance quality of care for individuals identified as having chronic or special health care needs known to be responsive to application of clinical practice guidelines and other techniques. For members with the following chronic conditions, but not limited to, for adults:
   - Diabetes
   - Asthma
   - COPD
   - Congestive heart failure
   - Behavioral health/mental illness

   And for children:
   - Diabetes
   - Asthma

   The HMO must ensure the treatment and care guidelines indicated as part of the required PCP assignment strategy in Art. III, I. are met.

3. The HMO agrees to implement systems to independently identify members with special health care needs and to utilize data generated by the systems or data that may be provided by the Department to facilitate outreach, assessment and care for individuals with special health care needs.

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

1. The HMO must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides services to the HMO's members, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under BadgerCare Plus. The HMO's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process. The HMO must complete its credentialing review within no more than 60 days from the receipt of a complete application.

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

2. The HMO must periodically monitor (no less than every three years) the provider's documented qualifications to ensure that the provider still meets the HMO's specific professional requirements.

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

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

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

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

6. The HMO must have a formal process of peer review of care delivered by providers and active participation of the HMO's contracted providers in the peer review process. This process may include internal medical audits, medical evaluation studies, peer review committees, evaluation of outcomes of care, and systems for correcting deficiencies. The HMO must supply documentation of its peer review process upon request.

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

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

9. The HMO must determine and verify at specified intervals that:

   a. Each provider, other than an individual practitioner is licensed to operate in the state, if licensure is required, and in compliance with any other applicable state or federal requirements; and

   b. The HMO verifies if the provider claims accreditation, or is determined by the HMO to meet standards established by the HMO itself.

10. These standards do not apply to:

    a. Providers who practice only under the direct supervision of a physician or other provider, and

    b. Hospital-based providers such as emergency room physicians, anesthesiologists, and other providers who provide services only incident to hospital services.

    These exceptions do not apply if the provider contracts independently with the HMO.

E. Member Feedback on Quality Improvement

1. The HMO must have a process to maintain a relationship with its members that promotes two way communications and contributes to quality of care and service. The HMO must treat members with respect and dignity.

2. The HMO is encouraged to find additional ways to involve members in quality improvement initiatives and in soliciting member feedback on the quality of care and services the HMO provides. Other ways to bring members into the HMO's efforts to improve the health care delivery system include but are not limited to focus groups, consumer advisory councils, member participation on the governing board, the QAPI committees or other committees, or task forces related to evaluating services. All efforts to solicit feedback from members must be approved by the Department.

3. The HMO must brief a sample of members on the Annual Performance Report prior to submitting the report to the Department.

F. Medical Records

1. The HMO must have policies and procedures for participating provider medical records content and documentation that have been communicated to providers and a process for evaluating its providers' medical records based on the HMO's policies. These policies must address patient confidentiality, data organization and completeness, tracking, and important aspects of documentation such as accuracy, legibility, and safeguards against loss, destruction, or unauthorized use. The HMO must also have confidentiality policies and procedures that are applicable to administrative functions that are concerned with confidential patient information. Those policies must include information with respect to disclosure of member-identifiable medical record and/or enrollment information and specifically provide:

   a. That members may review and obtain copies of medical records information that pertains to them.

   b. That policies above must be made available to members upon request.

2. Patient medical records must be maintained in an organized manner (by the HMO, and/or by the HMO's subcontractors) that permits effective patient care, reflect all aspects of patient care and be readily available for patient encounters, administrative purposes, and Department review.

3. Because the HMO is considered a contractor of the state and therefore (only for the limited purpose of obtaining medical records of its members) entitled to obtain medical records according to Wis. Adm. Code, DHS 104.01(3), the Department requires BadgerCare Plus certified providers to release relevant records to the HMO to assist in compliance with this section. The HMO that has not specifically addressed photocopying expenses in their provider contracts or other arrangements,

are liable for charges for copying records only to the extent that the Department would reimburse on a FFS basis.

4. The HMO must have written confidentiality policies and procedures in regard to individually-identifiable patient information. Policies and procedures must be communicated to HMO staff, members, and providers. The transfer of medical records to out-of-plan providers or other agencies not affiliated with the HMO (except for the Department) are contingent upon the receipt by the HMO of written authorization to release such records signed by the member or, in the case of a minor, by the member's parent, guardian, or authorized representative.

5. The HMO must have written quality standards and performance goals for participating provider medical record documentation and be able to demonstrate, upon request of the Department, that the standards and goals have been communicated to providers. The HMO must actively monitor compliance with established standards and provide documentation of monitoring for compliance with the standards and goals upon request of the Department.

6. Medical records must be readily available for HMO-wide Quality Assessment/Performance Improvement (QAPI) and Utilization Management (UM) activities and provide adequate medical and other clinical data required for QAPI/UM, and Department use.

7. The HMO must have adequate policies in regard to transfer of medical records to ensure continuity of care when members are treated by more than one provider. This may include transfer to local health departments subject to the receipt of a signed authorization form as specified in Subsection 4 (with the exception of immunization status information which does not require member authorization).

8. Requests for completion of residual functional capacity evaluation forms and other impairment assessments, such as queries as to the presence of a listed impairment, must be provided within 10 business days of the request (at the discretion of the individual provider and subject to the provider's medical opinion of its appropriateness) and according to the other requirements listed above. The HMO and its providers and subcontractor may charge the member, authorized representative, or other third party a reasonable rate for the completion of such forms and other impairment assessments. Such rates may be reviewed by the Department for reasonableness and may be modified based on this review.

9. Minimum medical record documentation per chart entry or encounter must conform to the Wis. Adm. Code, Chapter DHS 106.02, (9)(b) medical record content.

G. Utilization Management (UM)

1. The HMO must have documented policies and procedures for all UM activities that involve determining medical necessity, and the approval or denial of medical services. Qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s). The HMO may not deny coverage, penalize providers, or give incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or result in the under-utilization of services.

   The HMO must communicate to providers the criteria used to determine medical necessity and appropriateness. The criteria for determining medical necessity may not be more stringent than Wis. Adm. Code DHS 101.03 (96m). Documentation of denial of services must be available to the Department upon request.

2. If the HMO delegates any part of the UM program to a third party, the delegation must meet the requirements in this Contract.

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

4. The HMO's policies must specify time frames for responding to requests for initial and continued service determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. In addition, the HMO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (interrater reliability).

   a. Within the time frames specified, the HMO must give the member and the requesting provider written notice of:

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

      2) The member's right to file a grievance or request a state fair hearing.

   b. Authorization decisions must be made within the following time frames and in all cases as expeditiously as the member's condition requires:

1) Within 14 days of the receipt of the request, or

2) Within three business days if the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.

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

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

5. Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence, current standards of medical practice, or a consensus of relevant health care professionals, and are regularly updated.

6. The HMO oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

7. Postpartum discharge policy for mothers and infants must be based on medical necessity determinations. This policy must include all follow-up tests and treatments consistent with currently accepted medical practice and applicable federal law. The policy must allow at least a 48-hour hospital stay for normal spontaneous vaginal delivery, and 96 hours for a cesarean section delivery, unless a shorter stay is agreed to by both the physician and the member. The HMO may not deny coverage, penalize providers, or give incentives or payments to providers or members. Post hospitalization follow-up care must be based on the medical needs and circumstances of the mother and infant. The Department may request documentation demonstrating compliance with this requirement.

H. Dental Services Quality Improvement

The HMO QAPI Committee and QAPI coordinator will review subcontracted dental programs quarterly to ensure that quality dental care is provided and that the HMO and the contractor comply with the following:

1. The HMO or HMO affiliated dental provider must advise the member within 30 days of effective enrollment of the name of the dental provider and the address of the dental provider's site. The HMO or HMO affiliated dental provider must also inform the member in writing how to contact his/her dentist (or dental office), what dental services are covered, when the coverage is effective, and how to appeal denied services.

2. The HMO or HMO affiliated dental provider who assigns all or some BadgerCare Plus HMO members to specific participating dentists must give members at least 30 days after assignment to choose another dentist. Thereafter, the HMO and/or affiliated provider must permit members to change dentists at least twice in any calendar year and more often than that for just cause.

3. HMO-affiliated dentists must provide a routine dental appointment to an assigned member within 90 days after the request. Member requests for emergency treatment must be addressed within 24 hours after the request is received.

4. Dental providers must maintain adequate records of services provided. Records must fully disclose the nature and extent of each procedure performed and should be maintained in a manner consistent with standard dental practice.

5. The HMO affirms by execution of this Contract that the HMO's peer review systems are consistently applied to all dental subcontractors and providers.

6. The HMO must document, evaluate, resolve, and follow up on all verbal and written complaints they receive from BadgerCare Plus members related to dental services.

7. The HMO must submit progress reports to the Department as part of its Annual Quality Performance report documenting the outcomes or current status of activities intended to increase utilization among members (including use of preventive services, comprehensive care and emergency services) and to recruit and retain providers (including pediatric dental providers, orthodontists and oral surgeons), specifically commenting on the requirements listed above. The HMO must also report on the activities it is undertaking to reach the dental utilization performance benchmarks in Add. VI. These reports must include an assessment of the effectiveness of previous activities and any corrective action take based on the assessment.

I. Accreditation

1. The Department encourages the HMO to actively pursue accreditation by the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC), Utilization Review Accreditation Commission (URAC) or other recognized accrediting bodies approved by the Department. 42 CFR §. 438.360 provides that the Department may recognize "a private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in §. 422.158."

The Centers for Medicare and Medicaid Services (CMS) has recognized the following accrediting bodies: The National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care (AAAHC). The Department may recognize other accreditation bodies as they may qualify for such recognition.

2. The achievement of full accreditation by an accreditation body approved by the Department and satisfaction of the requirements of the HMO Accreditation Incentive Program as specified by the Department will result in the HMO qualifying for the Accreditation Incentive.

   Where accreditation standards conflict with the standard set forth in this Contract, the Contract prevails unless the accreditation standard is more stringent.

J. Performance Improvement Priority Areas and Projects

The HMO must develop and ensure implementation of program initiatives to address the specific clinical needs of the HMO's enrolled population served under this Contract. These priority areas may include clinical and non-clinical Performance Improvement Projects (PIPs).

The Department will permit the development of collaborative relationships among the HMOs, local health departments, community-based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services in priority areas. Complete encounter data for all reported services must be provided. The Department and the HMO will collaborate in the area of service and clinical care improvements by the development and sharing of "best practices" and use of encounter data-driven performance measures.

1. Health plans must focus its PIPs on one of the following Department priority areas. Additionally, CMS, in consultation with the State and other stakeholders, may specify performance measures and topics for performance improvement projects. The HMO may propose alternative performance improvement topics during the preliminary topic selection summary process; approval is at the Department's discretion. The Department's priority areas are:

   a. Clinical

      - HealthCheck
      - Tobacco cessation
      - Blood lead testing
      - Childhood immunizations
      - Healthy birth outcomes

- Diabetes management
- Asthma management
- Childhood obesity interventions
- Dental

b. Non-Clinical
- Access and availability of services
- Member satisfaction

2. All HMOs are required to submit at least two PIPs.

3. Health plans should submit PIPs which target policy interventions for performance improvement. Plans should not submit baseline studies which are designed to evaluate if a problem exists.

4. In the event that a health plan demonstrates a need to continue an intervention for PIP submission for a second year, the health plan should incorporate the EQRO's mutually agreed upon recommendations in the subsequent year.

5. The HMO must submit a preliminary PIP proposal summary stating the proposed topic, the study question, and a brief description of the intervention and the study design. The preliminary summary must address Steps 1 through Step 6 (per list of PIP steps, included as point 12) and must be submitted to DHS in template format via email to the health plan's Contract Monitor. This preliminary summary must be submitted by the first business day of December of each calendar year and will describe the interventions the plan will implement throughout the year.

   DHS and the EQRO will review and approve or disapprove the preliminary PIP proposal, and meet with the HMO during the month of December. DHS will determine if the topic selected by the plan is aligned with the Department's goals. The EQRO will review the methodology and the study design proposed by the plan. Suggestions arising from the EQRO and HMO dialogue should be given consideration as the HMO proceeds with the PIP implementation.

   If the proposal is rejected by DHS, health plans must re-submit a new or revised PIP proposal that will be subject to DHS and the EQRO's review protocol.

6. After receiving the State's approval, the plan must communicate with the EQRO throughout the implementation of the project if questions arise. This includes communication (conference call) on the preliminary summary submission with the EQRO and DHS Contract Monitor. The health plan should contact the EQRO throughout the year to discuss any concerns with the health plan's study. The HMO should perform ongoing

monitoring of the project throughout the year to ensure its interventions are successful.

7. After implementing the PIP over one calendar year, health plans must submit their completed PIP reports by the first business day of June of the following calendar year. Health plans have the option of submitting their PIP in a report format as long as the report addresses CMS mandated protocol ("Validating Performance Improvement Projects", CMS-R-305). Alternately, health plans may submit their PIP report in a template format provided by DHS.

8. The EQRO has the liberty to contact the plans in circumstances where they need further clarification on certain issues. The plan can also contact the EQRO throughout the PIP process in order to ensure that they understand and incorporate appropriately the EQRO recommendations.

9. The EQRO may recommend a health plan's PIP for inclusion as part of Wisconsin's Best Practices Seminars. All health plans must participate in DHS Best Practices Seminars.

10. The Department will consider that the plan failed to comply with PIP requirements if:

    a. The plan submits a final PIP on a topic that was not approved by DHS and the EQRO through the preliminary summary process, unless subsequent approval was granted by DHS.

    b. The EQRO finds that the PIP does not meet federal regulations.

    c. The plan does not submit the final PIP by its due date as indicated in the Contract. The Department may grant extensions of this deadline, if requested prior to the due date.

    Failure to comply with PIP requirements may result in the application of sanctions described in Article XI.

12. Ten Steps to A Successful PIP

    Step 1: Describe the project/study topic.

    Step 2: Describe the study questions/project aims.

    Step 3: Describe the selected study indicators/project measures.

    Step 4: Describe the identified population for which the study or project is aimed at.

    Step 5: Describe the sampling methods used (if any).

Step 6: Describe the organization's data collection procedures.

Step 7: Describe the organization's interventions and improvement strategies.

Step 8: Describe the organization's data analysis and interpretation of results of data collection.

Step 9: Describe the likelihood that the reported improvement is real improvement.

Step 10: Describe whether the organization has sustained its documented improvement.

K. Healthy Birth Outcomes

The HMO must promote healthy birth outcomes through the following strategies:

1. The HMO must implement the Medical Home pilot as detailed in Art. III, R.

2. The HMO's Medical Director or Department-approved representative must participate in the Department's sponsored quality efforts during the period of the contract (e.g., best practices seminars).

3. The HMO is encouraged to participate as a member in the University of Wisconsin School of Medicine and Public Health-sponsored Maternal and Child Health Lifecourse Collaborative in Milwaukee, Racine and Kenosha.

4. The HMO must meet the following requirements with regard to women not participating in the medical home pilot and are at high risk of a poor birth outcome. For this purpose, these women include:

    - Women with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death)
    - Women with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension)
    - Women under 18 years of age

5. The HMO must have a plan in place to identify women at high risk of a poor birth outcome. The plan must specifically address options for identifying high-risk women previously unknown to the BadgerCare Plus program, (e.g., use of a pregnancy notification form). The HMO may use the Department's High Risk Pregnancy Report (provided by the

Department on a monthly basis) to identify women who had a poor birth outcome while receiving BadgerCare Plus.

6. If pregnant, the HMO must ensure that these members receive early and continuous care throughout the pregnancy and post-partum period, as soon as the member is identified as being pregnant. The HMO must ensure that appropriate referrals and timely follow-up are made for all identified needs (for example, nutrition counseling, smoking cessation, or behavioral health).

7. The HMO must meet the following requirements with regard to both women participating in the Medical Home pilot and who are at high risk of a poor birth outcome:

   a. The HMO must have strategies in place for post-partum care, including depression screening and family planning services. Contraception options should be explored and the initial appointment for post-partum care should be made prior to discharge.

   b. The HMO must have a plan in place for interconception care to ensure that the member is healthy prior to a subsequent pregnancy. At a minimum, the plan must address the needs of high-risk women with chronic conditions such as diabetes and hypertension.

8. As part of the Annual Performance Report, the HMO must report out annually to the Department on the effectiveness of the above strategies and plans.

L. Comprehensive Community Development Initiatives

The HMO must collaborate with the Department on the implementation of any State initiatives focused on supporting comprehensive community development in targeted neighborhoods or regarding defined populations. Such initiatives may include efforts to advance health promotion, expand access to health care prevention and treatment, improve educational attainment, and expand access to other social services.

M. Emergency Department Utilization Management

1. ED Utilization Management Plan

The HMO must submit an ED Utilization Management Plan to the Department by September 15, 2010 with a goal of reducing ED visits and achieving the performance benchmarks indicated in Add. VI. The HMO must provide the Department with an assessment of the effectiveness of this plan as part of the Annual Performance Report.

The plan must include:

a. A strategy to reduce the rate of ED visits per member;

b. A strategy to reduce the percent of members with three or more ED visits and no primary care provider visit within a 12 month period;

c. A strategy to reduce the rate of members that visit the ED for an ambulatory sensitive condition;

d. A process that seeks out feedback and recommendations from EDs within the HMO's service area.

e. Information on activities related to member incentives, improving access to and emphasizing primary care, care management programs for high-volume ED users, the use of information systems to identify high utilizers of target ED services, and internal evaluation of the effectiveness of these activities.

2. Wisconsin Health Information Exchange (WHIE) Membership

The HMO must serve as a paying member of the Wisconsin Health Information Exchange (WHIE).

N. Annual Performance Reporting

The HMO must provide a written report to the Department annually on the overall performance of the HMO for the previously completed calendar year. The report must address how the HMO is facilitating access to all needed services by its members in a way that promotes prevention, wellness and appropriate utilization of services. The report must include examples of how providers and subcontractors are engaged to accomplish these objectives.

The report is due to the Department no later than June 1 of each calendar year and must be submitted in accordance to the formatting specifications provided by the Department. Prior to submitting the report to the Department, the HMO must present the report at a meeting of the HMO's QAPI Committee that includes BadgerCare Plus member representatives and community advocates as indicated in Art. IV, A. An HMO that fails to comply with the follow reporting requirements will be subject to sanctions as indicated in Article XI.

1. Report components

The Annual Performance Report must address each of the following components:

a. RFP proposal strategies. The HMO must reference each strategy the HMO included in its RFP proposal as part of the Technical Requirements section for how it would meet DHS performance benchmarks and ensure members receive high-quality care appropriate for their needs during the course of the contract. For each strategy, the HMO must indicate when the strategy was/will be implemented; any modifications that have been made to the originally proposed strategy and why; and an assessment of the effectiveness of the strategy. The HMO may discuss the status of its strategies as part of its response to the report components that follow or as a stand-alone section in the report.

b. Provider network. The HMO must provide written documentation and assurance of the network adequacy criteria listed in Art. III, H. Specifically, the HMO must submit justification as to why the HMO's network is adequate in size and scope to meet the needs of the BadgerCare Plus population. The HMO must report on any corrective action the HMO has taken in order to maintain a sufficient provider network.

   The HMO must submit to the Department its minimum standards for waiting times for care and waiting time for appointments for PCPs, ob-care providers, pediatricians, mental health providers, and the specialties indicated in Art. III, H. The HMO must also submit a completed template, to be provided by the Department, that tracks actual waiting times for appointments and care as monitored by the HMO. The HMO shall conduct surveys and site visits to monitor compliance with appointment waiting time standards and shall include these findings in the report, as well as the corrective action it will take so that providers meet the HMO's standards and improve access for BadgerCare Plus members.

c. Primary care management. The HMO must provide an assessment of the effectiveness of its primary care provider assignment strategy and care management for members with chronic conditions as detailed in Art. III, I. The assessment must specifically address:

   - quality of care members receive
   - member compliance in visiting their assigned primary care provider
   - HMO's strategy to reduce the number of members who do not show up for appointments
   - rate at which members use the primary care provider vs. the emergency department
   - rate at which members with chronic conditions had a visit with their PCP for their condition.

For any HMO that reported as part of their RFP proposal submission that they would provide enhanced reimbursement for PCP clinics that function as a medical home, the HMO must indicate the specific clinics serving BadgerCare Plus members that meet the HMO's medical home criteria and are receiving an enhanced reimbursement from the HMO. As indicated in Art. III, S, the HMO must include a description of the HMO's criteria for serving as a medical home and the HMO's process for evaluating clinics annually as to whether they meet the criteria. The HMO must describe how this reimbursement process is implemented. The HMO must also provide evidence to the Department that they are supplying their in-network providers with materials that explain in detail what their medical home criteria is and how a clinic would be reimbursed for functioning as a medical home.

If the HMO is not currently reimbursing any PCP clinics for serving as a medical home and indicated as part of their RFP submission that they would, the HMO must provide justification why and report on what they are doing to promote the medical home model among their in-network PCP clinics. The HMO must also provide evidence to the Department that they are supplying their in-network providers with materials that explain in detail what their medical home criteria is and how a clinic would be reimbursed for functioning as a medical home.

d. Quality performance benchmarks. The HMO must provide an assessment of the effectiveness of its strategy to meet and exceed the Department's quality performance benchmarks for the following measures as indicated in Add. VI:

a. Childhood Immunization status
b. Blood Lead testing of 1 and 2 year olds
c. Use of Appropriate Medications for People with Asthma
d. Comprehensive Diabetes care: HbA1C Testing and LDL-C Screening
e. Tobacco cessation

The HMO must comment on any activities it has implemented to reach the benchmarks including, but not limited to, provider incentives (financial or non-financial), provider training and monitoring, member interventions, and outreach and education targeted to each measure.

The HMO must describe its strategy to ensure quality throughout its provider network in the HMO's effort to meet and exceed all of the Department's quality benchmarks detailed in Add. VI. The HMO must include data at the provider level on its network's performance demonstrating that members are receiving high-

quality services from providers. If the HMO is not reaching the Department's quality benchmarks, it must include the corrective action that it is taking.

e. ED utilization management. The HMO must report out on the effectiveness of its ED Utilization Management plan described in Art. IV, M. The HMO must also report on the activities it is undertaking to reach the ED utilization performance benchmarks in Add. VI. The report should include barriers and challenges to the plan, along with the corrective action the HMO will take to improve their plan and achieve the performance benchmarks.

f. Dental utilization. The HMOs must submit progress reports documenting the outcomes or current status of activities intended to increase utilization among members and recruit and retain providers (including pediatric dental providers, orthodontists, and oral surgeons), specifically commenting on the requirements listed as part of Dental Services Quality Improvement in Art. IV, H. The HMO must also report on the activities it is undertaking to reach the dental utilization performance benchmarks in Add. VI. These reports must include an assessment of the effectiveness of previous activities and activities and any corrective action taken based on the assessment.

g. Healthy Birth Outcomes. The HMO must report out on the effectiveness of its strategies and plans for promoting healthy birth outcomes with women at high risk of a poor birth outcome, who are not participating in the Medical Home pilot as detailed in section Art. IV, K.4.

h. Final PIPs. The HMO must submit completed PIPs from the previous calendar year as indicated in Art. IV, J. A copy of the PIPs must also be submitted to the Department's EQRO.

i. Medical Home pilot. The HMO must report out on the implementation of the medical home pilot following the guidelines listed in Art. III, R.

j. Member appointment compliance. The HMO must report on the effectiveness of its strategy to reduce the number of members who do not show up for appointments. The HMO must provide data results to support its evaluation and indicate any corrective action it will take in response to the evaluation.

k. Member Communication Plans and Outreach Plans. The HMO must submit for approval by the Department its members' communication plan and outreach plan it and/or its subcontractors plan to implement for the proceeding year as indicated in Art. III,

L. This plan must include the HMO's outreach and education plan for newly enrolled members.

The HMO must also include an assessment of the effectiveness of the previous year's plan that was submitted to and approved by the Department and indicate any changes made based on the assessment.

l. Cultural competency. The HMO must report on the effectiveness of its strategy for addressing the special health needs of members needing specific culturally competent services in accordance with Art. III, I. The HMO must provide data results to support its evaluation and indicate any corrective action it will take in response to the evaluation.

m. HMO Advocate. The HMO must submit the results of the evaluation conducted of the HMO advocate position, work plan(s) and job duties to ensure a sufficient number of FTEs are allocated to the position, as indicated in Art. III, I. The HMO must submit any corrective action taken in response to the evaluation.

n. Subcontractor performance. The HMO must submit any additions or deletions to the list of subcontractors the HMO indicated during certification that it has established contracts with. The HMO must provide results of its required annual subcontractor performance review as indicated in Article II and any corrective action taken in response to the review.

o. Community Involvement. The HMO must indicate any community health improvement activities the HMO has engaged in during the previous year, including any collaborative partnerships the HMO has formed with community-based organizations to help promote prevention and wellness in the HMO's community.

p. Cost-effectiveness of network. The HMO must describe how it evaluates the cost-effectiveness of its provider network using available data sources including but not limited to WCHQ's performance measures or WHIO data. The HMO must provide data results to support its evaluation and indicate any corrective action it will take in response to the evaluation.

q. Integrated Delivery System (IDS). For any HMO that the Department determined met the criteria as an IDS as part of the RFP proposal evaluation, the HMO must report on how they continue to meet the Department's definition of an IDS in the service area.

r. Healthiest Wisconsin 2020. The Department will brief HMOs on the specific objectives, focus areas that influence the health of the public and long-term goals for the decade that comprise the Healthiest Wisconsin 2020 agenda in Fall 2010. As part of the Annual Performance Report, the HMO must report on, for a minimum of the 10 objectives, what activities the HMO has undertaken to advance the state's Healthiest Wisconsin 2020 agenda. This report should include those activities they are working on in collaboration with their local health departments. The HMO may reference the objectives as part of its responses to the report components listed above.

ARTICLE V

V. FUNCTIONS AND DUTIES OF THE DEPARTMENT

In consideration of the functions and duties of the HMO contained in this Contract, the Department must:

A. Enrollment Determination

Identify BadgerCare Plus Standard and Benchmark Plan members who are eligible for enrollment in the HMO as the result of eligibility under the following eligibility status codes:

Medical Status Code	Description	BadgerCare Plus Plan
1B	parents	BC+ Standard Plan
2B	parents	BC+ Standard Plan
3B	parents	BC+ Standard Plan
4B	parents (self employed & farmers)	BC+ Benchmark Plan
5B	caretakers	BC+ Standard Plan
AA	pregnant woman	BC+ Benchmark Plan + dental
AB	pregnant woman	BC+ Standard Plan
B8	parents/caretakers community waiver elig	BC+ Standard Plan
B9	transitional grandfathering (Prev. elig. under BC) community waiver elig	BC+ Standard Plan
BA	pregnant woman	BC+ Standard Plan
BB	pregnant woman	BC+ Benchmark Plan + dental
BC	child, ages 1 through 5	BC+ Standard Plan
BE	child, under age 19	BC+ Standard Plan
BF	child, ages 6 through 18	BC+ Standard Plan

BG	child, ages 6 through 18	BC+ Standard Plan
BH	child, under age 19	BC+ Benchmark Plan + dental
BI	child, under age 19	BC+ Benchmark Plan + dental
BJ	child, under age 6	BC+ Standard Plan
BL	parents/caretakers	BC+ Standard Plan
BM	caretakers	BC+ Standard Plan
BN	caretakers	BC+ Standard Plan
BO	caretakers (self employed & farmers)	BC+ Benchmark Plan
BP	transitional grandfathering (Prev. elig. under MA or BC up to 130%)	BC+ Standard Plan
BQ	transitional grandfathering (Prev. elig. under BC)	BC+ Standard Plan
BR	transitional grandfathering (Prev. elig. under BC)	BC+ Standard Plan
BY	youths exiting out of home care	BC+ Standard Plan
C1	child < age 1	BC+ Standard Plan
C2	child < age 1	BC+ Benchmark Plan + dental
C3	child, ages 1 through 5	BC+ Standard Plan
HC	child, ages 1 through 5 HIRSP KIDS ONLY	BC+ BMP w/ SP drug coverage
HG	child, ages 6 through 18 HIRSP KIDS ONLY	BC+ BMP w/ SP drug coverage
HI	child, under age 19, HIRSP KIDS ONLY	BC+ BMP w/ SP drug coverage
N1	CEN - mom in SP or MA on DOB	BC+ Standard Plan
N3	CEN - mom in BMP on DOB	BC+ BMP + Dental

N4	CEN - mom in SP or MA on DOB	BC+ Standard Plan
PM	pregnant minor, under age 19	BC+ Benchmark Plan + dental
T1	HCTC, adults	BC+ BMP, den
T2	TAG, adults	BC+ BMP, den
T3	HCTC, child < 19	BC+ BMP, den
TB	pregnant minor, under age 19 - tribal member	BC+ Benchmark Plan + dental
TC	child, under age 19 - tribal member	BC+ Benchmark Plan + dental
TF	child, ages 1 through 5, tribal member	BC+ Standard Plan
TG	child, ages 6 through 18, tribal member	BC+ Standard Plan
TK	child, < 19, tribal member	BC+ Benchmark Plan + dental
TP	pregnant minor, under age 19 - tribal member	BC+ Benchmark Plan + dental
X6	earnings extension, 12 mo, adult	BC+ Standard Plan
X7	child support extension, 4 mo, adult	BC+ Standard Plan
X8	earnings extension - 12 mo, child < 19	BC+ Standard Plan
X9	child support extension - 4 mo, child < 19	BC+ Standard Plan

B. Enrollment

Promptly notify the HMO of all BadgerCare Plus members enrolled in the HMO under this Contract. Notification will be effected through the HMO Enrollment Reports. All members listed as an ADD or CONTINUE on the Initial or Final HMO Enrollment Report are members of the HMO during the enrollment month. The reports will be generated in the sequence specified under HMO enrollment reports. These reports shall be available through electronic file transfer capability and will include medical status codes. The Department will make all reasonable efforts to enroll pregnancy cases as soon as possible for BadgerCare Plus.

C. Disenrollment

Promptly notify the HMO of all BadgerCare Plus members no longer eligible to receive services through the HMO under this Contract. Notification will be effected through the HMO Enrollment Reports which the Department will transmit to the HMO for each month of coverage throughout the term of the Contract. The reports will be generated in the sequence under the HMO Enrollment Report below. Any member who was enrolled in the HMO in the previous enrollment month, but does not appear as an ADD or CONTINUE on either the Initial or Final HMO Enrollment Report for the current enrollment month is disenrolled from the HMO effective the last day of the previous enrollment month.

D. Enrollment Errors

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

E. HMO Enrollment Reports

For each month of coverage throughout the term of the Contract, the Department will transmit "HMO Enrollment Reports" to the HMO. These reports will provide the HMO with ongoing information about its BadgerCare Plus members and disenrollees and will be used as the basis for the monthly capitation claim payments to the HMO. The HMO Enrollment Reports will be generated in the following sequence:

1. BadgerCare Plus Standard and Benchmark Plans:

    a. The Initial HMO Enrollment Report will list all of the HMO's members and disenrollees for the enrollment month that are known on the date of report generation. The Initial HMO Enrollment Report will be available to the HMO on or about the twenty-first of

each month. A capitation claim shall be generated for each member listed as an ADD or CONTINUE on this report. Members who appear as PENDING on the Initial Report and are reinstated into the HMO prior to the end of the month will appear as a CONTINUE on the Final Report and a capitation claim will be generated at that time.

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

2. The Department will provide the HMO with effective dates for medical status code changes, county changes and other address changes in each enrollment report to the extent that the county reports these to the Department.

F. Utilization Review and Control

Waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other BadgerCare Plus restrictions for the provision of contract services provided by the HMO to members, except as may be required by the terms of this contract.

G. HMO Review

Submit to the HMO for prior approval materials that describe the specific HMO. Approved materials will be distributed by the Department or County to members.

H. Department Audit Schedule

The HMO will be notified approximately 30 days prior to regularly scheduled, routine audits being conducted via a letter from the Division of Health Care Access and Accountability. The Department will develop an annual schedule of known audits for the next Contract period.

I. HMO Review of Study or Audit Results

Submit to the HMO for a 30 business day review/comment period, any BadgerCare Plus and HMO audits, HMO report card, HMO Consumer Satisfaction Reports, or any other BadgerCare Plus HMO studies the Department releases to the public that identifies the HMO by name. The review/comment period will commence on the first business day after the audit report is submitted to the HMO. The HMO may request an extension and the Department will

exercise reasonable discretion in making the determination to waive the 30 business day review/comment requirement.

J. Vaccines for Children

Assure that HMO providers participate in the Vaccines for Children (VFC) program for administration of immunizations to BadgerCare Plus HMO members according to the policies and procedures in the Wisconsin Health Care Programs Online Handbook. The Department will reimburse the HMO for the cost of new vaccines that are newly approved during the contract year and not yet part of the Vaccine for Children program. The reimbursement of the vaccine shall be the same as the Department reimburses FFS providers during the period of VFC availability. The HMO retains liability for the cost of administering the vaccines.

K. Coordination of Benefits

Maintain a report of recovered money reported by the HMO and its subcontractor.

L. BadgerCare Plus Provider Reports

Provide a monthly electronic listing of all BadgerCare Plus certified providers to include, at a minimum, the name, address, BadgerCare Plus provider ID number and/or National Provider Identifier, if applicable, and dates of certification for BadgerCare Plus.

M. Member Health Status and Primary Language Report

The Department will provide the HMO with a member health status and primary language report of all members who have agreed to participate with the gathering of this data. The reports will be provided to the HMO on a monthly basis. The purpose of this report is to assist the HMO with continuity of care issues and with the identification of non-English speaking members and to facilitate appointments for members who have urgent health care needs.

N. Fraud and Abuse Training

The Department will provide fraud and abuse detection training to the HMO annually.

O. Provision of Data to the HMO

Provide to the HMO immunization information from the Wisconsin Immunization Registry, to the extent available.

ARTICLE VI

VI. PAYMENT TO THE HMO

A. Capitation Rates

In consideration of full compliance by the HMO with contract requirements, the Department agrees to pay the HMO monthly payments based on the capitation rates for BadgerCare Plus Standard and Benchmark plans. 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 HMO under previous contracts nor does it include services that are not covered under the State Plan. Specifics are:

- The Department's enhanced funding policies include NICU risk sharing and ventilator dependent members. The HMO cannot submit a request for enhanced funding under more than one of the two funding policies for the same member for the same date(s) of service.

- The Department will conduct an analysis comparing actual HMO member's diagnosis and service usage intensity (utilization and costs) with the comparable FFS or HMO equivalent population using the Chronic Illness and Disability Payment System (CDPS).

- CDPS adjusters will be 100% in 2011 for BadgerCare Plus – Standard and Benchmark Plan members.

- For members with a pregnancy-related medical status code, the Department will pay the Standard Plan or Benchmark Plan capitation rate per member on a monthly basis and a kick payment upon delivery. The kick payment will be paid when the Department receives an encounter record indicating a delivery.

  For a member who first enrolls in the HMO prior to January, 2011 and had previously been enrolled in, and received prenatal services from, a different BadgerCare Plus HMO in the same service area, the kick payment may be adjusted to redistribute the prenatal costs.

- The Department will reimburse HMOs outside the capitation rate for reporting of ICD -9-CM V85.5 series diagnosis codes, and Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. Reimbursement will be consistent with the FFS implementation timeline and FFS policies as described in the ForwardHealth Provider Updates. The Department will develop the necessary forms that must be submitted for reimbursement. All services must be reflected in accepted encounter data. The HMO shall perform provider outreach and education regarding SBIRT services, and reporting of V85.5 series diagnosis codes.

B. Actuarial Basis

The capitation rate is calculated on an actuarial basis recognizing the payment limits set forth in 42 CFR 438.6.

C. Annual Negotiation of Capitation Rates

The monthly capitation rates are recalculated on an annual basis. The HMO will have 30 days from the date of the written notification to accept the new capitation rates in writing or to initiate termination or non-renewal of the Contract. The capitation rates are not subject to renegotiation by the HMO once they have been accepted. The Department may elect to renegotiate rates as required by changes in federal or state laws, rules or regulations. However, no change will be considered unless the total impact is plus or minus 1% of the aggregate capitation rate.

The Department may adjust capitation rates to reflect the implementation of provider rate changes. The rate adjustment would be certified as actuarially sound and approved by CMS in the form of a contract amendment.

D. Reinsurance

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

E. Payment Schedule

Payment to the HMO is based on the HMO Enrollment Reports that the Department transmits to the HMO. Payment for each person listed as an ADD or CONTINUE on the HMO Enrollment Reports shall be made by the Department within 75 days of the date the report is generated. Any capitation claim that is not paid within these time limits will be denied by the Department and the member will be disenrolled from the HMO for the capitation month specified on the capitation claim. Notification of all paid and denied claims will be given through the weekly Remittance Status Report, which is available in hard copy. Specifics for:

- **Capitation Payments for Newborns**

  The HMO will authorize provision of contract services to the newborn child of an enrolled mother for the first 10 days of life. The child's date of birth should be counted as day one. In addition, if the child is reported within 100 days of the date of birth, the HMO will provide contract services to the child from its date of birth until the child is disenrolled from the HMO. The HMO will receive a separate capitation payment for the month of birth and for all other months the HMO is responsible for providing contract services to the child. If the child is not reported within 100 days of

the date of birth, the child will not be retroactively enrolled into the HMO. In this case, the HMO is not responsible for payment of services provided prior to the child's enrollment and will receive no capitation payments for that time period and may recoup payments from providers for any services that were authorized in that 100 day time period. The providers who gave services in this 100 day time period may then bill the Department on a FFS basis. Examples of these situations can be found in the Claims Submission section of the Wisconsin Health Care Programs Online Handbook.

The HMO or their providers must complete an HMO Newborn Report. The HMO or their providers will report all births to the Department's fiscal agent as soon as possible after the date of birth, but at least monthly. If the HMO delegates the newborn reporting responsibility to providers, HMOs must specify in their subcontracts that the providers are responsible for newborn reporting. Prompt HMO reporting of newborns will facilitate retroactive, enrollment and capitation payments for newborns, since this newborn reporting will ensure the newborn's BadgerCare Plus eligibility for the first 12 months of life contingent upon the newborn continuously residing with the mother.

Infants weighing less than 1200 grams will be exempt from enrollment if the data submitted by the HMO or the provider supports the infant's low birth weight. If an infant weighs less than 1200 grams, the HMO or provider should check the box on the BadgerCare Plus Newborn Report.

F. Coordination of Benefits (COB)

The HMO must actively pursue, collect and retain all monies from all available resources for services to members covered under this Contract except where the amount of reimbursement the HMO can reasonably expect to receive is less than the estimated cost of recovery (this exception does not apply to collections for ventilator dependent patients). COB recoveries will be done by post-payment billing (pay and chase) for certain prenatal care and preventive pediatric services. Post-payment billing will also be done in situations where the third party liability (TPL) is derived from a parent whose obligation to pay is being enforced by the State Child Support Enforcement Agency and the provider has not received payment within 30 days after the date of service.

1. Cost effectiveness of recovery is determined by, but not limited to time, effort, and capital outlay required to perform the activity. The HMO upon request of the Department must be able to specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which the HMO determines seeking reimbursement would not be cost effective. COB activities include pursuit of the HMO's subrogation rights under the Ch. 49 of the WI Statutes.

2. To ensure compliance, the HMO must maintain records of all COB collections and report them to the Department on a quarterly basis. The COB report must be submitted in the format specified in this Contract (Art. VII). The HMO must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for members. The HMO must seek from all members' information on other available resources. The HMO must also seek to coordinate benefits before claiming reimbursement from the Department for the ventilator dependent members:

   a. Other available resources may include, but are not limited to, all other state or federal medical care programs that are primary to BadgerCare Plus, group or individual health insurance, ERISAs, service benefit plans, the insurance of absent parents who may have insurance to pay medical care for spouses or minor members, and subrogation/worker's compensation collections.

   b. Subrogation collections are any recoverable amounts arising out of the settlement of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the HMO under Act 31, Laws of 1989, s. 49.89(9). After attorneys' fees and expenses have been paid, the HMO will collect the full amount paid on behalf of the member.

3. Section 1912(b) of the Social Security Act must be construed in a beneficiary-specific manner. The purpose of the distribution provision is to permit the beneficiary to retain TPL benefits to which he or she is entitled except to the extent that BadgerCare Plus (or the HMO on behalf of BadgerCare Plus) is reimbursed for its costs. The HMO is free, within the constraints of state law and this Contract, to make whatever case it can to recover the costs it incurred on behalf of its member. It can use the max fee schedule, an estimate of what a capitated physician would charge on a FFS basis, the value of the care provided in the market place, or some other acceptable proxy as the basis of recovery. However, any excess recovery, over and above the cost of care (however the HMO chooses to define that cost), must be returned to the beneficiary. The HMO may not collect from amounts allotted to the beneficiary in a judgment or court-approved settlement.

4. COB collections are the responsibility of the HMO or its subcontractors. Subcontractors must report COB information to the HMO. The HMO and its subcontractors must not pursue collection from the member, but directly from the third party payer. Access to medical services must not be restricted due to COB collection.

5. The following requirement applies if the Contractor (or the Contractor's parent firm and/or any subdivision or subsidiary of either the Contractor's

parent firm or of the Contractor) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organization(s), and/or employer self-insurer health plan(s):

a. Throughout the Contract term, these insurers and third-party administrators must comply in full with the provision of Wis. Stats., Subsection 49.475. Such compliance must include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided must be consistent with the Department's written specifications.

b. Throughout the Contract term, these insurers and third-party administrators must also accept and properly process post payment billings from the Department's fiscal agent for health care services and items received by BadgerCare Plus members.

6. If at any time during the Contract term any of the insurers or third party administrators fail, in whole or in part to collect from third party payers, the Department may take the remedial measures specified in this Contract.

G. Recoupments

The Department will not normally recoup HMO per capita payments when the HMO actually provided services. However, if the BadgerCare Plus member cannot use HMO facilities, the Department will recoup the HMO capitation payments. Such situations are described more fully below:

1. The Department will recoup the HMO capitation payments for the following situations where a member's HMO status has changed before the first day of a month for which a capitation payment has been made:

   a. Member moves out of the HMO's service area.

   b. Member enters a public institution.

   c. Member dies.

2. The Department will recoup the HMO capitation payments for the following situations where the Department initiates a change in a member's HMO status on a retroactive basis, reflecting the fact that the HMO was not able to provide services. In these situations, recoupments for multiple months' capitation payments are more likely:

a. Correction of a computer or human error, where the person was never really enrolled in the HMO.

b. Disenrollments of members for reasons of pregnancy and continuity of care, or for the reasons specified in this Contract.

3. If membership is disputed between two HMOs, the Department will be the final arbitrator of HMO membership and reserve the right to recoup an inappropriate capitation payment.

4. If the HMO member moves out of the HMO's service area, the member will be disenrolled from the HMO on the date the member moved as verified by the eligibility worker. If the eligibility worker is unable to verify the member's move, the HMO may mail a "certified return receipt requested" letter to the member to verify the move. The member must sign for the letter. A copy of the letter and the signed return receipt must be sent to the Department or its designee within 20 days of the member's signature date. If this criteria is met the effective date of the disenrollment is the first of the month in which the certified returned receipt requested letter was sent. Documentation that fails to meet the 20 day criteria will result in disenrollment the first day of the month that the HMO supplied information to the Department or its designee. This policy does not apply to extended service area requests that have been approved by the HMO unless the member moves out of the extended service area or the HMO's service area. Any capitation payment made for periods of time after disenrollment will be recouped.

5. If the HMO is unable to meet the HealthCheck requirements.

H. Neonatal Intensive Care Unit (NICU) Risk-Sharing Payment(s)

The HMO may seek reimbursement as specified. The Department will reimburse each HMO for a portion of the NICU costs incurred by the HMO per county for those members who meet the criteria defined in Subsection 1 below and if the HMO's average number of NICU days per thousand member years per county exceeds 75 days per thousand member years per county during the Contract period.

1. Coverage Criteria

a. NICU days cover any newborn transferred or directly admitted after birth to a Level II, Level III, or Level IV SCN/NICD for treatment and/or observation under the care of a neonatologist or pediatrician. NICU coverage continues until the infant is deemed medically stable to be discharged to a newborn nursery, medical floor or home. Level II, III, and IV facilities provide the following services:

1) Level II facilities provide a full range of services for low birth weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates.

2) Level III facilities provide a full range of newborn intensive care services for neonatal patients who do not require intensive care but require 6-12 hours of nursing each day.

3) Level IV facilities provide a full range of services for severely ill neonates who require constant nursing and continuous cardiopulmonary and other support.

b. NICU days also cover any newborn infant transferred or directly admitted after birth to a Level II, Level III, or Level IV SCN/NICD who requires transfer to another institution for a severe compromised physical status, diagnostic testing or surgical intervention that cannot be provided at the hospital or initial admission. NICU coverage continues until the infant is transferred back to the initial hospital and deemed medically stable to be discharged to a newborn nursery, medical floor or home.

2. Reimbursement Criteria

a. The HMO's NICU reimbursement amount is calculated by contract period and by county. For NICU risk sharing, a "contract period" is defined as one year.

b. The Department will reimburse the HMO for 90% of the HMO's NICU cost per day, not to exceed a reimbursement of $1,443 per day, for each day that the HMO's average number of NICU days per thousand member years exceeds 75 NICU days per thousand member years per county during the Contract period.

c. The HMO's NICU cost per day includes the HMO's NICU inpatient payment per day and the HMO's associated physician payments. Associated physician payments refer to the total HMO payments made by the HMO to the physician(s) for services provided to the infant during the NICU stay. Associated physician payments are divided by the number of days reported for the NICU stay to determine the HMO's payment per day of associated physician payments.

Amounts paid must include payments for all physician and hospital services that were proved during the report period regardless of the HMO's actual payment date.

d. The Department makes the NICU reimbursement to the HMO after the end of the Contract year, after the HMO has submitted all needed NICU data. The Department will reimburse the HMO within 60 days of receipt of all necessary data from the HMO. The Department may make a final adjustment to the NICU reimbursement amount one year after the initial payment. This adjustment will be based on adjustments to eligible months and, updated information from the HMO such as the number of NICU days, inpatient payments, associated physician payments and amounts recovered from third parties.

e. The number of eligible months for the NICU calculation must include the HMO's entire BadgerCare Plus Standard and Benchmark Plan population. If a member's medical status code is retroactively backdated to an SSI medical status code and the HMO receives a capitation payment for those months, those months must also be included in the NICU calculation. The Department will make the final determination regarding the number of eligible months for the NICU calculation by HMO, by county and by year, using Wisconsin ForwardHealth InterChange.

f. Costs for care provided to NICU members who are retroactively disenrolled are not payable. The HMO must back out the costs of care provided during the backdated period from their NICU reports.

3. Reporting Requirements

The HMO that chooses to submit their report(s) under the NICU enhanced funding policy must follow the reporting requirements below:

a. The HMO may submit an interim and final report for each contract period if the NICU criteria are met. The HMO does not have to file a report if the NICU criteria are not met:

1) An interim report must be submitted to the Department on or before April 1 of the following year (i.e., an interim report for the period January 1, 2010, through December 31, 2010, must be submitted on or before April 1, 2011).

2) The final report must be submitted on or before April 1, one year after the submission of an interim report (i.e., a final report for the period January 1, 2010, through December 31, 2010, must be submitted on or before April 1, 2012).

b. The HMO must submit all data by county and in the format requested by the Department for calculating the NICU reimbursement on or before April 1 of the following calendar year. The data and data format requirements are defined Article VII.

c. The HMO must submit their NICU report(s) to the Department's Bureau of Fiscal Management.

4. Dispute Resolution

Disputes regarding the Department's payment or nonpayment of NICU services as well as any adjustments made by the HMO (e.g., adjustments to provider payments, NICU days or adjustments due to amounts

recovered from third parties) must be submitted in the next report period as specified in Article VII, K or they will not be considered..

I. Payment(s) for Ventilator Dependent Members

For the purposes of this reimbursement, a ventilator-assisted patient must be admitted to a hospital and require equipment that provides total respiratory support or the patient must have died while on respiratory support. This equipment may be a volume ventilator, a negative pressure ventilator, a continuous positive airway pressure (CPAP) system, or a Bi (inspiratory and expiratory) PAP. The patient may need a combination of these systems. Any equipment used only for the treatment of sleep apnea does not qualify as total respiratory support

1. BadgerCare Plus Criteria

   Total respiratory support must be required for a total of six or more hours per 24 hours. The patient must have total respiratory support for at least 30 days that need not be continuous. Day one is the day that the patient is placed on the ventilator. If the patient is on the ventilator for less than six hours on the first day, the use must continue into the next day and be more than six total hours. Each day that the patient is on the ventilator for part of any day, as long as it is part of the six total hours per 24 hours, it counts as a day for enhanced funding. The absolute need for respiratory support must be supported by appropriate medical documentation.

2. Payment Requirements for All Policies

   The Department will pay 100% of the HMO's medical cost up to 150% of the Medicaid fee-for-service costs of providing BadgerCare Plus covered services to BadgerCare Plus HMO members who meet the ventilator dependent criteria. Reimbursement will only be for Medicaid covered services paid by the HMO. Other associated costs, such as administration or interest, will not be reimbursed.

   a. Enhanced Funding

      1) Newborns

         The period of enhanced funding for newborns who are on total respiratory support at birth, will begin with the newborn's date of birth. The period of enhanced funding will end on the newborn's date of death if the newborn dies while on total respiratory support or the last day of the month of the qualifying hospital stay.

      2) All Other Members

The period of enhanced funding for all other members who meet the ventilator dependency criteria will begin on the first day of the month the member was hospitalized. The period of enhanced funding will end on the member's date of death if the member dies while on total respiratory support or the last day of the month of the qualifying hospital stay.

b. Payment Adjustments For All Policies

Adjustments that will be made to the HMO's final payment include, but are not limited to:

- Reimbursement(s) already paid to the HMO in the form of capitation payments for members who qualify as being ventilator dependent will be deducted from the HMO's 100% reimbursement.

- Costs for care provided to ventilator dependent members who are retroactively disenrolled are not payable. The HMO must back out the cost of care that was provided during the period the member was retroactively disenrolled from their reports.

- Costs for services provided after the member's date of death are not covered by the Medicaid program. If they are submitted for payment they will be denied.

c. Payment Dispute Resolution For All Policies

Disputes regarding the Department's payment or nonpayment of ventilator dependent BadgerCare Plus services as well as any adjustments made by the HMO (e.g., adjustments to provider payments or adjustments due to amounts recovered from third parties) must be submitted in the next report period.

3. Documentation Requirements

To qualify members for reimbursement, the HMO must submit documentation that is required for each policy at the same time as the quarterly reports (Article VI). The HMO may use the Department's designated form or develop their own as long as it contains the required information as specified for each policy.

a. BadgerCare Plus

- A signed statement from the physician attesting to the need of the patient.

- Copies of the vent flow chart or progress notes that show the need for continuation of total ventilator support, and any change in the type of ventilator support and the removal of the ventilator support.

4. Reporting Requirements For All Policies

The HMO must submit detail reports on a CD-Rom in an Excel file and hard copy. The reports must be submitted to the Department's Bureau of Fiscal Management on a quarterly basis as specified in Article VII and include all the data elements specified in Addendum IV.

As required by the Wis. Adm. Code DHS 106.03 payment data or adjustment data must be received within 365 days after the date of the service. Since the HMO is required to submit their ventilator claim(s) to the Department on a quarterly basis, the HMO will be given an additional three months plus 10 days to file their claim(s) or payment data adjustment(s). In addition, if the last date of service for an inpatient hospital facility stay occurs within the same timeline specified (365 days plus three months plus 10 days) the Department will reimburse the HMO for the facility charges that entire stay. If the HMO cannot meet these requirements, the HMO must provide documentation that substantiates the delay. The Department will make the final determination to pay or deny the services. The Department will exercise reasonable discretion in making the determination to waive the 365 day filing requirements.

J. Hospital Access Payment

Within the limits of the budgeted allocation from the hospital assessment fund, the Department will pay the HMO a monthly hospital inpatient access payment and a monthly hospital outpatient access payment. The Department's monthly hospital access payments to the HMOs are made as prospective "per member per month" payments, unadjusted for CDPS.

The HMO shall make payments to eligible hospitals based on the number of qualifying discharges and visits in the previous month. Payments must be sent within 15 calendar days after the HMO receives the monthly amounts from the Department. These payments are in addition to any amount the HMO is required by agreement to pay the hospital for provision of services to HMO members.

An "eligible hospital" means a Wisconsin hospital that is not a critical access hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the

psychiatric hospital and that is not a satellite of an acute care hospital. A list of qualifying hospitals is available from the Department upon request.

"Qualifying discharges and visits" are inpatient discharges and outpatient visits for which the HMO made payments in the month preceding the Department's monthly access payment to the HMO for services to the HMO's Medicaid and BadgerCare Plus members, other than Core Plan members or members who are eligible for both Medicaid and Medicare. HMOs shall exclude all members who are dually-eligible and all dual-eligible claims. If a third party pays the claim in full, and the HMO does not make a payment, the claim shall not count as a qualifying claim for the hospital access payment. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for the hospital access payment.

1. Method of payment to hospitals

   a. Payments must be sent to eligible hospitals within 15 calendar days of the HMO receiving the hospital access payments from the Department. The HMO shall pay out the full amounts of hospital access payments. The HMO will base its hospital payments upon the number of qualifying discharges and the number of qualifying visits regardless of the amount of the base claims payment for those discharges and visits. The HMO shall pay each eligible hospital based upon its percentage of the total number of qualifying discharges and the total number of qualifying visits for all eligible hospitals. The HMO shall calculate the percentage of the total access payment that each hospital would receive to the fourth decimal point.

   b. An example of the payment methodology is as follows:

      HMO A receives $1 million for inpatient access payments and $500,000 for outpatient access payments in the month of June. HMO A distributes inpatient and outpatient access payments to eligible hospitals received from the Department in June according to the following formula:

      1) Inpatient: HMO A counts 1,000 inpatient qualifying discharges paid in May (excluding Medicare crossover claims) to three eligible hospitals.

         Hospital X was paid for 300 discharges by HMO A in the month of May, and therefore, will receive 30% of the total inpatient access payment HMO A received from the Department in June.

2) Outpatient: HMO A counts 2,000 outpatient qualifying visits paid in May (excluding Medicare crossover claims) to five eligible hospitals.

Hospital X was paid for 400 visits by HMO A in the month of May, and therefore, will receive 20% of the total outpatient access payment HMO A received from the Department in June.

2. Payment of SFY09 base hospital rates

For HMOs, any reference made to the "FFS rate schedule" in HMO-hospital contracts that is meant to be used as the basis of HMO DRG payments for dates of service and discharges from July 1, 2008 through June 30, 2009 will be the SFY08 FFS hospital DRG rates.

3. Monthly reporting requirements

a. The HMO shall send a report along with its monthly payment to each eligible hospital that contains the following information:

1) The amount of the hospital access payments received from the Department for inpatient discharges;
2) The amount of the hospital access payments received from the Department for outpatient discharges;
3) That hospital's number of qualifying inpatient discharges;
4) The hospital's number of qualifying outpatient visits;
5) The total number of qualifying inpatient discharges for all qualifying hospitals;
6) The total number of qualifying outpatient visits;
7) Access payment amount per qualifying inpatient discharge;
8) Access payment amount per qualifying outpatient visit;
9) The amount of the total payment to that hospital.

b. Within 20 days of receipt of payment from the Department, the HMO must submit the report in Addendum IV, K to the Department.

4. Noncompliance

The Department shall have the right to audit any records of the HMO to determine if the HMO has complied with the requirements in this section L. If at any time the Department determines that the HMO has not complied with any requirement in this section L, the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department's determination of noncompliance. If the HMO fails to comply after an order, the Department may terminate the contract as provided under Article XII.

Upon request, the HMO must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

If the HMO fails to send payment to the hospital within 15 calendar days of receiving the hospital access payment from the Department, the HMO will pay a fine to the Department equal to three percent of the delayed payment.

5. Payment disputes

If the HMO or the hospital dispute the monthly amount that the HMO is required to pay the hospital, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The HMO or hospital may request a contested case hearing under Ch. 227 on the Department's determination.

6. Resolution of Reporting Errors

The HMO shall adjust prior hospital access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient visits. If an error is discovered, the adjustment will be applied on a prospective basis. Errors shall be corrected in the next distribution of the monthly access payments the HMO receives from DHS.

Inpatient discharges and outpatient visits that were excluded in error shall be added into the calculation for the distribution of the next monthly access payments the HMO receives from DHS.

Discharges and visits that were included in error in previous payments shall be corrected in the next distribution of the monthly access payments the HMO receives from DHS. The number of discharges and visits paid in error will be subtracted from the number of discharges and visits eligible for payment in the current payment month. If there are insufficient numbers of discharges or visits in the current payment month to offset the error, the remaining uncorrected discharges or visits shall be carried forward and corrected in the next payment month.

K. Ambulatory Surgical Center (ASC) Assessment

The Department will pay the HMO a monthly ambulatory surgical center payment, within the limits of the budgeted allocation from the Medicaid Trust fund. The Department's monthly ambulatory surgical center payments to the HMOs are made as prospective "per member per month" payments, unadjusted for CDPS and rate region realignment.

Payments must be sent to the ASCs within 15 calendar days after receipt of the monthly amounts from the Department. The HMO shall make payments to eligible ambulatory surgical centers based on the number of qualifying visits paid in the previous month. These payments are in addition to any amount the HMO is required by agreement to pay the ASC for provision of services to HMO members.

An "eligible ASC" is a Medicare certified ASC in the state of Wisconsin. A list of qualifying ASCs is available from the Department upon request.

"Qualifying visit" is any visit for which the HMO made payments in the month preceding the Department's monthly access payment to the HMO for services to the HMO's Medicaid and BadgerCare Plus members, other than Core Plan members. HMOs shall include all members who are dually-eligible and all dual-eligible visits.

- Non-Crossover Claims

  For non-crossover claims, if a third party pays the claim in full, and the HMO does not make a payment, the claim shall not count as a qualifying claim for the ASC access payment. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying visit for the ASC access payment.

- Crossover Claims

  For crossover claims, if the HMO adjudicates the claim to be valid, the claims shall count as a qualifying visit for the ASC access payment even if the adjudication results in a payment of zero. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying visit for the ASC access payment.

1. Method of payment to ambulatory surgical centers

   Payments must be sent to eligible ASCs within 15 calendar days of the HMO receiving the ambulatory surgical center payments from the Department. The HMO shall pay out the full amounts of ambulatory surgical center payments. The HMO will base its ASC payments upon the number of qualifying visits regardless of the amount of the base visit

payment for those visits. The HMO shall pay each eligible ASC based upon its percentage of the total number of qualifying visits for all eligible ASCs. The HMO shall calculate the percentage of the total access payment that each ASC would receive to the fourth decimal point. If the HMO has no qualifying visits, the HMO shall return payment to the Department and submit a report to the Department stating "no payments were made".

a. An example of the payment methodology is as follows:

HMO A receives $100,000 for ASC access payments in the month of June. HMO A distributes access payments received from the Department in June to eligible ASCs according to the following formula:

HMO A counts 100 inpatient qualifying visits paid in May (including Medicare crossover claims and excluding visits paid for Core Plan members) to three eligible ASCs.

ASC X was paid for 30 visits by HMO A in the month of May, and therefore, will receive 30% of the total access payment HMO A received from the Department in June.

2. Monthly reporting requirements

a. The HMO shall send a report along with its monthly payment to each eligible ASC that contains the following information:

1. The amount of the ASC payments received from the Department;
2. The ASC's number of qualifying visits;
3. The total number of qualifying visits for all qualifying ASCs;
4. Access payment amount per qualifying visit;
5. The amount of the total payment to that ASC.

b. The HMO must submit the report in Addendum IV, K to the Department within 20 calendar days of receipt of payment from the Department.

3. Noncompliance

The Department shall have the right to audit any records of the HMO to determine if the HMO has complied with the requirements in this section. If at any time the Department determines that the HMO has not complied with any requirement in this section, the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department's determination of noncompliance. If the HMO

fails to comply after an order, the Department may terminate the contract as provided under Article XII.

Upon request, the HMO must submit a list of qualifying visits to the Department and any other records the Department deems necessary to determine compliance.

If the HMO fails to send payment to the ASC within 15 calendar days of receiving the ASC access payment from the Department, the HMO will pay a fine to the Department equal to three percent of the delayed payment.

4. Payment disputes

If the HMO or the ASC dispute the monthly amount that the HMO is required to pay the ASC, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The HMO or ASC may request a contested case hearing under Ch. 227 on the Department's determination.

5. Resolution of Reporting Errors

The HMO shall adjust prior ASC payments that were based on an inaccurate counting of qualifying visits. If an error is discovered, the adjustment will be applied on a prospective basis. Errors shall be corrected in subsequent distributions of the monthly access payments the HMO receives from DHS.

Visits that were excluded in error shall be added into the calculation for the distribution of the next monthly access payments the HMO receives from DHS.

Visits that were included in error in previous payments shall be corrected in the next distribution of the monthly access payments the HMO receives from DHS. The number of visits paid in error will be subtracted from the number of visits eligible for payment in the current payment month. If there are insufficient numbers of visits in the current payment month to offset the error, the remaining uncorrected visits shall be carried forward and corrected in the next payment month.

L. Critical Access Hospital (CAH) Access Payment

Within the limits of the budgeted allocation from the Critical Access Hospital (CAH) assessment fund, the Department will pay the HMO a monthly CAH inpatient access payment and a monthly CAH outpatient access payment. The Department's monthly CAH access payments to the HMOs are made as prospective "per member per month" payments, unadjusted for CDPS.

The HMO shall make payments to eligible CAHs based on the number of qualifying discharges and visits in the previous month. Payments must be sent to the CAH with 15 calendar days after the HMO receives the monthly amounts from the Department. These payments are in addition to any amount the HMO is required by agreement to pay the CAH for provision of services to HMO members.

An "eligible CAH" means a Wisconsin CAH that is not an acute care hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital. A list of qualifying CAHs is available from the Department upon request.

"Qualifying discharges and visits" are inpatient discharges and outpatient visits for which the HMO made payments in the month preceding the Department's monthly access payment to the HMO for services to the HMO's Medicaid and BadgerCare Plus Members, other than Core Plan members or members who are eligible for both Medicaid and Medicare. HMOs shall exclude all members who are dually-eligible and all dual-eligible claims. If a third party pays the claim in full, and the HMO does not make a payment, the claim shall not count as a qualifying claim for the CAH access payment. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for the CAH access payment.

1. Method of payment to hospitals

   Payments must be sent to eligible CAHs within 15 calendar days of the HMO receiving the CAH access payments from the Department. The HMO shall pay out the full amounts of CAH access payments. The HMO will base its CAH payments upon the number of qualifying discharges and the number of qualifying visits regardless of the amount of the base claims payment for those discharges and visits. The HMO shall pay each eligible CAH based on upon its percentage of the total number of qualifying discharges and the total number of qualifying visits for all eligible CAHs. The HMO shall calculate the percentage of the total access payment that each hospital would receive to the fourth decimal point.

   a. An example of the payment of methodology is as follows:

HMO A receives $1 million for inpatient access payments and $500,000 for outpatient access payments in the month of June. HMO A distributes inpatient and outpatient access payments to eligible CAHs received from the Department in June according to the following formula:

1) Inpatient: HMO A counts 1,000 inpatient qualifying discharges paid in May (excluding Medicare crossover claims) to three eligible CAHs.

   CAH X was paid for 300 discharges by HMO A in the month of May, and therefore, will receive 30% of the total inpatient access payment HMO A received from the Department in June.

2) Outpatient: HMO A counts 2,000 outpatient qualifying visits paid in May (excluding Medicare crossover claims) to five eligible CAHs.

   CAH X was paid for 400 visits by HMO A in the month of May, and therefore, will receive 20% of the total outpatient access payment HMO A received from the Department in June.

2. Monthly reporting requirements

   a. The HMO shall send a report along with its monthly payment to each eligible CAH that contains the following information:

      1) The amount of the CAH access payments received from the Department for inpatient discharges;
      2) The amount of the CAH access payments received from the Department for outpatient discharges;
      3) The CAHs number of qualifying inpatient discharges;
      4) The CAHs number of qualifying outpatient visits;
      5) The total number of qualifying inpatient discharges for all qualifying CAHs;
      6) The total number of qualifying outpatient visits;
      7) Access payment amount per qualifying inpatient discharge;
      8) Access payment amount per qualifying outpatient visit;
      9) The amount of the total payment to that CAH.

   b. Within 20 calendar days of receipt of payment from the Department, the HMO must submit the report in Addendum IV, K to the Department.

3. Noncompliance

The Department shall have the right to audit any records of the HMO to determine if the HMO has complied with the requirements in this section L. If at any time the Department determines that the HMO has not complied with any requirement in this section L, the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department's determination of noncompliance. If the HMO fails to comply after an order, the Department may terminate the contract as provided under Article XII.

Upon request, the HMO must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

If the HMO fails to send payment to the CAH within 15 calendar days of receiving the CAH access payment from the Department, the HMO will pay a fine to the Department equal to three percent of the delayed payment.

4. Payment disputes

If the HMO or the CAH dispute the monthly amount that the HMO is required ot pay the CAH, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The HMO or CAH may request a contested case hearing under CH. 227 on the Department's determination.

5. Resolution of Reporting Errors

The HMO shall adjust prior CAH access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient visits. If an error is discovered, the adjustment will be applied on a prospective basis. Errors shall be corrected in the next distribution of the monthly access payments the HMO receives from DHS.

Inpatient discharges and outpatient visits that were excluded in error shall be added into the calculation for the distribution of the next monthly access payments the HMO receives from DHS.

Discharges and visits that were included in error in previous payments shall be corrected in the next distribution of the monthly access payments the HMO receives from DHS. The number of discharges and visits paid in error will be subtracted from the number of discharges and visits eligible for payment in the current payment month. If there are insufficient numbers of discharges or visits in the current payment month

to offset the error, the remaining uncorrected discharges or visits shall be carried forward and corrected in the next payment month.

M. Payment Method

All payments, recoupments, and debit adjustments for payments made in error, distributed by the Department to the HMO will be made via Electronic Funds Transfer (EFT) via enrollment through the secure ForwardHealth Portal account.

HMOs are responsible for maintaining complete and accurate EFT information in order to receive payment. If a HMO fails to maintain complete and accurate information and DHS makes a payment to an incorrect account, the Department will be held harmless and will not reissue a payment.

All arrangements between the financial institution specified for EFT and the HMO must be in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.

EFT information provided by the HMOs via their secure ForwardHealth Portal account constitute a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and if any such information is false, criminal or other penalties may be imposed under these laws.

The requirements and obligations for EFT are in addition to any and all other requirements and obligations applicable to HMO in connection with their contract and their participation in any program that is part of ForwardHealth, including but not limited to requirements and obligations set forth in federal and state statutes and rules and applicable handbooks and updates.

ARTICLE VII

VII. COMPUTER/DATA REPORTING SYSTEM, DATA, RECORDS AND REPORTS

A. Required Use of the secure ForwardHealth Portal

All HMOs must request a secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions and other business with the DHS.

HMOs must assign users roles/permissions within the secure ForwardHealth Portal account to ensure only authorized users have access to data and functions provided. HMOs must ensure all users understand and comply with all HIPAA regulations.

B. Access to and/or Disclosure of Financial Records

The HMO and any subcontractors must make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the HMO or subcontractors that relate to the HMO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this Contract. The HMO must comply with applicable record keeping requirements specified in **Wis. Adm. Code DHS 105.02(1)-(7)** as amended.

C. Access to and Audit of Contract Records

Throughout the duration of this Contract, and for a period of five years after termination of this Contract, the HMO must provide duly authorized representatives of the state or federal government access to all records and material relating to the HMO's provision of and reimbursement for activities contemplated under the Contract. Such access shall include the right to inspect, audit and reproduce all such records and material, including but not limited to computer records system, invoices, and to verify reports furnished in compliance with the provisions of this Contract. All information so obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations. Refusal to provide required materials during an audit may subject the HMO to sanctions in Article XI.

D. Computer Data Reporting System

The HMO must maintain a computer/data reporting system that meets the following Department requirements. The HMO is responsible for complying with all the Department's reporting requirements and with ensuring the accuracy and completeness of the data as well as the timely submission of data. The data submitted must be supported by records available to the Department or its designee. The Department reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract. The HMO must have a contact person responsible for the computer/data reporting system and who can answer questions from the Department and resolve problems identified by the Department regarding the requirements listed below:

1. The HMO must have a claims processing system that is adequate to meet all claims processing and retrieval requirements specified.

2. The HMO must have a computer/data collection, processing, and reporting system sufficient to monitor HMO enrollment/disenrollment (in order to determine on any specific day which members are enrolled or disenrolled from the HMO) and to monitor service utilization for the Utilization Management requirements of Quality Assessment/Performance Improvement (QAPI).

3. The HMO must have a computer/data collection, processing, and reporting system sufficient to support the QAPI requirements. The system must be able to support the variety of QAPI monitoring and evaluation activities, including the monitoring/evaluation of quality of clinical care and service; periodic evaluation of HMO providers; member feedback on QAPI; maintenance of and use of medical records in QAPI; and monitoring and evaluation for annual QAPI study topics.

4. The HMO must have a computer and data processing system sufficient to accurately produce the data, reports, and encounter data set, in the formats and time lines prescribed by the Department in this Contract to the HMO is required to submit electronic test encounter data files as required by the Department in the format specified by the Department (Art. VII). The electronic test encounter data files are subject to Department review and approval before production data is accepted by the Department. Production claims or other documented encounter data must be used for the test data files.

5. The HMO must capture and maintain a claim record of each service or item provided to members, using CMS 1500, UB-04, NCPDP, HIPAA transaction code sets, or other claim, or claim formats that are adequate to meet all reporting requirements of this Contract. The computerized database must be a complete and accurate representation of all services the HMO covers for the Contract period. The HMO is responsible for monitoring the integrity of the database, and facilitating its appropriate use

for such required reports as encounter data and targeted performance improvement studies.

6. The HMO must have a computer processing and reporting system that is capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

7. The HMO reporting system must have the ability to identify all denied claims/encounters using national HIPAA Claim Adjustment Reason Codes.

8. The HMO system must be capable of reporting original and reversed claim detail records or encounters.

9. The HMO system must be capable of correcting an error to the encounter record within 90 days of notification by the Department.

10. The HMO must maintain and populate a tobacco registry (electronic database of information about members with identified tobacco or nicotine addiction or current smoker status).

The HMO 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.

E. Coordination of Benefits (COB), Encounter Record, Formal Grievances and Birth Cost Reporting Requirements

The HMO agrees to furnish to the Department and to its authorized agents, within the Department's time frame and format, information that the Department requires to administer this Contract, including but not limited to the following:

1. *Coordination of Benefits (COB)*

   Summaries of amounts recovered from third parties for services rendered to members under this Contract.

2. *Encounter Record for Each Member Service*

   An encounter record for each service provided to members covered under this Contract. The encounter data set must include at least those data elements specified.

3. *Formal Grievances*

   Copies of all formal grievances and documentation of actions taken on each grievance.

4. *Birth Cost*

As specified in Addendum IV, E.

F. Encounter Data Reporting Requirements

The HMO that contracts with the Department to provide BadgerCare Plus services must submit monthly encounter data files according to the specifications and submission protocols published in the HMO Encounter Data User Manual.

1. Reporting Requirement

The rules governing the level of detail when reporting encounters should be those rules established by the following classification schemes: ICD-9-CM (or ICD-10-CM) diagnosis codes and CPT and HCPCS procedure codes National Drug Codes (NDC), CDT codes, hospital revenue codes for inpatient and outpatient hospital services, and hospital inpatient Diagnostic Related Group (DRG) codes, if DRG codes are used.

Multiple encounters can occur between a single provider and a single member on a day. For example, if a physician provides a limited office visit, administers an immunization, and takes a chest x-ray, and the provider submits a claim or report specifically identifying all three services, then there are three encounters, and the HMO will report three encounters to the BadgerCare Plus Programs.

2. Testing Encounter Data

A new HMO must test the encounter data set until the Department is satisfied that the HMO is capable of submitting valid, accurate, and timely encounter data according to the schedule and timetable.

3. Primary HMO Contact Person

The HMO must specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting HMO encounter and utilization data, and a secondary contact person in the event the primary contact person is not available.

4. HMO Encounter Technical Workgroup Requirement

The HMO must assign staff to participate in HMO encounter technical workgroup meetings periodically scheduled by the Department. This workgroup's purpose is to enhance the HMO and BadgerCare Plus data submission protocols and improve the accuracy and completeness of the data.

5. Encounter Data Completeness and Accuracy

The Department will conduct data validity and completeness audits during the Contract period. At least one of these audits will include a review of the HMO's encounter data system and system logic.

6. Analysis of Encounter Data

The Department retains the right to analyze encounter data and use it for any purpose it deems necessary. However, the Department will make every effort to ensure that the analysis does not violate the integrity of the reported data submitted by the HMO.

The HMO that subcontracts with providers must have the provisions for assuring that the data required on the HMO Utilization Report is reported to the HMO by the subcontractor. For example, subcontracts with providers of mental health or dental services must have a provision ensuring that survey and encounter data is reported to the HMO in an accurate and timely fashion.

The Department agrees to involve the HMO in the planning process prior to implementing any changes in questions or measures, format and definitions, and will request the HMO to review and comment on those changes before they go into effect.

G. Records Retention

The HMO must retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including paper and electronic claim forms, for a period of not less than five years from the date of termination of this Contract. Records involving matters that are the subject of litigation shall be retained for a period of not less than five years following the termination of litigation. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, if the Department approves the microfilming procedures as reliable and supported by an effective retrieval system.

Upon expiration of the five year retention period and upon request, the subject records must be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

H. Reporting of Corporate and Other Changes

The HMO must report to the Department any change in corporate structure or any other change in information previously reported. The HMO must report the

change as soon as possible, but no later than 30 days after the effective date of the change. Changes in information covered under this section include all of the following:

1. Any change to the information the HMO previously provided in response to the Department's questions in the current HMO certification application or any previous RFB/RFP for BadgerCare Plus HMO Contracts. This includes any change in information provided by the HMO as a "new HMO," within the meaning of the HMO certification application or RFB/RFP.

2. Any change in information relevant to ineligible organizations.

3. Any change in information relevant to ownership and business transactions of the HMO.

I. Provider and Facility Network Data Submission

1. The HMO that contracts with the Department to provide BadgerCare Plus services must submit a detailed provider network and facility report, in the format designated by DHS, to the State's FTP on a monthly basis and when the HMO experiences significant change with respect to network adequacy. (Facility report includes any physical address in which HMO providers serve members, i.e. clinics and hospitals.

2. The provider network and facility data file shall include only Medicaid-certified providers who are contracted with the HMO to provide contract services to BadgerCare Plus members. The provider network and facility data submission must be completed by the first business day of every month. Reporting dates are included in Article VII, K.

3. HMOs must submit full and complete, accurate, provider network and facility data. The Department will provide the HMO with the required and critical data fields. The Department retains the right to conduct audits of provider and facility data for completeness and accuracy during the contract period. Incomplete or inaccurate provider and/or facility data will subject the HMO to administrative sanctions outlined in Article XI.

J. Medical Loss Ratio Reporting

Each participating HMO must provide a Medical Loss Ratio (MLR) report annually for each calendar year by July 15 of the following year.

The report must include one (1) MLR page for each specific BadgerCare Plus population:

- Standard Plan
- Benchmark Plan

Instructions for completing the report:

- Enter the following fields, **MCO name, reporting month, monthly eligible months, and aggregate payments by rate region.**

- Each month report the amount of **Payments for Medical Services** made as of the effective date for services incurred through the end of the month on a cumulative calendar year to date basis.

- Report the amount of **Payments by the Claims Processing System**. For Medical Services these payments should be reported by category of service.

- Report for each month the total amount of **Capitation Payments.** Capitation payments should include payments made directly to a service provider on a capitated basis.

- Report for each month the total amount of **Subcontract Payments for Medical Services**. Subcontract payments should include payments made for services that are coordinated or arranged by a subcontractor. Include a description of each service and expenditure amount.

- Report for each month the total amount of **Reinsurance Payments**. Reinsurance payments are payments made to a licensed or authorized reinsurer to limit medical and hospital expenses by reducing maximum expenses on an individual basis, on an aggregate basis, or both.

- Report for each month the total amount of **Other Payments/Adjustments to Medical Costs**. Other payments may include settlements and claims payments made outside the claims processing system. Other payments/adjustments made for services incurred prior to the reporting month must be excluded.

- Report for each month the total amount of **Grant Payments**, if applicable.

- Report for each month the total amount of **Provider Incentives**, if applicable.

- Report for each month total amount of **Recoveries Not Reflected in Payments by the Claims System**. Recoveries may include reinsurance payments, subrogation payments, and other settlement payments received.

- Report the **Remaining IBNR for the Month**. The remaining IBNR is the estimate amount to be paid for services incurred through the report month but not yet reported. IBNR should not include estimated bonus payments, unless specifically accounted for in the provider's contract. A brief explanation of the IBNR estimate should be attached. All prior periods should be updated each month.

The Department may request additional changes to the report at a future date. The report format will be sent to the HMO prior to the due date of each year. Additional details on how to individually group each of the categories may be provided by the Department. The HMO must provide supporting details of each of the above categories upon request of the Department.

K. Contract Specified Reports and Due Dates

2010 - 2013 REPORTS AND DUE DATES

Type of Report	Frequency	Report Period	Reporting Unit	Report Format	Location in Contract
Encounter Data File	Monthly, on 10th	Previous Month	Fiscal Agent	Electronic Media	Art. VII, E
HMO Provider and Facility Network	First business day of every month, or for significant changes	Next month	DHS	Electronic Media	Art. III, H Art. VII, I
Annual Performance Report	June 1	Annual	BBM	Electronic Media	Art. IV, M
Formal/Informal Grievance Experience Summary Report	Quarterly (within 30 days of end of quarter)	Previous Quarter	BBM	Hardcopy	Art. IX Add. IV, H Art. VII, E
Attestation Form	Quarterly	Previous Quarter	BBM	Hardcopy	Add. III, C Add. IV, I
Common Carrier Data	Quarterly	Previous Quarter	BFM – Rate Section	CD-Rom	Art. III, E Add. IV, J
Ventilator Dependent Report	Quarterly (within 30 days of the end of the quarter)	Previous Quarter	BFM	CD-Rom & Hardcopy	Art. VI, I Add. IV, A
Coordination of Benefits Report	Quarterly (within 45 days of end of quarter)	Previous Quarter	BBM	Electronic Media	Art. VI, F Art. VII, E
Neonatal ICU Patient Care Data	April 1	Annual	BFM	Hardcopy	Art. VI, H Add. IV, C
Initial Performance Improvement Project Topic Selection Summary	First business day of December	Annual	BBM & EQRO	Electronic Media	Art. IV, A Art. IV, J
Individual Hospital Access Payment Data	Monthly, at the time of access payment	Previous month	Any hospital the HMO made payments to	As determined by hospital contract	Art. VI, J Add. IV, K

	(Within 15 calendar days of receiving payment from DHS)				
Summary Hospital Access Payment Report	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically	Art. VI, J Add. IV, K
Individual Ambulatory Surgical Center Access Payment Data	Monthly, at the time of access payment (Within 15 calendar days of receiving payment from DHS)	Previous month	Any ASC the HMO made payments to	As determined by ASC contract	Art. VI, K Add. IV, L
Summary Ambulatory Surgical Center Access Payment Report	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically	Art. VI, K Add. IV, L
Individual Critical Access Hospital (CAH) Payment Data	Monthly, at the time of access payment (Within 15 calendar days of receiving payment from DHS)	Previous month	Any CAH the HMO made payments to	As determined by CAH contract	Art. VI, K Add. IV, K
Summary Critical Access Hospital Access Payment Report	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically	Art. VI, K Add. IV, K
Newborn Report	Monthly	Previous Month	Fiscal Agent	Password-protected E-mail or Fax	Add. IV, F
Affirmative Action (AA) Plan	Within 15 days of award of contract	Contract period	AA/CRC Office	As specified on VendorNet	Art. III, C

Civil Rights Compliance Letter of Assurance and Plan	Within 15 days of award of contract	Contract period	AA/CRC Office or filed until request	As specified on DHS website	Art. III, C
Member PCP assignment	First business day of every month	Next month	BBM	Electronic Media	Art. III, I
PCP data sharing plan	September 15, 2010	Term of contract	BBM	Hardcopy	Art. III, I
ED Utilization Management Plan	September 15, 2010	Term of contract	BBM	Hardcopy	Art. IV, M
Medical home pilot implementation plan	September 15, 2010	Term of contract	BBM	Hardcopy	Art. III, R
Medical home semi-annual evaluation	December 1 and June 1 (as part of Annual Performance Report)	Annually	BBM	Hardcopy	Art. III, R
Medical Loss Ratio (MLR) report	July 15	Annually	BFM	Electronic media	Art. VII, J

Any reports that are due on a weekend or holiday are due the following business day.

BBM = Bureau of Benefits Management
BFM = Bureau of Fiscal Management

Report Mailing Addresses:	Department of Health Services Bureau of Benefits Management P.O. Box 309 Madison, WI 53701-0309	Fiscal Agent Managed Care Unit P.O. Box 6470 Madison, WI 53716-0470	Department of Health Services Affirmative Action/Civil Rights Compliance Office P.O. Box 7850 Madison, WI 53707-7850	Department of Health Services Bureau of Fiscal Management P.O. Box 309 Madison, WI 53701-03

The Department electronically produces multiple reports and resources for use by BadgerCare Plus HMOs, which are listed at the following website: https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage.

ARTICLE VIII

VIII. ENROLLMENT AND DISENROLLMENTS

A. Enrollment

The HMO must accept as enrolled all persons who appear as members on the HMO Enrollment Reports. The Department reserves the right to assign a BadgerCare Plus member into a specific HMO when the member fails to choose an HMO during a required enrollment period.

Persons otherwise eligible for enrollment into the HMO cannot enroll if they are already participating in:

(1) A Community Integration Program (CIP); or
(2) A Community Options Program (COP); or
(3) Family Care (FC); or
(4) PACE or Partnership Program

BadgerCare Plus Standard and Benchmark Plans:
Enrollment in the HMO is voluntary by the member except where limited by departmental implementation of a State Plan Amendment or a Section 1115(a) waiver. The current State Plan Amendment and 1115(a) waiver require mandatory enrollment into an HMO for those service areas in which there are two or more HMOs with sufficient slots for the HMO eligible population and in rural areas, as defined in 42 CFR 438.52, where there is only one HMO with an adequate provider network as determined by the Department.

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

B. Enrollment Levels

The HMO must designate a maximum enrollment level for the entire service area. The enrollment level must be no less than 25,000 members. The Department may take up to 60 days from the date of written notification to implement maximum enrollment level changes. The HMO must accept as enrolled all persons who appear as members on the HMO Enrollment Reports up to the HMO specified enrollment level for its service area. The number of members may exceed the maximum enrollment level by 5% on a temporary basis. The Department does not guarantee any minimum enrollment level. The maximum enrollment level the HMO indicates on the effective date of the initial period of this contract will be fixed for the first 18 months of the contract or a time period designated by the Department. After then, the maximum enrollment level for a service area may be

increased or decreased during the course of the Contract period based on mutual acceptance of a different maximum enrollment level.

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

C. Enrollment and Disenrollment Practices

The HMO must permit the Department to monitor its enrollment and disenrollment practices. The HMO will not discriminate in enrollment or disenrollment activities between individuals on the basis of health status or requirement for health care services, including those who have AIDS or are HIV-positive. This includes a member with a diminished mental capacity, who is uncooperative and displays disruptive behavior due to the member's special needs.

The Department must ensure that members with medical status codes that are not eligible for HMO enrollment are appropriately disenrolled according to Department policy.

This section does not prevent the HMO from assisting in the disenrollment process for individuals who the Department determines should be assigned a different medical status code.

D. Disenrollment Requests

1. Voluntary Disenrollment

   All BadgerCare Plus members shall have the right to disenroll from the HMO pursuant to 42 CFR 438.56 unless otherwise limited by a State Plan Amendment or a Section 1115(a) waiver of federal laws. A voluntary disenrollment shall be effective no later than the first day of the second month following the month in which the member requests termination. Wisconsin currently has a State Plan Amendment and an 1115(a) waiver which allows the Department to "lock-in" members to the HMO for a period of 12 months in mandatory HMO service areas, except that disenrollment is allowed for just cause. Voluntary exemptions and disenrollments from the HMO are allowed for a variety of reasons.

   Members may also request disenrollment upon automatic reenrollment under 42 CFR 438.56(g) if the temporary loss of BadgerCare Plus enrollment has caused the member to miss the annual enrollment period.

   The HMO must give each member written notification of any significant change in disenrollment rights and time frames at least 30 days before the intended effective date of the change.

2. Involuntary Disenrollment

The Department may approve an involuntary disenrollment with an effective date that will be the next available benefit month based on enrollment system logic, except for specific cases or persons where there is a situation where enrollment would be harmful to the interests of the member or in which the HMO cannot provide the member with appropriate medically necessary contract services for reasons beyond its control. For any request for involuntary disenrollment, the HMO must submit a disenrollment request to the Department and include evidence attesting to cause which might include, but is not limited to:

a. Just Cause

The HMO may request and the Department will approve disenrollment requests for specific cases or persons where there is just cause. Just cause is defined as a situation where enrollment would be harmful to the interests of the member or in which the HMO cannot provide the member with appropriate medically necessary contract services for reasons beyond its control. The HMO may not request just cause disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the HMO seriously impairs the entity's ability to furnish services to either this particular member or other members) (42 CFR 438.56).

Examples of some just cause disenrollment requests are:

1) The member does not comply with critical aspects of the individual care plan or is unable to maintain a reasonable working relationship with the team or physician, despite repeated good faith efforts by the HMO to communicate the seriousness of the problem and attempt alternate methods of providing care in a manner more consistent with member preferences.

2) The member refuses critical services and/or is unwilling to meet significant conditions of participation, despite repeated good faith efforts by the HMO to communicate the seriousness of the problem and attempt alternate methods of providing care in a manner more consistent with member preferences.

3) The plan does not, because of moral or religious objections, cover the service the member seeks. The HMO must notify

the Department of any services that they would not provide due to moral or religious objections.

E. Out of Service Area, County Waiver Programs, and Loss of BadgerCare Plus Disenrollments

The member will be disenrolled if any of the following occur:

1. Out-of-Service Area

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

2. County Case Management Waiver Programs or Other Managed Care Programs

   The member is or will be participating in CIP, COP, or PACE/Partnership, other home and community waivers, or other managed care programs (such as Family Care). The HMO must inform the Enrollment Specialist of the effective dates that the member is/was participating in the county waiver program or other managed care program to accommodate a timely disenrollment. Disenrollment shall be effective the first of the month in which the member entered the other program. Exemptions are not backdated more than four months from the date the request is received. Any capitation payments made for months subsequent to disenrollment will be recouped.

3. Loss of BadgerCare Plus Eligibility

   If a member loses BadgerCare Plus eligibility or dies, the member shall be disenrolled. The date of disenrollment shall be the date of BadgerCare Plus eligibility termination or the date after the date of death. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

F. Other Disenrollment and Exemption Requests

Other disenrollment and exemption requests will be processed as soon as possible and will generally be effective the first day of the next month of the request, unless otherwise specified. All disenrollment and exemption requests must be directed to the Department's Enrollment Specialist.

Disenrollment and exemption requests will not normally be backdated. The Department will not use its authority regarding backdating unreasonably. If the disenrollment or exemption is approved, the HMO will not be liable for services, as of the effective date of the disenrollment or exemption. If the Department fails to make a disenrollment or exemption determination within 30 days of receipt of all necessary information, the disenrollment or exemption is considered approved.

The HMO must direct all members with disenrollment and exemption requests to the Department's Enrollment Specialist.

1. Other Disenrollment Criteria:

   a. Inmates of a Public Institution (All Plans)

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

   b. Medicare Beneficiaries

      Members who become eligible for Medicare will be disenrolled effective the first of the month of notification to the BadgerCare Plus program from the Social Security Administration (SSA). Even if SSA awards Medicare eligibility retroactively, the effective date of HMO disenrollment will be the first of the month of notification.

   c. Native American

      Members who are Native American and members of a federally recognized tribe are eligible for disenrollment.

2. Exemptions

   Exemption requests must come from the member, the member's family, or legal guardian. Below are listed the exemption criteria that the Department uses to grant exemptions. The exemption chart (Subsection G of this Article) indicates which medical status for each eligibility category that is eligible for each exemption. Even if a BadgerCare Plus member meets the exemption criteria, the Department may, in its sole discretion, deny an exemption.

   a. AIDS or HIV-Positive

Members with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code, or who are HIV-positive and on anti-retroviral drug treatment approved by the federal Food and Drug Administration, are eligible for an exemption. The HMO must not counsel or otherwise influence a member or potential member in such a way as to encourage exemption from enrollment or continued enrollment. The exemption is processed as soon as possible and is effective on the first day of the month that the anti-retroviral treatment began or the date that the member is diagnosed with AIDS. Exemptions are not backdated more than nine months from the date the request is received.

b. Certified Nurse Midwives or Nurse Practitioners

Members may be eligible for an exemption from enrollment if all the following criteria are met:

- The member resides in a service area of a certified nurse midwife or nurse practitioner.
- The member chooses to receive her pregnancy care from a certified nurse midwife or a nurse practitioner.
- The certified nurse midwife or nurse practitioner is not affiliated with any HMO in the service area either as an independently certified provider or as a non-billing provider.

c. Commercial HMO Insurance

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

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

When the Department's member eligibility file indicates commercial HMO coverage limiting a member to providers outside the BadgerCare Plus HMO network and the member seeks services from the BadgerCare Plus HMO network providers, the BadgerCare Plus HMO network providers may refuse to provide services to that member and refer him/her to their commercial network, except in the case of an emergency.

d. Federally Qualified Health Centers (All Plans)

Members may be eligible for an exemption from enrollment if the following criteria are met:

- The member resides in the service area of an FQHC.
- The member chooses to receive their primary care from the FQHC.
- The FQHC is not affiliated with any HMO within the service area.

e. Mental Health and Substance Abuse Exemption

Requests for exemption from HMO enrollment must be initiated by the case head or the member who meets one or more of the following:

- A child meeting criteria for severe emotional disturbance (SED) who is enrolled or has been accepted in a SED program, such as intensive in-home psychotherapy or child/adolescent day treatment, during the term of the SED treatment.

- A person participating in a methadone treatment program, or who has been determined to need methadone treatment unless the person declines to receive such treatment. Members who request exemption prior to participation in a methadone treatment program may be exempted for a maximum of two months, and the exemption may be extended if they continue to participate in the program.

- A person with a complex physical or psychiatric condition who has extensive non-medical programming needs best provided or coordinated by the 51.42, 51.437, and/or social or human services systems (such as Community Support Programs, Comprehensive Community Services, etc.).

When the HMO confirms that at least one of these conditions exists, the HMO must inform the BadgerCare Plus case head of their options to enroll the affected member in the HMO or to request that the person remain in the FFS system. The HMO shall not encourage a member to request an exemption from enrollment or to continue enrollment. The Department, the local boards, and the county social service departments may notify members or potential members of their options independently where such notification is deemed appropriate.

f. Ninth Month Pregnancy

Members who deliver or are expected to deliver the first month they are assigned to the HMO may be eligible for exemption. In order for an exemption to occur the member:

- Must have been automatically assigned or reassigned and must not have been in the HMO to which they were assigned or reassigned within the last seven months; and
- Must be seeking care from a provider (physician and/or hospital) not affiliated with the HMO to which they were assigned.

Exemptions requests can be made by the HMO, a provider, or the member.

g. Medicaid SSI Families

Families may be eligible for an exemption from enrollment if:

- There are one or more members in the family who are receiving SSI benefits, and
- The SSI member receives primary care from a provider who does not accept any HMO, and
- Other family members receive their primary care from the same provider as the SSI member.

The exemption request may be made by the SSI member, parent,
or guardian.

h. Third Trimester Pregnancy

Members who are in their third trimester of pregnancy when they are expected to enter the HMO may be eligible for an exemption. In order for an exemption to occur the member:

- Must have been automatically assigned or reassigned to their current HMO; and
- The member must be seeking care from a provider (physician or hospital) who is either not affiliated with the HMO to which they were assigned or is affiliated but the HMO is closed to new enrollment.

Only the member, legal guardian, or authorized representative can make exemption requests. The exemption request must be made before the end of the second month in the HMO or before the birth, whichever occurs first.

i. Transplant

Members who have had a transplant that is considered experimental such as a liver, heart, lung, heart-lung, pancreas, pancreas-kidney or bone marrow transplant are eligible for an exemption.

1) Members who have had a transplant that is considered experimental will be permanently exempted from HMO enrollment the first of the month in which surgery is performed.

2) In the case of autologous bone marrow transplants, the person will be permanently exempted from HMO enrollment the date the bone marrow was extracted.

3) Members who have had one or more of the transplant surgeries referenced above prior to enrollment in an HMO will be permanently exempted. The effective date will be either the first of the month not more than six months prior to the date of the request, or the first of the month of the HMO enrollment, whichever is later. Exemption requests may be made by the HMO and should be directed to the Department's fiscal agent Nurse Consultant.

j. Admission to a Birth-to-3 Exemption

A child from birth through two years of age (including two year olds), who is severely developmentally disabled or suspected of a severe developmental delay, or who is admitted to a Birth-to-3 program is eligible for an exemption. Exemption request must be made by the case head of the member or the County Birth-to-3 programs, on behalf of a member. Exemption requests should be directed to the Department's Enrollment Specialist. Exemptions are backdated no more than two months from the date the request is received.

G. System Based Disenrollments and Exemptions

1. Listed below are the reasons for exemption by medical status category:

Exemption Type	BadgerCare Plus (Standard and Benchmark)
Loss of BadgerCare Plus Enrollment	Yes
Out-of-State or Out-of-Service Area Move	Yes
CIP, COP, or Other Home and Community Based Waivers or Family Care	Yes

2. Listed below are the exemption criteria which may be approved by the Department by medical status category:

Exemption Type	BadgerCare Plus (Standard and Benchmark)
Ninth Month Pregnancy	Yes
Third Trimester Pregnancy	Yes
SSI Family Member	Yes
Nurse Midwife/Certified Nurse Practitioner	Yes
FQHC	Yes
Mental Health and/or Substance Abuse	Yes
HIV/AIDS	Yes
Commercial HMO	Yes
Native American	Yes
Birth-to-3	Yes

3. The HMO may request the following disenrollments by medical status categories:

Disenrollment Type	BadgerCare Plus (Standard and Benchmark)
Just Cause	Yes
CIP, COP, Family Care Waivers	Yes
Infants with Low Birth Weight	Yes
Transplants	Yes
Nursing Homes	No
Inability to Complete Patient Plan of Care	No
Living in a Public Institution	Yes
Medicare Beneficiaries	Yes

H. Member Lock-In Period

1. *BadgerCare Plus Standard and Benchmark Plans*

Under the Department's State Plan Amendment, mandatory members will be locked into the HMO for 12 months. The first 90 days of the 12-month lock-in period is an open enrollment period during which the member may change HMOs without cause.

I. Reenrollment

A member may be automatically reenrolled into the HMO if they were solely disenrolled because she/he loses BadgerCare Plus eligibility for a period of six months or lesser length. If a member wants to choose another HMO, they may do so at any time within 90 days after re-enrollment.

ARTICLE IX

IX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The grievance process refers to the overall system that includes complaints, grievances and appeals or expedited appeals as defined in Article I. BadgerCare Plus members and/or their authorized representative may grieve any aspect of service delivery provided or arranged by the HMO, to the HMO and to the Department. The member may appeal an action to the HMO, the Department and/or to the Division of Hearings and Appeals.

A. Procedures

The HMO must:

1. Have written policies and procedures that detail what the grievance and appeal system is and how it operates.

2. Identify a contact person in the HMO to receive grievances and appeals and be responsible for routing and processing.

3. Operate a complaint process that members can use to get problems resolved without going through the formal, written grievance process. However, the HMO must treat any verbal requests seeking to appeal as an appeal and confirm those in writing, unless the member or authorized representative requests expedited resolution.

4. Operate a grievance process that members can use to grieve in writing or orally.

5. Inform members about the existence of the complaint and grievance processes and how to use them.

6. Attempt to resolve complaints, grievances and appeals informally.

7. Respond to grievances and appeals in writing within 10 business days of receipt, except in cases of emergency or urgent (expedited grievance) situations. This represents the first response. The HMO must resolve the grievance or appeal within two business days of receipt of a oral or written expedited grievance, or sooner if possible.

8. Operate a grievance process within the HMO that members can use to grieve or appeal any negative response to the Board of Directors of the HMO. The HMO Board of Directors may delegate the authority to review grievances and appeals to the HMO grievance appeal committee, but the delegation must be in writing. If a grievance appeal committee is established, the BadgerCare Plus HMO Advocate must be a member of the

committee. The decision makers responsible for reviewing a member's grievance or appeal must not have participated in prior decision making.

9. Provide the member and his or her representative an opportunity, before and during the appeals process, to examine member's case file, including medical records, and any other documents and records considered during the appeals process.

10. Grant the member the right to appear in person before the grievance appeal committee to present written and oral information. The member may bring a representative to the meeting. The HMO must inform the member in writing of the time and place of the meeting at least seven days before the meeting or in expedited grievances or appeals, the HMO must also notify the member orally of the limited time to present additional information.

11. Maintain a record keeping "log" of complaints and grievances that includes a short, dated summary of each problem, the response, and the resolution. The log must distinguish between BadgerCare Plus members, if the HMO serves both populations. If the HMO does not have a separate log for BadgerCare Plus and their commercial members, the log must distinguish between the programs. The HMO must submit quarterly reports to the Department of all complaints, grievances and appeals (Addendum IV, H). The analysis of the log will include the number of complaints, grievances and appeals divided into two categories, program administration and benefit denials. HMOs should report [in Addendum IV, H, 1 (a-c)] those members that grieved or appealed to the HMO's grievance appeal committee.

12. Maintain a record keeping system for grievances and appeals that includes a copy of the original grievance or appeal, the response, and the resolution. The system must distinguish BadgerCare Plus from commercial members.

13. At the time of the HMO's initial grievance denial of an action decision the HMO must notify the member that the grievance denial decision may be appealed to the Department and/or to the Division of Hearings and Appeals. The member or his/her authorized representative may appeal orally, but must follow up with a signed written appeal.

14. Ensure that individuals with the authority to require corrective actions are involved in the grievance process.

15. Distribute to its gatekeepers[1] and IPAs the informational flyer on member grievance and appeal rights (the Ombuds Brochure). When a new

[1] The word "gatekeeper" in this context refers to any entity that performs a management services contract, a behavioral health science IPA, or a dental IPA, and not to individual physicians acting as a gatekeeper to primary care services.

brochure is available, the HMO must distribute copies to its gatekeepers and IPAs within three weeks of receipt of the new brochure.

16. Ensure that its gatekeepers and IPAs have written procedures for describing how members are informed of denied services. The HMO will make copies of the gatekeepers' and IPAs' grievance procedures available for review upon request by the Department.

17. Inform members about the availability of interpreter services and provide interpreter services for non-English speaking and hearing impaired members throughout the HMO's grievance process.

B. Grievance and Appeal Process

The member may choose to use the HMO's grievance and appeal process or may appeal to the Department instead of using the HMO's grievance and appeal process. If the member chooses to use the HMO's process, the HMO must provide an initial response within 10 business days and a final response within 30 days of receiving the grievance or appeal. If the HMO is unable to resolve the grievance or appeal within 30 days, the time period may be extended another 14 days from receipt if the HMO notifies the member in writing that the HMO has not resolved the grievance or appeal, when the resolution may be expected, and why the additional time is needed. The total timeline for the HMO to finalize a formal grievance or appeal may not exceed 45 days from the date of the receipt. The HMO must include the resolution and date of appeal resolution in the written notification to the member or their authorized representative.

Any grievance or appeal decision by the HMO may be appealed by the member and/or their authorized representative to the Department. The Department shall review such appeals and may affirm, modify, or reject any formal decision of the HMO at any time after the member files the formal appeal. The Department will request the name and credentials of the person making the denial decision as part of the grievance process. The Department will give a final response within 30 days from the date the Department has all information needed for a decision. Also, a member can submit a grievance or appeal directly to the Department at any time during the grievance process. Any decision made by the Department under this section is subject to member appeal rights to the extent provided by state and federal laws and rules. The Department will receive input from the member and the HMO in considering grievances and appeals.

For an expedited grievance or appeal, the HMO must resolve all issues within two business days of receiving the oral or written request for an expedited grievance. The HMO must make reasonable effort to provide oral notice, in addition to written notice for the resolution.

The HMO must ensure that punitive action is not taken against anyone who either requests an expedited resolution or supports a member's grievance.

A member may request a State Fair Hearing. The parties to the State Fair Hearing will include the HMO as well as the member and his or her representative or the representative of a deceased member's estate.

The HMO must authorize or provide the disputed services promptly and expeditiously as the member's health condition requires if the services were not furnished while the appeal is pending and the decision to deny, limit, or delay services is reversed.

C. Notifications to Members

When the HMO, its gatekeepers, or its IPAs discontinues, terminates, suspends, limits, or reduces a service (including services authorized by the HMO the member was previously enrolled in or services received by the member on a FFS basis), the HMO must notify the affected member(s), and his/her provider when appropriate, in writing at least 10 days before the date of action except as provided below. When the HMO, its gatekeepers, or its IPAs deny coverage of a new service, the HMO must notify the member of the denial in writing.

The period of advanced notice is shortened to 5 days if probable member fraud had been verified.

Notice need only be given by the date of the action for the following:

- in the death of a member (as soon as the HMO is made aware of the member's death);
- a signed written member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);
- the member's admission to an institution where he is ineligible for further services;
- the member's address is unknown and mail directed to him has no forwarding address;
- the member has been accepted for Medicaid services by another local jurisdiction;
- the member's physician prescribes the change in the level of medical care;
- an adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or
- the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the

nursing facility for 30 days (applies only to adverse actions for NF transfers).

Notices for both ongoing services and new benefits must include all of the following:

1. The nature of the intended action.

2. The reasons for the intended action. The reason must be clearly stated in sufficient detail to ensure that the member understands the action being taken by the HMO.

3. The fact that the member and/or his/her authorized representative has the right to appeal within 45 days of the date of the notice.

4. The member has the right to examine the documentation the HMO used to make its determination prior to the HMO grievance committee hearing or the DHA.

5. The fact that interpreter services are available free of charge during the grievance and appeal process and how the member can access those services.

6. A sentence in various languages that explains who to call for interpreter services or a copy of the letter in the appropriate language.

7. The right of the member to have a representative assist him/her at any point in the appeal process including reviews or hearings.

8. The right of the member to present "new" information before or during the grievance and appeal process including reviews or hearings.

9. The fact that punitive action will not be taken against a member who appeals the HMO's decision.

10. That the process for requesting an oral or written expedited grievance or appeal requires a medical provider to verify that delay can be a health risk. If the HMO determines the grievance or appeal does not meet expedited requirements, the HMO will review the grievance within the standard timeframes.

11. An explanation of the member's right to appeal the HMO's decision to the Department at any point in the process.

12. The fact that the member, if appealing the HMO action, may file a request for a hearing with the Division of Hearings and Appeals (DHA) at any point in the process.

13. The fact that the member can receive help in filing a grievance or appeal by calling the HMO Advocate or the Ombuds at a toll free number.

14. The address and telephone number of the HMO Advocate and the Ombuds.

Notifications to members of termination, suspension, or reduction of an ongoing benefit (including services authorized by the HMO the member was previously enrolled in or services received by the member on a FFS basis), must in addition to items 1 through 14 above, also include the following:

a. The fact that a benefit will continue during the appeal or DHA fair hearing process if the member requests that it continue within 10 days of notification or before the effective date of the action, whichever is later.

b. The circumstances under which a benefit will continue during the grievance and appeal process.

c. The fact that if the member continues to receive the disputed service, the member may be liable for the cost of care if the decision is adverse to the member.

This notice requirement does not apply when the HMO, its gatekeeper or its IPA triages a member to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary.

The Department must review and approve all notice language prior to its use by the HMO. Department review and approval will occur during the BadgerCare Plus certification process of the HMO and prior to any change of the notice language by the HMO.

D. Continuation of Benefits Requirements

If the member files a request for a hearing with the DHA on or before the later of the effective date or within 10 days of the HMO mailing the notice of action to reduce, limit, terminate or suspend benefits, upon notification by the DHA the HMO will notify the member they are eligible to continue receiving care but may be liable for care if DHA upholds the HMO's decision. If the member requests that the services in question be continued pending the outcome of the fair hearing, the following conditions apply:

1. If the DHA reverses the HMO's decision the HMO is responsible to cover services provided to the member during the administrative hearing process.

2. If the DHA upholds the HMO's decision, the HMO may pursue reimbursement from the member for all services provided to the member, to the extent that the services were covered solely because of this requirement.

   Benefits must be continued until one of the following occurs:

   - The member withdraws the appeal.
   - A state fair hearing decision adverse to the member is made.
   - The authorization expires or the authorization service is met.

E. Reporting of Grievances to the Department

The HMO must forward both the complaint and grievance reports to the Department within 30 days of the end of a quarter in the format specified. Failure on the part of the HMO to submit the quarterly complaint and grievance reports in the required format within five days of the due date may result in any or all sanctions available under this Contract.

ARTICLE X

X. SUBCONTRACTS

This Article does not apply to subcontracts between the Department and the HMO. The Department shall have sole authority to determine the conditions and terms of such subcontracts. Subcontractor (hereinafter identified as subcontractor) agrees to abide by all applicable provisions of (HMO NAME)'s contract with the Department of Health Services, hereinafter referred to as the BadgerCare Plus HMO Contract. Subcontractor compliance with the BadgerCare Plus HMO Contract specifically includes but is not limited to the requirements specified below.

A. Subcontract Standard Language

The HMO must ensure that all subcontracts are in writing and include the following standard language when applicable.

1. Subcontractor uses only BadgerCare Plus-certified providers in accordance with this Contract.

2. No terms of this subcontract are valid which terminate legal liability of the HMO.

3. Subcontractor agrees to participate in and contribute required data to HMO Quality Assessment/Performance Improvement programs.

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

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

6. Subcontractor agrees to comply with all non-discrimination requirements
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7. Subcontractor agrees to comply with all record retention requirements and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements.

8. Subcontractor agrees to provide representatives of the HMO, as well as duly authorized agents or representatives of the Department and the federal Department of Health and Human Services, access to its premises and its contracts, medical records, billing, including contractual rates agreed upon between the HMO and the subcontractor, and administrative records. Refusal will result in sanctions or penalties in Article XI against the HMO for failure of its subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

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

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

11. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus benefits (e.g., COB recovery procedures that delay or prevent care).

12. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

13. Subcontractor agrees not to bill BadgerCare Plus members for medically necessary services covered under this Contract and provided during the members' period of HMO enrollment. Subcontractor also agrees not to bill members for any missed appointments while the members are eligible under the BadgerCare Plus – Standard Plan. This provision will remain in effect even if the HMO becomes insolvent. However, BadgerCare Plus – Benchmark members can be billed for missed appointments, also if a member agrees in writing to pay for a non-covered service, then the HMO, HMO provider, or HMO subcontractor can bill.

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

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

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

16. Subcontractor agrees to abide by the HMO marketing/informing requirements. Subcontractor will forward to the HMO for prior approval all flyers, brochures, letters and pamphlets the subcontractor intends to distribute to its members concerning its HMO affiliation(s), or changes in affiliation, or relating directly to the BadgerCare Plus population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the HMO and the Department.

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

B. Subcontract Submission Requirements

1. Changes in Established Subcontracts

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

      1) Technical changes do not have to be approved.

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

   b. The Department will review the subcontract changes and respond to the HMO within 15 business days. If the Department does not respond to the request for review within 15 business days of submission, the HMO must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within five business days of this contact.

2. New Subcontracts

   The HMO must submit new subcontracts to the Department for review and approval before they take effect. If the Department does not respond to the request for review within 15 business days of submission, the HMO must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within five business days of this contact.

C. Review and Approval of Subcontracts

The Department may approve, approve with modification, or deny subcontracts under this Contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the state and BadgerCare Plus members, including but not limited to the proposed subcontractor's past performance. The Department will:

1. Give the HMO:

   - 120 days to implement a change that requires the HMO to find a new subcontractor, and

   - 60 days to implement any other change required by the Department.

2. Acknowledge the approval or disapproval of a subcontract within 15 business days after its receipt from the HMO.

3. Review and approve or disapprove each new subcontract before the Contract takes effect. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to of this Contract.

4. Ensure that the HMO has included the standard subcontract language as specified in Section A of this Article (except for specific provisions that are inapplicable in a specific HMO management subcontract).

D. Transition Plan

The HMO may be required to submit transition plans when a primary care provider(s), mental health provider(s), gatekeeper or dental clinic terminates their contractual relationship with the HMO. The transition plan will address continuity of care issues, member notification and any other information required by the Department to ensure adequate member access. The Department will either
approve, deny, or modify the transition plan within 15 business days of receipt or prior to the effective date of the subcontract change.

E. Notification Requirements Regarding Subcontract Additions or Terminations

The HMO must:

1. Notify the Department of Additions or Terminations

The HMO must notify the Department within 10 days of subcontract additions or terminations involving:

- A clinic or group of physicians, mental health providers, or dentists,
- An individual physician,
- An individual mental health provider and/or clinic,
- An individual dental provider and/or clinic.

This Department notification must be through the submission of an updated provider network to the FTP server.

2. Notify the Department of a Termination or Modification that Involves Reducing Access to Care

The HMO must notify the Department within seven days of any notice by the HMO to a subcontractor, or any notice to the HMO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce member access to care. This Department notification must be to both the HMO's Contract Monitor and through the submission of an updated provider network to the FTP server.

If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then the Department may invoke the remedies pursuant to this Contract. These remedies include contract termination (notice to the HMO and opportunity to correct are provided for), suspension of new enrollment, and giving members an opportunity to enroll in a different HMO.

In addition to the monthly submission, the HMO must submit an updated provider and facility file when there has been a significant change with respect to network adequacy, as defined by the Department, in the HMO's operations that would affect adequate capacity and services.

3. Notify Members of Provider Terminations

The HMO must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member whose PCP, mental health provider, gatekeeper or dental clinic terminates a contract with the HMO. The Department must approve all notifications before they are sent to members.

F. Management Subcontracts

The Department will review HMO management subcontracts to ensure that:

1. Rates are reasonable.

2. They clearly describe the services to be provided and the compensation to be paid.

3. Any potential bonus, profit-sharing, or other compensation, not directly related to the cost of providing goods and services to the HMO, is identified and clearly defined in terms of potential magnitude and expected magnitude during this Contract period. Any such bonus or profit-sharing must be reasonable compared to the services performed. The HMO must document reasonableness. A maximum dollar amount for such bonus or profit-sharing shall be specified for the Contract period.

   The requirements addressed in 1. through 3. do not have to relate to non-BadgerCare Plus members if the HMO wishes to have separate arrangements for non-BadgerCare Plus members.

ARTICLE XI

XI. REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

A. Suspension of New Enrollment

Whenever the Department determines that the HMO is out of compliance with this Contract, the Department may suspend the HMO's right to receive new enrollment under this Contract. When exercising this option, the Department, must notify the HMO in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the Contract.

The Department may also notify members of the HMO's non-compliance and provide an opportunity to enroll in another HMO.

B. Department-Initiated Enrollment Reductions

The Department may reduce the maximum enrollment level and/or number of current members whenever it determines that the HMO has failed to provide one or more of the Contract services required under the Contract or the HMO has failed to maintain or make available any records or reports required under this Contract that the Department needs to determine whether the HMO is providing contract services as required. The HMO will have at least 30 days to correct the non-compliance prior to the Department taking any action set forth in this paragraph. The Department may reduce enrollment sooner than the time period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized.

C. Other Enrollment Reductions

The Department may also suspend new enrollment or disenroll members in anticipation of the HMO not being able to comply with federal or state law at its current enrollment level. Such suspension shall not be subject to the 30 day notification requirement.

D. Withholding of Capitation Payments and Orders to Provide Services

Not withstanding the provisions of this Contract, the Department may withhold portions of capitation payments as liquidated damages or otherwise recover damages from the HMO on the following grounds:

1. Whenever the Department determines that the HMO has failed to provide one or more of the medically necessary covered services required under the Contract, the Department may either order the HMO to provide such service, or withhold a portion of the HMO's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

   If the Department orders the HMO to provide services under this section and the HMO fails to provide the services within the timeline specified by the Department, the Department may withhold from the HMO's capitation payments an amount up to 150% of the FFS amount for such services.

   When it withholds payments under this section, the Department must submit to the HMO a list of the participants for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

   If the Department acts under this section and subsequently determines that the services in question were not covered services:

   a. If the Department withheld payments, it will restore to the HMO the full capitation payment; or

   b. If the Department ordered the HMO to provide services under this section, it will pay the HMO the actual documented cost of providing the services.

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

3. If the HMO fails to comply with state and federal compliance requirements for abortions, hysterectomies and sterilizations, the Department may impose liquidated damages in the amount of $10,000.

4. The term "erred encounter record" means an encounter record that has failed an edit when a correction is expected by the Department. If the HMO fails to correct an error to the encounter record within the time frame specified, the Department may assess liquidated damages of $5 per erred encounter record per month until the error has been corrected. The liquidated damage amount will be deducted from the HMO's capitation payment. When applied, these liquidated damages will be calculated and assessed on a monthly basis.

   If upon audit or review, the Department finds that the HMO has removed an erred encounter record without the Department's approval, the Department may assess liquidated damages for each day from the date of original error notification until the date of correction.

   The following criteria will be used prior to assessing liquidated damages:

   - The Department will calculate a percentage rate by dividing the number of erred records not corrected within 90 days (numerator), by the total number of records in error (denominator) and multiply the result by 100.
   - Records failing non-critical edits, as defined in the HMO Encounter Data User Manual, will not be included in the numerator.
   - If this rate is 2% or less, liquidated damages will not be assessed.
   - The Department will calculate this rate each month.

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

   B. At a minimum, HMOs must submit encounter data monthly for all claims adjudicated in the prior month.

   C. If it is found that an HMO submitted inaccurate encounter data that was used in the development of the CY10 rates, the Department may assess damages associated with the reporting error. The damages will be the priced amount of the inaccurate encounter records.

5. Whenever the Department determines that the HMO has failed to perform the administrative functions, the Department may withhold a portion of future capitation payments sufficient to directly compensate the Department for the program's costs of providing health care services and

items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.

6. In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages.

7. Notwithstanding the provisions of this subsection, in any case where the Department deducts a portion of capitation payments under the Contract, the following procedures will be used:

   a. The Department will notify the HMO's contract administrator no later than the second business day after the Department's deadline that the HMO has failed to submit the required data or the required data cannot be processed.

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

   c. If the HMO submits encounter data late but submits it within five business days from the deadline, the Department will rescind liquidated damages if the data can be processed according to the criteria published in the HMO Encounter Data User Manual. The Department will not edit the data until the process period in the subsequent month.

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

   e. If the HMO repeatedly fails to submit required data or reports, or submits data that cannot be processed, the Department will require the HMO to develop an action plan to comply with the Contract requirements that must meet Department approval.

   f. After the corrective action plan has been implemented, if the HMO continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under Section A (Suspension of New Enrollment), or under Section B (Department-Initiated Enrollment Reductions) of this Article, or both, in addition to liquidated damages that may have been imposed for a current violation.

   g. If the HMO notifies the Department that it will discontinue contracting with the Department at the end of a contract period, but reports or data are due for a contract period, the Department retains

the right to withhold up to two months of capitation payments otherwise due the HMO that will not be released to the HMO until all required reports or data are submitted and accepted after expiration of the Contract. Upon determination by the Department that the reports and data are accepted, the Department will release the monies withheld.

E. Inappropriate Payment Denials

The HMO that inappropriately fails to provide or deny payments for services may be subject to suspension of new enrollments, withholding, in full or in part, of capitation payments, contract termination, or refusal to contract in a future time period, as determined by the Department. The Department will select among these sanctions based upon the nature of the services in question, whether the failure or denial was an isolated instance or a repeated pattern or practice, and whether the health of a member was injured, threatened or jeopardized by the failure or denial. These sanctions apply not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal was made (i.e., the Department knows about the documented abuse from other sources).

F. Sanctions

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny BadgerCare Plus payments to the HMO for members who enroll after the date on which the HMO has been found to have committed one of the violations identified in the federal law. State payment for members of the contracting organization is automatically denied whenever, and for as long as, federal payment for such members has been denied as a result of the commission of such violations. The state may impose sanctions if the HMO has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

G. Sanctions and Remedial Actions

The Department may pursue all sanctions and remedial actions with the HMO that is taken with FFS providers, including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [42 U.S.C. 1396v(d)(2)].

H. Temporary Management

The state will impose temporary management when there is continued egregious behavior by the HMO, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

- There is substantial risk to member's health; or
- The sanction is necessary to ensure the health of the HMO's members while improvements are made to remedy violations of 42 CFR 438.700 or until there is an orderly termination or reorganization of the HMO.

ARTICLE XII

XII. TERMINATION AND MODIFICATION OF CONTRACT

A. Termination by Mutual Consent

This Contract may be terminated at any time by mutual written agreement of both the HMO and the Department.

B. Unilateral Termination

This Contract between the parties may be terminated by either party as follows:

1. Either party may terminate this Contract at any time, due to modifications mandated by changes in federal or state laws, rules or regulations that materially affect either party's rights or responsibilities under this Contract. At least 90 days prior to the proposed date of termination, the party initiating the termination must notify the other party of its intent to terminate this Contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the Contractor's reasonable and necessarily incurred termination expenses.

2. Either party may terminate this Contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this Contract. The party exercising this option must notify the other party in writing of this intent to terminate this Contract and give the other party 30 days to correct the identified violation, breach or non-performance of Contract. If such violation, breach or non-performance of Contract is not satisfactorily addressed within this time period, the exercising party may terminate this Contract. The termination date shall always be the last day of a month. The Contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that member health or welfare is jeopardized by continued enrollment in the HMO. A "substantial failure to perform" for purposes of this paragraph includes any violation of any requirement of this Contract that is repeated or ongoing, that goes to the essentials or purpose of the Contract, or that injures, jeopardizes or threatens the health, safety, welfare, rights or other interests of members.

3. Either party may terminate this Contract if federal or state funding of contractual services rendered by the Contractor become or will become permanently unavailable. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the Contractor will be temporarily suspended or unavailable, the Department shall immediately notify the Contractor, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, the Department or the Contractor may suspend performance of any

or all of the Contractor's obligations under this Contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or Contractor shall attempt to give notice of suspension of performance of any or all of the Contractor's obligations by 60 days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the Contractor may remove suspension hereunder by written notice to the Department, to be made within 30 days from the date the funds are reinstated. In the event the Contractor elects not to reinstate services, the Contractor shall give the Department written notice of its reasons for such decision, to be made within 30 days from the date the funds are reinstated. The Contractor shall make such decision in good faith and will provide to the Department documentation supporting its decision. In the event of termination under this Section, this Contract shall terminate without termination costs to either party.

C. Obligations of Contracting Parties Upon Termination

When termination of the Contract occurs, the following obligations must be met by the parties:

1. Where this Contract is terminated unilaterally by the Department due to non-performance by the HMO or by mutual consent with termination initiated by the HMO:

    a. The Department will be responsible for notifying all members of the date of termination and process by which the members will continue to receive contract services.

    b. The HMO will be responsible for all expenses related to said notification.

    c. The Department will grant the HMO a hearing before termination by the Department occurs. The Department will notify the members of the hearing and allow them to disenroll from the HMO without cause.

2. Where this Contract is terminated on any basis not given in 1 above including non-renewal of the Contract for a given contract period:

    a. The Department will be responsible for notifying all members of the date of termination and process by which the members will continue to receive contract services.

    b. The Department will be responsible for all expenses relating to said notification.

3. Where this Contract is terminated for any reason the following payment criteria will apply:

   a. Any payments advanced to the HMO for coverage of members for periods after the date of termination will be returned to the Department within the period of time specified by the Department.

   b. The HMO will supply all information necessary for the reimbursement of any outstanding BadgerCare Plus claims within the period of time specified by the Department.

   c. If a contract is terminated, recoupments will be handled through a payment by the HMO within 90 days of contract termination.

D. Modification

This Contract may be modified at any time by written mutual consent of the HMO and the Department or when modifications are mandated by changes in federal or state laws, rules or regulations. If changes in state or federal laws, rules or regulations require the Department to modify its contract with the HMO, the HMO will receive written notice.

If the Department exercises its right to renew this Contract, as allowed, the Department will recalculate the capitation rate for succeeding calendar years. The HMO will have 30 days to accept the new capitation rate in writing or to initiate termination of the Contract. If the Department changes the reporting requirements during the Contract period, the HMO shall have 180 days to comply with such changes or to initiate termination of the Contract.

ARTICLE XIII

XIII. INTERPRETATION OF CONTRACT LANGUAGE

When disputes arise, the Department has the right to final interpretation and/or application of the Contract language. The HMO will abide by the interpretation and/or application.

ARTICLE XIV

XIV. CONFIDENTIALITY OF RECORDS AND HIPAA REQUIREMENTS

The parties agree that all information, records, and data collected in connection with this Contract will be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, Wis. Stats., DHS 108.01, Wis. Adm. Code, 42 CFR 431 Subpart F, 42 CFR 438 Subpart F and 45 CFR 160, 162, and 164 and any other confidentiality law to the extent that these requirements apply. Except as otherwise required by law, rule or regulation, access to such information shall be limited by the HMO and the Department to persons who, or agencies which, require the information in order to perform their duties related to this Contract, including the U.S. Department of Health and Human Services and such others as may be required by the Department.

A. Duty of Non-Disclosure and Security Precautions

Contractor shall not use Confidential Information for any purpose other than the limited purposes set forth in the Agreement. Contractor shall hold the Confidential Information in confidence, and shall not disclose such Confidential Information to any persons other than those directors, officers, employees, and agents *("Representatives")* who have a business-related need to have access to such Confidential Information in furtherance of the limited purposes of this Agreement and who have been apprised of, and agree to maintain, the confidential nature of such information in accordance with the terms of this Agreement. Contractor shall be responsible for the breach of this Agreement by any of its Representatives.

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

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

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

B. Limitations on Obligations

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

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

C. Legal Disclosure

If Contractor or any of its Representatives shall be under a legal obligation in any administrative, regulatory or judicial circumstance to disclose any Confidential Information, Contractor shall give the State prompt notice thereof (unless it has a legal obligation to the contrary) so that the State may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor and its Representatives shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

D. Unauthorized Use, Disclosure, or Loss

If Contractor becomes aware of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Agreement, or if any Confidential Information is lost or cannot be accounted for, Contractor shall notify the State's (Contract Monitor/Contact Liaison/Privacy Officer) within the same business day the Contractor becomes aware of such use, disclosure, or loss. Such notice shall include, to the best of the Contractor's knowledge at that time, the persons affected, their identities, and the Confidential Information disclosed.

The Contractor shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The Contractor shall reasonably cooperate with the State's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its Confidential Information, including complying with a reasonable Corrective Action Plan.

If the unauthorized use, disclosure, or loss is of Personally Identifiable Information, or reasonably could otherwise identify individuals, Contractor shall, at its own cost, take any or all of the following measures that are directed by the State as part of a Corrective Action Plan:

1. Notify the affected individuals by mail or the method previously used by the State to communicate with the individual. If the Contractor cannot with reasonable diligence determine the mailing address of the affected individual and the State has not previously contacted that individual, the Contractor shall provide notice by a method reasonably calculated to provide actual notice.
2. Notify consumer reporting agencies of the unauthorized release.
3. Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the State for one year from the date the individual enrolls in credit monitoring.
4. Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as established by the State.
5. Adequately staff customer service telephone lines to assure an actual wait time of less than five (5) minutes for callers.

If the unauthorized use, disclosure, or loss is of Individually Identifiable Health Information, Contractor shall, at its own cost, notify the affected individuals by mail or the method previously used by the State to communicate with the individual. If the Contractor cannot with reasonable diligence determine the mailing address of the affected individual and the State has not previously contacted that individual, the Contractor shall provide notice by a method reasonably calculated to provide actual notice. In addition, the Contractor will take other measures as are directed by the State as part of a Corrective Action Plan.

E. Trading Partner requirements under HIPAA. For the purposes of this section Trading Partner means the HMO.

1. Trading Partner Obligations:

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

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

   c. Trading Partner must not use any code or data elements that are either marked “not used” in the HHS Transaction Standard’s

implementation specifications or are not in the HHS Transaction Standard's implementation specifications (45 CFR Part 162.915(c)).

d. Trading Partner must not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications (45 CFR Part 162.915(d)).

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

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

3. Trading Partners or Trading Partner's Business Associate have responsibilities to adequately test business rules appropriate to their types and specialties.

4. Trading Partner or their Business Associate agrees to cure transaction errors or deficiencies identified by the Department.

5. Trading Partner or Trading Partner's Business Associate understands that from time-to-time HHS may modify and set compliance dates for the HHS Transaction Standards. Trading Partner or Trading Partner's Business associate must incorporate by reference any such modifications or changes (45 CFR Part 160.104).

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

7. Privacy

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

b. The Department and the Trading Partner or Trading Partner's Business Associate will promptly notify the other party of any unlawful or unauthorized use or disclosure of PHI that may have an impact on the other party that comes to the party's attention, and will cooperate with the other party in the event that any litigation arises concerning the unlawful or unauthorized disclosure of use of PHI.

c. The Department retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by the Trading Partner, Trading Partner's Business Associate, or any agent, contractor or third Party that received PHI from the Trading Partner.

8. Security

a. The Department and the Trading Partner or Trading Partner's Business Associate must maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, security access codes, envelope, backup files, and source documents. Each party will immediately notify the other party of any unauthorized attempt to obtain access to or otherwise tamper with data, data transmissions security access codes, envelope, backup files, source documents other party's operating system when the attempt may have an impact on the other party.

b. The Department and the Trading Partner or Trading Partner's Business associate must develop, implement, and maintain appropriate security measures for its own operating system. The Department and the Trading Partner or Trading Partner's Business Associate must document and keep current its security measures. Each party's security measure will include, at a minimum, the requirements and implementation features set forth in 'site specific HIPAA rule' and all applicable HHS implementation guidelines.

F. Liquidated Damages: Equitable Relief: Indemnification

Indemnification: In the event of a breach of this Section by Contractor, Contractor shall indemnify and hold harmless the State of Wisconsin and any of its officers, employees, or agents from any claims arising from the acts or omissions of the Contractor, and its subcontractors, employees and agents, in violation of this Section, including but not limited to costs of monitoring the credit of all persons whose Confidential Information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the State in the enforcement of this Section. In addition, notwithstanding anything to the contrary herein, the Contractor shall compensate the State for its actual staff time and other costs associated with the State's response to the unauthorized use or disclosure constituting the breach.

Equitable Relief. The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury will not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties

specifically agree that the State, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Agreement or under applicable law.

G. Liquidated Damages:

The Contractor agrees that an unauthorized use or disclosure of Confidential Information may result in damage to the State's reputation and ability to serve the public interest in its administration of programs affected by this Agreement. Such amounts of damages which will be sustained are not calculable with any degree of certainty and thus shall be the amounts set forth herein. Assessment under this provision is in addition to other remedies under this Agreement and as provided in law or equity. The State shall assess damages as appropriate and notify the Contractor in writing of the assessment. The Contractor shall automatically deduct the damage assessments from the next appropriate monthly invoice, itemizing the assessment deductions on the invoice.

Liquidated Damages shall be as follows:

1. $100 for each individual whose Confidential Information was used or disclosed;

2. $100 per day for each day that the Contractor fails to substantially comply with the Corrective Action Plan under this Section.

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

H. Compliance Reviews

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

I. Survival

This Section shall survive the termination of the Agreement.

ARTICLE XV

XV. DOCUMENTS CONSTITUTING CONTRACT

A. Current Documents

In addition to this base agreement, the Contract between the Department and the HMO includes:

- the contents of RFP # 1684 DHCAA-SM (including all attachments) and RFP addenda, revisions and Questions and Answers documents,
- the Proposal submitted to the Department by the HMO in response to the RFP,
- existing BadgerCare Plus provider publications addressed to the HMO, and
- the terms of the most recent HMO certification application issued by this Department for HMO contracts, as clarified by any questions and answers released pursuant to said HMO certification application by the Department, and the HMO's signed application.

In the event of any conflict in provisions among these documents, the following order of precedence shall apply:

- the base contract;
- all documents comprising the RFP
- HMO certification application
- the Proposal

B. Future Documents

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

ARTICLE XVI

XVI. DISCLOSURE STATEMENT(S) OF OWNERSHIP OR CONTROLLING INTEREST IN AN HMO AND BUSINESS TRANSACTIONS

A. Ownership or Controlling Interest Disclosure Statement(s)

The HMO agrees to submit to the Department full and complete information as to the identity of each person or corporation with an ownership or controlling interest in the HMO, or any subcontractor in which the HMO has a 5% or more ownership interest. A "person with an ownership or controlling interest" means a person or corporation that:

1. Owns, directly or indirectly, 5% or more of the HMO's capital or stock or receives 5% or more of its profits:

    a. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the HMO or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the HMO; or

    b. Is an officer or director of the HMO (if it is organized as a corporation or is a partner in the HMO (if it is organized as a partnership).

2. Calculation of 5% Ownership or Control is as follows:

    The percentage of direct ownership or control is the percentage interest in the capital, stock or profits.

    The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation that owns 80% of the stock of the HMO, the person owns 8% of the HMO.

    The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest that a person owns in that obligation by the percent of the HMO's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the HMO's assets, the person owns 6% of the HMO.

3. Information to be Disclosed

The following information must be disclosed:

a. The name and address of each person with an ownership or controlling interest of 5% or more in the HMO or in any subcontractor in which the HMO has direct or indirect ownership of 5% or more;

b. A statement as to whether any of the persons with ownership or controlling interest is related as spouse, parent, child, or sibling to any other of the persons with ownership or controlling interest; and

c. The name of any other organization in which the person also has ownership or controlling interest. This is required to the extent that the HMO can obtain this information by requesting it in writing. The HMO must keep copies of all of these requests and the responses to them, make them available upon request, and advise the Department when there is no response to a request.

4. Potential Sources of Disclosure Information:

This information may already have been reported on form HCFA-1513, "Disclosure of Ownership and Controlling Interest Statement." Form HCFA-1513 is likely to have been completed in two different cases. First, if the HMO is federally qualified and has a Medicare contract, it is required to file form HCFA-1513 with CMS within 120 days of the HMO's fiscal year end. Secondly, if the HMO is owned by or has subcontracts with BadgerCare Plus providers that are reviewed by the state survey agency, these providers may have completed form HCFA-1513 as part of the survey process. If form HCFA-1513 has not been completed, the HMO may supply the ownership and controlling information on a separate report or submit reports filed with the state's insurance or health regulators as long as these reports provide the necessary information for the prior 12 month period.

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

A managed care entity may not knowingly have as a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's a person who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under the

Federal Acquisition Regulation or who has an employment, consulting, or other agreement for the provision of items and services that are significant and material to the entity's obligations under its contract with the state.

B. Business Transaction Disclosures

The HMO that is not federally qualified must disclose to the Department information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.)

1. Party In Interest as defined in Section 1318(b) of the Public Health Service Act, is:

    a. Any director, officer, partner, or employee responsible for management or administration of the HMO and HIO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the HMO; any person who is the beneficial owner of more than 5% of the HMO; or, in the case of the HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

    b. Any organization in which a person described in Subsection A, 1 above is director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the HMO;

    c. Any person directly or indirectly controlling, controlled by, or under common control with the HMO; or

    d. Any spouse, child, or parent of an individual described in Subsections 1, 2, or 3 above.

2. Business Transactions That Must be Disclosed Include:

    a. Any sale, exchange or lease of any property between the HMO and a party in interest.

    b. Any lending of money or other extension of credit between the HMO and a party in interest.

    c. Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

3. Information That Must Be Disclosed In The Transactions Between the HMO and a Party In Interest Includes:

   a. The name of the party in interest for each transaction.

   b. A description of each transaction and the quantity or units involved.

   c. The accrued dollar value of each transaction during the fiscal year.

   d. Justification of the reasonableness of each transaction.

   If the BadgerCare Plus HMO Contract is being renewed or extended, the HMO must disclose information on those business transactions that occurred during the prior contract period. If the Contract is an initial contract with BadgerCare Plus, but the HMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving BadgerCare Plus enrollment. All of these HMO business transactions must be reported.

ARTICLE XVII

XVII. MISCELLANEOUS

A. Indemnification

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

1. Any failure, inability, or refusal of the HMO or any of its subcontractors to provide contract services.

2. The negligent provision of contract services by the HMO or any of its subcontractors.

3. Any failure, inability or refusal of the HMO to pay any of its subcontractors for contract services.

B. Independent Capacity of Contractor

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

C. Omissions

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

D. Choice of Law

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

E. Waiver

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

construed as a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement contained herein.

F. Severability

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

G. Survival

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

H. Force Majeure

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

I. Headings

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

J. Assignability

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

K. Right to Publish

The HMO must obtain prior written approval from the Department before publishing any material on subjects addressed by this Contract.

L. Media Contacts

The HMO agrees to forward to the Department all media contacts regarding BadgerCare Plus programs or members.

ARTICLE XVIII

XVIII. HMO SPECIFIC CONTRACT TERMS

A. Initial Contract Period

The respective rights and obligations of the parties as set forth in this Contract shall commence on September 1, 2010, and unless earlier terminated, shall remain in full force effective through December 31, 2013. The specific terms for enrollment, rates, risk-sharing, and chiropractic coverage are as specified in the Contract.

B. Renewals

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

C. Specific Terms of the Contract

The specific terms are agreed to as set forth in this Contract. The Contract rates to which the HMO agrees are indicated by the Department. Except as stated:

1. The specific terms in the HMO's completed application for certification are incorporated into this Contract, including whether chiropractic services will be provided by the HMO.

2. For each rate period in this Contract, the HMO agrees not to reduce its service area that was in effect at the time of acceptance of the rates.

3. The HMO's service area and maximum enrollment are specified in its certification application.

4. Rates for county(ies) in which enrollment is accepted.

5. The capitation rates to which the HMO agrees are indicated by the Department in the Exhibits section.

6. Future Adjustments: These rates may be changed to reflect legislative changes in BadgerCare Plus reimbursement or changes in approved services.

7. The Department will make case mix adjusted payments to the HMO for BadgerCare Plus – Standard and Benchmark Plan members if the prospective Chronic Illness and Disability Payment System (CDPS) based

adjustment method is approved by CMS. The payment rates for members will be adjusted based upon the prospective CDPS scores applied prospectively to the rate schedule in the attached Exhibits, subject to CMS approval. If the prospective CDPS case mix adjustment method is not approved by CMS, the Department will revert to a retrospective CDPS case mix adjustment method.

D. Contracted Populations

We agree to provide services for the BadgerCare Plus Medicaid population enrolled in the Standard and Benchmark Plans.

In WITNESS WHEREOF, the State of Wisconsin has executed this agreement:

HMO Name	State of Wisconsin
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

Note: The HMO that elects to enter into a subcontract with the state, for the provision of Chiropractic Services, must sign and date the Subcontract for Chiropractic Services (following page). This subcontract will not become effective without a signature.

SUBCONTRACT FOR CHIROPRACTIC SERVICES

A. THIS AGREEMENT is made and entered into by and between the HMO and the Department of Health Services.

The parties agree as follows:

1. The Department agrees to be at risk for and pay claims for chiropractic services covered under this Contract.

2. The HMO agrees to a deduction from the capitation rate of an amount of money based on the cost of chiropractic services. This deduction is reflected in the Contract that is being signed on the same date.

B. This is the only subcontract for services that the Department is entering into with the HMO.

C. The provisions of the Contract regarding subcontracts, do not apply to this subcontract.

The term of this subcontract is for the same period as the Contract between the HMO and the Department for medical services.

HMO Name	**State of Wisconsin**
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM I

MEMORANDA OF UNDERSTANDING

I. MOU Submission Requirements

The HMO must submit to the Department copies of new MOUs, or changes in existing MOUs for review and approval before they take effect. This requirement will be considered met if the Department has not responded within 15 business days after receipt of the MOU.

The HMO shall submit MOUs referred to in this Contract and this Addendum to the Department upon the Department's request and during the certification process if required by the Department.

II. Emergency Services MOU or Contract

The HMO may have a contract or an MOU with hospitals or urgent care centers within the HMO's service area(s) to ensure prompt and appropriate payment for emergency services.

A. The MOU Shall Provide For:

1. The process for determining whether an emergency exists.

2. The requirements and procedures for contacting the HMO before the provision of urgent or routine care.

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

4. Payments for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.

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

B. The HMO's Liability for Emergency Situations

Unless a contract or MOU specifies otherwise, the HMO is liable to the extent that FFS would have been liable for the emergency situation. The Department reserves the right to resolve disputes between the HMO, hospitals and urgent care centers regarding emergency situations based on FFS criteria.

III. County and Other Human Service Agencies MOU or Contract Requirements for Services Ordered by the Courts

The HMO must make a good faith attempt to negotiate either an MOU or a contract with the counties in their service area. The MOU, contract, or written documentation of a good faith attempt must be available when requested by the Department. Failure of the HMO to have an MOU, contract or a demonstrated good faith effort, as specified, by the Department, may result in the application by the Department of remedies, specified under this Contract. For guidance on expectations for coordination with counties and Institutes for Mental Disease (IMDs), please see DMHSAS/DHCAA Memo Series 2009-02, February 20, 2009, available on the Department's website.

A. MOU Requirement with Boards Created Under Wis. Stats., §. 51.42, 51.437 or 46.23.

At a minimum the MOU must specify the conditions under which the HMO will either reimburse the Board(s) or another contract provider, or directly cover medical services, including, but not limited to, examinations ordered by a court, specified by the Board's designated assessment agency in a member's driver safety plan as provided under DHS 62. It is the responsibility of both the HMO and the Board to ensure that court orders the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full BadgerCare Plus rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own provider arrangements, the HMO is not liable. Reasonable arrangements, in this situation, are certified providers with facilities and services to safely meet the medical and psychiatric needs of the member within a prompt and reasonable time frame. The MOU shall further specify reimbursement arrangements between the HMO and the Board's provider for assessments performed by the Board's designated assessment agency under DHS 62, Intoxicated Driver Program rules. The MOU shall also specify other reporting and referral relationships if required by the Board or the HMO.

B. MOU Requirement with the Department of Social Services (DSS) Created Under Wis. Stats., s. 46.21 or 46.22, or the Human Service Department Created Under Wis. Stats., s. 46.23.

At a minimum the MOU must specify that the HMO will reimburse the DSS or its provider if the HMO cannot provide the treatment, or will directly cover medical services including examinations and treatment which are ordered by a court. It is the responsibility of both the HMO and the DSS to ensure that courts order the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full BadgerCare Plus rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own provider arrangements, the

HMO is not liable. The MOU will also specify the reporting and referral relationships for suspected cases of child abuse or neglect pursuant to Wis. Stats., s. 48.981. The MOU shall also specify a referral agreement for HMO members who are physically disabled and who may be in need of supportive home care or other programming provided or purchased by the county agency. The MOU may specify that evaluations for substitute care will be provided by a provider acceptable to both parties; the DSS may require in the MOU that the HMO specify expert providers acceptable to the DSS and the HMO in dealing with court-related children's services, victims of child abuse and neglect, and domestic abuse.

The HMO and the counties may develop alternative MOU language, if both parties agree. However, all elements defined above must be addressed in the MOU. As an alternative to an MOU, the HMO may enter into contracts with the counties. Any contracts the HMO enters into with the counties must be in compliance with Part A of this Addendum and would supersede any MOU requirements.

ADDENDUM II

STANDARD MEMBER HANDBOOK LANGUAGE FOR BADGERCARE PLUS

INTERPRETER SERVICES

English – For help to translate or understand this, please call 1-800-xxx-xxxx (TTY).

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-xxx-xxxx (TTY).

Russian – Если вам не всё понятно в этом документе, позвоните по телефону 1-800-xxx-xxxx (TTY).

Hmong – Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-xxx-xxxx (TTY).

Interpreter services are provided free of charge to you.

IMPORTANT [HMO NAME] TELEPHONE NUMBERS

Customer Service	1-800-xxx-xxxx	[Hours/Days Available]
Emergency Number	1-800-xxx-xxxx	Call 24 hours a day, seven (7) days a week
TDD/TTY	1-800-xxx-xxxx	

WELCOME

Welcome to [HMO NAME]. As a member of [HMO NAME], you will receive all your health care from [HMO NAME] doctors, and hospitals. See [HMO NAME] Provider Directory for a list of these providers. You may also call our Customer Service Department at 1-800-xxx-xxxx. Providers not accepting new patients are marked in the Provider Directory.

YOUR FORWARDHEALTH ID CARD

Always carry your ForwardHealth card with you, and show it every time you get care. You may have problems getting care or prescriptions if you do not have your card with you. Also bring any other health insurance cards you may have.

PRIMARY CARE PHYSICIAN (PCP)

It is important to call your primary care physician (PCP) first when you need care. This doctor will manage all your health care. If you think you need to see another doctor, or a specialist, ask your PCP. Your PCP will help you decide if you need to see another doctor, and give you a referral. Remember, you must get approval from your PCP before you see another doctor.

You can choose your primary care physician (PCP) from those available (NOTE: For women you may also see a women's health specialist (for example an OB/GYN doctor or a nurse midwife) without a referral, in addition to choosing your PCP). There are HMO doctors who are sensitive to the needs of many cultures. To choose a PCP, or to change to a different PCP, call our Customer Service Department at 1-800-xxx-xxxx.

EMERGENCY CARE

Emergency care is care needed right away. This may be caused by an injury or a sudden illness. Some examples are:

Choking	Severe or unusual bleeding
Trouble breathing	Suspected poisoning
Serious broken bones	Suspected heart attack
Unconsciousness	Suspected stroke
Severe burns	Convulsions
Severe pain	Prolonged or repeated seizures

If you need emergency care, go to a [HMO NAME] provider for help if you can. BUT, if the emergency is severe, go to the nearest provider (hospital, doctor or clinic). You may want to call 911 or your local police or fire department emergency services if the emergency is severe.

If you must go to a [non-HMO NAME] hospital or provider, call [HMO NAME] at 1-800-xxx-xxxx as soon as you can and tell us what happened. This is important so we can help you get follow up care.

Remember, hospital emergency rooms are for true emergencies only. Call your doctor or our 24-hour emergency number at [1-800-xxx-xxxx] before you go to the emergency room, unless your emergency is severe

URGENT CARE

Urgent Care is care you need sooner than a routine doctor's visit. Urgent care is not emergency care. Do not go to a hospital emergency room for urgent care unless your doctor tells you to go there.

Some examples of urgent care are:

Most broken bones	Minor cuts
Sprains	Bruises
Non-severe bleeding	Most drug reactions
Minor burns	

If you need urgent care call [insert instructions here—call clinic, doctor, 24-hour number, nurse line, etc.] We will tell you where you can get care. You must get urgent care from [HMO NAME] doctors unless you get our approval to see a [non-HMO NAME] doctor.

Remember do not go to a hospital emergency room for urgent care unless you get approval from [HMO NAME] first.

HOW TO GET MEDICAL CARE WHEN YOU ARE AWAY FROM HOME

Follow these rules if you need medical care but are too far away from home to go to your assigned primary care physician (PCP) or clinic.

For severe emergencies, go to the nearest hospital, clinic, or doctor.

For urgent or routine care away from home, you must get approval from us to go to a different doctor, clinic or hospital. This includes children who are spending time away from home with a parent or relative. Call us at 1-800-xxx-xxxx for approval to go to a different doctor, clinic, or hospital.

PREGNANT WOMEN AND DELIVERIES

If you become pregnant, please let [HMO NAME} and your county human services department know right away. This is to make sure you get the extra care you need. You may also not have co-pays when you are pregnant.

You must go to a [HMO NAME] hospital to have your baby. Talk to your [HMO NAME] doctor to make sure you understand which hospital you are to go to when it's time to have your baby.

Also, talk to your doctor if you plan to travel in your last month of pregnancy. Because we want you to have a healthy birth and a good birthing experience, it may not be a good time for you and your unborn child to be traveling. We want you to have a healthy birth and your [HMO Name] doctor knows your history and is the best doctor to help you have a healthy birth. Do not go out of area to have your baby unless you have [HMO NAME] approval.

WHEN YOU MAY BE BILLED FOR SERVICES

It is very important to follow the rules when you get medical care so you are not billed for services. You must receive your care from [HMO NAME] providers and hospitals unless you have our approval. The only exception is for severe emergencies.

If you travel outside of Wisconsin and need emergency services, health care providers can treat you and send claims to [HMO NAME]. You will have to pay for any service you get outside Wisconsin if the health care provider refuses to submit claims or refuses to accept [HMO NAME] payment as payment in full.

[HMO NAME] does not cover any service, including emergency services, provided outside of the United States, Canada and Mexico.

BILLING MEMBERS

Covered and Non-Covered Services

Under BadgerCare Plus – Standard Plan if you receive a bill for services, call our Customer Service Department at 1-800-xxx-xxxx. You do not have to pay for covered services (other than a required co-payment) that are provided by a BadgerCare Plus certified provider and that [HMO NAME] is required to provide you unless prior authorization is denied and you are told there will be a charge for the service before it is provided.

Generally, charging a member for a non-covered service is allowed, except for certain non-covered services or activities related to covered services, like missed appointments, telephone calls and translation services.

Under BadgerCare Plus – Benchmark Plan the HMO and its providers and subcontractors may bill you for deductibles for covered services that are provided by a BadgerCare Plus certified provider.

You may request non-covered services from providers, and providers may collect payment for non-covered services from you if you accept responsibility for payment and make payment arrangements with the provider. Providers may bill you up to their usual and customary charges for non-covered services.

Co-payments

Under the BadgerCare Plus - Standard Plan the HMO and its providers and subcontractors may bill you for nominal co-payments. The following members are exempt from co-payments:

- Nursing home residents,
- Pregnant women,
- Members under 19 years of age who are members of a federally recognized tribe, and
- Members under 19 years of age with incomes at or below 100 percent of the Federal Poverty Level (FPL).

Under BadgerCare Plus – Benchmark Plan the HMO and its providers and subcontractors may bill you for co-payments for covered services or for other medical services that are provided by a BadgerCare Plus certified provider. The following members are exempt from co-payments:

- Pregnant women,
- Members under 19 years of age who are members of a federally recognized tribe.

OTHER INSURANCE

If you have other insurance in addition to [HMO NAME], you must tell your doctor or other provider. Your health care provider must bill your other insurance before billing [HMO NAME]. If your [HMO NAME] doctor does not accept your other insurance, call the HMO Enrollment Specialist at 1-800-291-2002. The Enrollment Specialist can tell you how to match your HMO enrollment with your other insurance so you can use both insurance plans.

SERVICES COVERED BY [HMO NAME]

The HMO is responsible to provide all medically necessary covered services under BadgerCare Plus Standard and Benchmark Plans (a summary of covered services and co-payments amounts are listed in Addendum V). (**The HMO must provide information for these sections that are approved by the Department.)**

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (language may be different based on which plan you are talking about in the handbook – see the summary of covered services and co-payments in Addendum V.)

[HMO NAME] provides mental health and substance abuse (drug and alcohol) services to all members. If you need these services, call [PCP, gatekeeper, customer service, as appropriate].

FAMILY PLANNING SERVICES (language may be different based on which plan you are talking about in the handbook – see the summary of covered services and co-payments in Addendum V.)

We provide confidential family planning services to all members. This includes minors. If you do not want to talk to your primary care doctor about family planning, call our Customer Service Department at 1–800-xxx-xxxx. We will help you choose a [HMO NAME] family planning doctor who is different from your primary care doctor.

We encourage you to receive family planning services from a (HMO Name) doctor. That way we can better coordinate all your health care. Federal law allows members to choose their provider, including physicians and family planning clinics, for reproductive care and supplies. Therefore, you can also go to any family planning clinic that will accept your ForwardHealth ID card even if the clinic is not part of (HMO NAME).

DENTAL SERVICES (The following language applies to BadgerCare Plus Standard Plan members. The Benchmark Plan has a limited dental benefit for certain populations. See a summary of covered services and co-payments in Addendum V.)

[HMO NAME] provides all covered dental services. But you must go to a [HMO NAME] dentist. See the Provider Directory or call the Customer Service Department at 1-800-xxx-xxxx for the names of our dentists.

As a member of (HMO NAME), you have a right to a routine dental appointment within 90 days after your formal request.

Dental Emergency: A dental emergency is an immediate dental service needed to treat dental pain, swelling, fever, infection, or injury to the teeth.

1. If you already have a dentist who is with (HMO Name):

    - Call the dentist's office.
    - Identify yourself or your child as having a dental emergency.
    - Tell the dentist's office what the exact dental problem is. This may be something like a toothache or swollen face. Make sure the office understands that you or your child is having a "dental emergency."
    - Call us if you need help with transportation to your dental appointment.

2. If you do not currently have a dentist who is with (HMO Name):

    - Call (HMO specific dental gatekeeper or HMO). Tell us that you/your child is having a dental emergency. We can help you get dental services.
    - Tell us if you need a ride to the dentist's office.
    - Alternative language for HMO's whose dental gatekeeper handles appointment for emergencies. Call (HMO Name) if you need help with transportation to the dentist's office. We can help with transportation.

For help with a dental emergency call (xxx-xxx-xxxx).

You have a right to obtain treatment for your dental emergency within 24 hours after receipt of your request.

CHIROPRACTIC SERVICES (Covered services are the same for BadgerCare Plus – Standard and Benchmark Plans. Co-payments differ between the Standard and Benchmark Plans. See Addendum V.)

Note to HMO: Use Statement 1 if you provide chiropractic services. Use Statement 2 if you do not provide chiropractic services.

1. [HMO NAME] provides covered chiropractic services for BadgerCare Plus Standard and Benchmark members. But you must go to a [HMO NAME] chiropractor. See the Provider Directory or call the Customer Service Department at 1-800-xxx-xxxx for the names of our chiropractors.

2. You may get chiropractic services from any chiropractor who will accept your Forward Health ID card if you are a BadgerCare Plus Standard or Benchmark member. Your chiropractic services are provided by the State, not [HMO NAME].

HEALTHCHECK

HealthCheck is a preventive health checkup program for members under the age of 21. The HealthCheck program covers complete health checkups. These checkups are very important for those under 21. The doctor wants to see those under 21 for regular checkups, not just when they are sick.

The HealthCheck health program has three purposes:

1. To find and treat health problems for those under 21.

2. To let you know about the special health services for those under 21.

3. To make those under 21 eligible for some health care not otherwise covered.

The HealthCheck program covers the medical care for health problems found during the checkup including medical care, eye care and dental care.

The HealthCheck checkup includes:

- Health and developmental history (including anticipatory guidance).
- Unclothed physical examination.
- Vision screening.
- Hearing screening.
- Dental screening and a referral to a dentist beginning at age one.
- Immunizations appropriate for age (shots).
- Blood and urine lab tests (including blood lead level testing when appropriate for age).

[HMO NAME] will help arrange for transportation for HealthCheck visits. Call our Customer Service Department a 1-800-xxx-xxxx.

To schedule a HealthCheck exam or for more information call our Customer Service Department at 1-800-xxx-xxxx.

TRANSPORTATION

BadgerCare Plus – Standard Plan Members

Note to HMO: Use Statement 1 if you arrange transportation for your members. Use Statement 2 if you arrange transportation in only part of your service area.

1. Bus or taxi rides to receive care are arranged by [HMO NAME]. Call our Customer Service Department at 1-800-xxx-xxxx if you need a ride.

2. Bus or taxi rides to receive care are arranged by [HMO NAME] if you live in [INSERT COUNTIES]. Call our Customer Service Department at 1-800-xxx-xxxx if you need a ride. If you live in a county that is not listed, please call your county Department of Social or Human Services for information about arranging a ride.

BadgerCare Plus – Benchmark Plan Members

Non-emergency transportation is not a covered benefit.

SPECIAL MEDICAL VEHICLE (SMV)

BadgerCare Plus – Standard Plan Members

[HMO NAME] covers transportation by special vehicle for those in wheelchairs. We may also cover this service for others if your doctor asks for it. Call our Customer Service Department at 1-800-xxx-xxxx if you need this service.

BadgerCare Plus – Benchmark Plan Members

Non-emergency transportation is not a covered benefit.

AMBULANCE

[HMO NAME] covers ambulance service for emergency care. We may also cover this service at other times, but you must have approval for all non-emergency ambulance trips. Call our Customer Service Department at 1-800-xxx-xxxx for approval.

PHARMACY BENEFITS

Your prescriptions and certain over-the-counter items are provided by the State, not (HMO Name).

You may receive a prescription from a [HMO Name] doctor, specialist, or dentist. You can fill your prescription at [*insert HMO Name clinic pharmacy if the HMO has their own pharmacies]* any pharmacy that is a provider for BadgerCare Plus.

Please show your ForwardHealth ID card to the pharmacy when you get your prescriptions filled. Do not show your (HMO Name) ID card to the pharmacy. You may have co-payments or have limits on covered medications.

IF YOU MOVE

If you are planning to move, contact your county Department of Social or Human Services. If you move to a different county, you must also contact the Department of Social or Human Services in your new county to update your eligibility.

If you move out of [HMO NAME'S] service area, call the HMO Enrollment Specialist at 1-800-291-2002. [HMO NAME] will only provide emergency care if you move out of our service area. The Enrollment Specialist will help you choose an HMO that serves your area.

HEALTH INSURANCE AFTER YOUR ELIGIBILITY ENDS

You have the right to purchase a private health insurance policy from [HMO NAME] when your eligibility ends. Call our Customer Service Department at [1-800-xxx-xxxx]. If you decide to purchase a policy from us, you have 30 days after the date your eligibility ends to apply.

SECOND MEDICAL OPINION

A second medical opinion on recommended treatments may be appropriate in some cases. Contact your doctor or our Customer Service Department for information.

HMO EXEMPTIONS

An HMO exemption means you are not required to join an HMO to receive your health care benefits. Most exemptions are granted for only a short period of time so you can complete a course of treatment before you are enrolled in an HMO. If you think you need an exemption from HMO enrollment, call the HMO Enrollment Specialist at 1-800-291-2002 for more information.

LIVING WILL OR POWER OF ATTORNEY FOR HEALTH CARE

You have a right to make decisions about your medical care. You have a right to accept or refuse medical or surgical treatment. You also have the right to plan and direct the types of health care you may receive in the future if you become unable to express your wishes. You can let your doctor know about your feelings by completing a living will or power of attorney for health care form. Contact your doctor for more information.

RIGHT TO MEDICAL RECORDS

You have the right to ask for copies of your medical record from your provider(s). We can help you get copies of these records. Please call [1-800-xxx-xxxx] for help. Please note: You may have to pay to copy your medical record. You also may correct wrong information in your medical records if your doctor agrees to the correction.

[HMO NAME'S] MEMBER ADVOCATE

[HMO NAME] has a Member Advocate to help you get the care you need. The Advocate can answer your questions about getting health care from [HMO NAME]. The Advocate can also help you solve any problems you may have getting health care from [HMO NAME]. You can reach the Advocate at 1-800-xxx-xxxx.

STATE OF WISCONSIN HMO OMBUDS PROGRAM

The State has Ombuds who can help you with any questions or problems you have as an HMO member. The Ombuds can tell you how to get the care you need from your HMO. The Ombuds can also help you solve problems or complaints you may have about the HMO Program or your HMO. Call 1-800-760-0001 and ask to speak to an Ombuds.

COMPLAINTS, GRIEVANCES AND APPEALS

We would like to know if you have a complaint about your care at [HMO NAME]. Please call [HMO NAME'S] Member Advocate at 1-800-xxx-xxxx if you have a complaint. Or you can write to us at:

[HMO name and mailing address]

If you want to talk to someone outside of [HMO NAME] about the problem, call the HMO Enrollment Specialist at 1-800-291-2002. The Enrollment Specialist may be able to help you solve the problem, or can help you write a formal grievance to [HMO NAME] or to the BadgerCare Plus programs.

The address to complain to the Wisconsin BadgerCare Plus Programs is:

BadgerCare Plus
Managed Care Ombuds
P. O. Box 6470
Madison, WI 53716-0470
(800) 760-0001

If your complaint or grievance needs action right away because a delay in treatment would greatly increase the risk to your health, please call [HMO NAME] as soon as possible at 1-800-xxx-xxxx.

We cannot treat you differently than other members because you file a complaint or grievance. Your health care benefits will not be affected.

You have the right to appeal to the State of Wisconsin Division of Hearings and Appeals (DHA) for a fair hearing if you believe your benefits are wrongly denied, limited, reduced, delayed or stopped by [HMO NAME]. An appeal must be made no later than 45 days after the date of the action being appealed. If you appeal this action to DHA before the effective date, the service may continue. You may need to pay for the cost of services if the hearing decision is not in your favor.

If you want a fair hearing, send a written request to:

Department of Administration
Division of Hearings and Appeals
P. O. Box 7875
Madison, WI 53707-7875

The hearing will be held in the county where you live. You have the right to bring a friend or be represented at the hearing. If you need a special arrangement for a disability, or for English language translation, please call (608) 266-3096 (voice) or (608) 264-9853 (hearing impaired).

We cannot treat you differently than other members because you request a fair hearing. Your health care benefits will not be affected.

If you need help writing a request for a Fair Hearing, please call either the BadgerCare Plus Ombuds at 1-800-760-0001 or the HMO Enrollment Specialist at 1-800-291-2002.

PHYSICIAN INCENTIVE PLAN

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services you might need. To get this information, call our Customer Service Department at 1-800-xxx-xxxx and request information about our physician payment arrangements.

PROVIDER CREDENTIALS

You have the right to information about our providers that includes the provider's education, board certification and recertification. To get this information, call our Customer Service Department at 1-800-xxx-xxxx.

MEMBER RIGHTS

- You have the right to ask for an interpreter and have one provided to you during any BadgerCare Plus covered service.

- You have the right to receive the information provided in this member handbook in another language or another format.

- You have the right to receive health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.

- You have the right to receive information about treatment options including the right to request a second opinion.

- You have the right to make decisions about your health care.

- You have the right to be treated with dignity and respect.

- You have the right to be free from any form of restraint or seclusion used as means of force, control, ease or reprisal.

YOUR CIVIL RIGHTS

[HMO NAME] provides covered services to all eligible members regardless of:

- Age
- Race
- Religion
- Color
- Disability
- Sex
- Sexual Orientation
- National Origin
- Marital Status
- Arrest or Conviction Record
- Military Participation

All medically necessary covered services are available to all members. All services are provided in the same manner to all members. All persons or organizations connected with [HMO Name] who refer or recommend members for services shall do so in the same manner for all members.

Translating or interpreting services are available for those members who need them. This service is free.

ADDENDUM III

GUIDELINES FOR THE COORDINATION OF SERVICES BETWEEN THE HMO, TARGETED CASE MANAGEMENT (TCM) AGENCIES, AND CHILD WELFARE AGENCIES

A. HMO Rights and Responsibilities

1. The HMO must designate at least one individual to serve as a contact person for case management providers. If the HMO chooses to designate more than one contact person, the HMO should identify the target populations for which each contact person is responsible.

2. The HMO may make referrals to case management agencies when they identify a member from an eligible target population who could benefit from case management services.

3. If the member or case manager requests the HMO to conduct an assessment, the HMO will determine whether there are signs and symptoms indicating the need for an assessment. In the mental health/substance abuse benefit area, a request for an assessment must be accepted in all situations. If the HMO finds that assessment is needed, the HMO will determine the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the HMO determines that no assessment is needed, the HMO will document the rationale for this decision.

4. The HMO must determine the need for medical treatment of those services covered under the HMO Contract based on the results of the assessment and the medical necessity of the treatment recommended.

5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required.

    - The case planning may be done through telephone contact or means of communication other than attending a formal case planning meeting. If the member requests the HMO case management liaison to attend a case plan meeting, the HMO needs to make every effort to honor this request.

    - The HMO must informally discuss differences in opinion regarding the HMO's determination of treatment needs if requested by the member or case manager.

    - The HMO case management liaison and the case manager must discuss who will be responsible for ensuring that the member receives the services authorized by and provided through the HMO.

- The HMO's role in the case planning may be limited to a confirmation of the services the HMO will authorize if the member and case manager find these acceptable.

ADDENDUM IV

REPORT FORMS AND WORKSHEETS

A. **Ventilator Dependent Quarterly Report Form and Detail Report Format**

VENTILATOR COST SUMMARY

HMO Name:_____
Report Period:_____
Number of Cases Reported:_____

Category of Service	Amount Billed	Amount Paid
Inpatient		
Outpatient		
Physician		
Pharmacy		
All Other		
Total		

MAIL TO: Bureau of Fiscal Management
ATTN: Ventilator Analyst
Room 265
P.O. Box 309
Madison, WI 53701-0309

Ventilator Dependent Detail Report

The detail report must be provided on CD-Rom in an Excel file format as well as a paper copy. Individual reports must be submitted for each program the HMO is contracted to serve (ie, BadgerCare Plus). All the reports must include the following data elements:

	Data Elements
1.	HMO Name
2.	HMO Provider Payee Number
3.	Eligibility Code: V-Vent
4.	Member BadgerCare Plus Number
5.	Member Last Name
6.	Member First Name
7.	Member's Date of Birth: mmddyyyy
8.	Members Gender: F (female) or M (male)
9	BadgerCare Plus Provider or NPI Number
10.	BadgerCare Plus Provider Last Name
11.	BadgerCare Plus Provider First Name
12.	Date of Service: From Date (mmddyyyy) (In ascending order not by provider.)
13.	Date of Service: To Date (mmddyyyy)
14.	Primary Diagnosis Code 1: ICD-9-CM or DRG
15.	Quantity: Do not zero fill
16.	Procedure/Drug Code: CPT4, ICD-9-CM, HCPCS, DRG
17.	Procedure/Drug Description: CPT4, ICD-9-CM, HCPCS, DRG
18.	Amount Billed: Include decimal (do not zero fill)
19.	Amount Paid: Include decimal (do not zero fill)
20.	County Code: County code where the member resides at time of each service
21.	Total Amount Billed for Each Individual Member: Include decimal (do not zero fill)
22.	Total Amount Paid for Each Individual Member: Include decimal (do not zero fill)

B. Coordination of Benefits Quarterly Report Form and Instructions for Completing

the Form

Note: In addition to the total dollar amount(s) billed and paid for all members the HMO must report the total dollar amount(s) billed and paid for each individual member.

In order to comply with CMS reporting requirements, the HMO must submit a Coordination of Benefits (COB) report regarding their BadgerCare Plus members. For the purposes of this report, the HMO member is any BadgerCare Plus member listed as an ADD or CONTINUE on the monthly HMO enrollment report(s) that are generated by the Department's Fiscal Agent.

Birth costs or delivery costs (e.g., routine delivery and associated hospital charges) are not to be included in the report.

The report is to be for the HMO's entire service area, aggregating separate service areas if the HMO has more than one service area. The report must be completed on a calendar quarterly basis and submitted to the Department's fiscal agent within 45 days of the end of the quarter being reported.

MAIL TO:

Bureau of Benefits Management
ATTN: (your specific HMO analyst)
Room 350
P.O. Box 309
Madison, WI 53701-0309

FAX TO:

Bureau of Benefits Management
ATTN: (your specific HMO analyst)
Room 350
(608) 261-7792

The COB report form follows this page.

STATE OF WISCONSIN
BADGERCARE PLUS
HMO REPORT ON COORDINATION OF BENEFITS

Name of HMO _____ Mailing Address _____

Office Telephone _____ _____

Provider Number _____ _____

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

_____, 20____ through _____, 20_____

A. **Cost Avoidance** – Indicate the dollar amount you denied as a result of your knowledge of other insurance that is available for the member.

Amount Cost Avoided:_____

B. **Recoveries (Post-Pay Billing/Pay and Chase)**– Indicate below the dollar amounts recovered as a result of:

Subrogation/Workers' Compensation:_____
(e.g., collections from auto, homeowners, or malpractice insurance, restitution payments from the Division of Corrections, collections from Worker's Compensation).

Other Recoveries:_____
(e.g., Third Party Liability (TPL), legal action, or any other recoveries that are not specifically noted above.)

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the HMO, except as noted on the report.

Signed: _____
Original Signature of Director or Administrator

Printed Name: _____

Title: _____

Date Signed: _____

C. Neonatal Intensive Care Unit (NICU) Risk-Sharing Report Format and Detail Data Requirements

HMO reporting of NICU costs must include all of the data elements specified in this section. Risk-sharing for NICU is based on the criteria defined in this Contract. NICU reports must be submitted to the Department's Bureau of Fiscal Management on or before April 1 of the following year. The HMO does not have to file a report if the NICU criteria is not met.

The NICU report form, detailed data format and worksheet follow this page.

HMO NEONATAL INTENSIVE CARE UNIT (NICU) REPORT FORM

HMO Name: _____

HMO BadgerCare Plus (Payee) Number _____

Report Period: January 1, 20____ through December 31, 20____

Questions regarding this report should be referred to:_____
(please print)

Telephone Number: _____

HMO DATA SUMMARY BY COUNTY

Hospital Inpatient Costs Associated with Level II, III, and IV NICU Services.

Number of Days	Number of Admissions	Amount Billed	Amount Paid

Physician Costs Associated with Level II, III, and IV NICU Services.

Amount Billed:	Amount Paid

D. HMO DETAILED NICU DATA FORMAT

The costs summarized in Section A must be reported by month, by county, and by year (i.e., if a member is in an NICU for two or more months, the NICU days, physician and hospital costs must be separated by the month in which they occurred). Amounts paid must include payments for all physician and hospital services that were provided during the report period regardless of the HMO's actual payment date. (See example of data should be reported below.)

Member Name	Member MA ID#	Admit Date	Discharge Date	Total # of NICU Adm	Month
Name	xxxxxxxxxx	07/01/07	07/22/07	1	July

NICU Hosp Data by Month First NICU Day	NICU Hosp Data by Month Last NICU Day	Total # of NICU Days by Month	NICU Amt Billed Hosp (prorated by month)	NICU Amt Paid Hosp (prorated by month)	NICU Amt Billed Phys (by month)	NICU Amt Paid Phys (by month)
07/01/07	07/22/07	20	$00,000.00	$00,000.00	$0,000.00	$00.00

MAIL TO:

Bureau of Fiscal Management
ATTN: NICU Analyst, Room 265
P.O. Box 309
Madison, WI 53701-0309

NICU WORKSHEET

The HMO may complete the worksheet following this page to determine if their NICU days meet the criteria defined. The HMO does not have to file a report if the NICU criteria is not met.

Neonatal Intensive Care Unit Risk-Sharing Worksheet

Calculation

1.	HMO member months:		_____
2.	Member years:	(line 1/12)	_____
3.	Threshold (75 days per 1000 member years):	(75 x line 2/1000)	_____
4.	NICU days reported by HMO:		_____
5.	NICU days over threshold to be reimbursed:	(line 4 – line 3)	_____
6.	Inpatient paid:		_____
7.	Physician paid:		_____
8.	Total cost:	(line 6 + line 7)	_____
9.	Average cost per day:	(line 8 /line 4)	_____
10.	90% of cost/day (Not to exceed $1,443):	(0.9 x line 9)	_____
11.	Reimbursement amount (Days x 90% cost):	(line 5 x line 10)	_____

E. Court Ordered Birth Cost Requests

County Child Support Agencies (CSA) obtain court orders requiring fathers to repay birth costs that have been paid by FFS as well as the HMO. In some counties, judges will not assign birth costs to the father based upon average costs. Upon request of the Fiscal Agent Contract Monitor, the HMO must provide actual charges less any payments made by a third party payer for the use by the court in setting actual birth and related costs to be paid by the father. Birth cost information must be submitted to the Bureau of Benefits Management within 14 days from the date the request was received by the HMO.

The birth cost report forms follows this page.

BADGERCARE PLUS HMO BIRTH COST REQUEST

PART I: Local Child Support Agency Portion

PART I: To be completed by the Local Child Support Agency. Please type or print, in a legible manner.

1. **HMO Name** _____

2. **Mother's Name** _____
(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Address _____
(Street Address)

_____
(City) (State) (Zip Code)

3. **Newborn's Name** _____
(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Date of Birth _____ Sex _____

Note: In cases of multiple births, a form must be completed for each newborn. In addition, the form(s) should not be submitted to the Bureau of Benefits Management until 60 days after the birth.

4. **I certify this information is accurate to the best of my knowledge**:

Name of Local Child Support Agency	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

5. **Mail To:**
Bureau of Benefits Management
ATTN: Birth Costs, Room 350

FAX To:
Bureau of Benefits Management
ATTN: Birth Costs

P.O. BOX 309 (608) 266-1096
MADISON, WI 53701-0309

PART II: HMO Portion

Part II: To be completed by the HMO. Please type or print in a legible manner.

1. **The actual payment for birthing costs for the mother and her baby.**

Mother's Name _____ID# _____

Baby's Name _____ID#_____DOB_____

Hospital/Birthing Center Payment (Mother) $ _____

Hospital/Birthing Center Payment (Newborn) $ _____

Physician Payment (Mother) $ _____

Physician Payment (Newborn) $ _____

Amount Paid by Other Insurance $ _____

2. **Comments: (i.e., retroactively disenrolled from [HMO NAME] effective [DATE], services denied)**

[State Denial Reason]: _____

3. **I certify this information is accurate to the best of my knowledge.**

Name of HMO	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

4. **Mail or FAX Part I and Part II within 14 days of receipt to:**

Mail To:
Bureau of Benefits Management
ATTN: Birth Costs, Room 350

FAX To:
Bureau of Benefits Management
ATTN: Birth Costs

P.O. Box 309 (608) 266-1096
Madison, WI 53701-0309

F. HMO Newborn Report

This report should be completed for infants born to mothers who are BadgerCare Plus eligible and enrolled in the HMO at the time of birth of the infant.

1.	HMO Name:	In this field enter the name of the HMO reporting.
	HMO NPI Number:	In this field enter the BadgerCare Plus NPI number of the HMO reporting.
	Taxonomy Code	In this field, enter the 10-digit provider taxonomy code.
	Telephone Number:	In this field enter the HMO telephone number the fiscal agent can call with questions about submitted newborn reports.
2.	Newborn Name:	In this field enter the name of the newborn infant. If the mother has not given a first and middle name to the baby at the time the report is completed, enter the last name of the newborn as the mother's last name; the first name/middle initial can be entered as "baby male" or "baby female."
	Date of Birth:	In this field enter the date of birth of the newborn infant, in MM/DD/YY format.
	Sex:	In this field check the sex of the newborn infant, male or female.
	Low Birth Weight <1200 grams:	In this field check the box if the newborn infant weighs less than 1200 grams.
	Twin:	In this field check no if the newborn infant is not a twin, check yes if the newborn infant is a twin. If the newborn infant is a twin, complete one newborn report for each twin.
	Date of Death:	In this field enter the date of death, if the newborn infant died, in MM/DD/YY format.
3.	Mother's Name:	In this field enter the first name, middle initial, and last name of the mother of the newborn infant.
	Address:	In this field enter the address of the mother of the newborn infant – street address, city, state, and zip code.
	Mother's ID Number:	In this field enter the BadgerCare Plus number of the mother of the newborn infant.

The HMO staff person (or provider if the HMO delegates this responsibility) completing the report should sign and date the form and send it to the address listed at the bottom of the report.

The HMO does not have to use the above format. However, whatever format the HMO uses, the HMO must submit all of the information described above to the Department's fiscal agent.

HMO Newborn Report follows this page.

BADGERCARE PLUS HMO NEWBORN REPORT

Please print, type, or complete in a legible manner:

1. HMO Name _____

   HMO Provider NPI Number _____

   Taxonomy Code _____

   Telephone Number _____

2. Newborn Name _____
   (First) (M.I.) (Last)

   Date of Birth _____ ☐ Male ☐ Female

   ☐ Low Birth Weight <1200 grams

   Twins: ☐ No ☐ Yes (If yes, complete two forms)

   Date of Death if Applicable _____

3. Mother's Name _____
   (First) (M.I.) (Last)

   Address _____
   (Street Address)

   _____
   (City) (State) (Zip Code)

4. Mother's BadgerCare Plus ID Number _____

5. I certify this information is accurate to the best of my knowledge.

   _____ _____
   Signature Date

Password-protected E-mail To:

vedsnewbornreporting@wisconsin.gov

FAX To:

Fiscal Agent
ATTN: Managed Care Unit
(608) 224-6318

G. HealthCheck Worksheet

HEALTHCHECK WORKSHEET

HMO: _____

			Age Groups					
		Calculation	**< 1**	**1 – 2**	**3 – 5**	**6 – 14**	**15 – 20**	**Total**
1	# of eligible months for members under age 21	Entered (Total is sum of age groups)						
2	# of unduplicated members under age 21	Entered						
3	Ratio of recommended screens per age group member	Given	5	1.5	1.0	0.5	0.5	
4	Average period of eligibility in years	Line 1 ÷ Line 2 ÷ 12						
5	Adjusted ratio of recommended screens per age group member	Line 3 x Line 4						
6	Expected # of screens (100% of required screens for ages and months of eligibility)	Line 2 x Line 5 (Total is sum of age groups)						
7	# of screens in 80% goal	Line 6 x 0.80 (Total is calculated by formula)						
8	Actual # of screens completed	Entered (Total is sum of age groups)						
9	Difference between goal and actual	Line 8 – Line 7 (If negative, goal was not met)						
10	% of HMO discount or premium if applicable*							
11	Amount per screen to be recouped	FFS maximum allowable fee* x Line 10						
12	Total recoupment	Line 11 x Line 9						

* Dates of service after January 1, 2008 do not have a discount factor applied.

H. Member Complaint and Grievance Reporting Forms

1. Grievance Experience Summary Report

Summarize each BadgerCare Plus grievance reviewed in the past quarter. If the HMO does not have a separate log for BadgerCare Plus and their commercial members, the log must distinguish between the programs.

HMOs should report those members that grieved or appealed to the HMO's grievance appeal committee (a – c).

a. Grievances Related to Program Administration

Member Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

b. Grievances Related to Benefit Denial/Reduction

Member Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

c. Summary

SUBTOTAL: Program Administration _____
SUBTOTAL: Benefit Denial/Reduction _____
TOTAL NUMBER OF GRIEVANCES: _____

2. HMO Reporting Form for Member Complaints

_____

HMO Name

- ☐ First Quarter
- ☐ Second Quarter
- ☐ Third Quarter
- ☐ Fourth Quarter
- ☐ Calendar Year 2010
- ☐ Calendar Year 2011
- ☐ Calendar Year 2012
- ☐ Calendar Year 2013

TYPE OF COMPLAINT	TOTAL NUMBER OF COMPLAINTS
1. ACCESS PROBLEMS	
2. BILLING ISSUES	
3. QUALITY OF CARE	
4. DENIAL OF SERVICE	
5. OTHER SPECIFY	

General Definitions

1. Access problems include any problem identified by the HMO that causes a member to have difficulty getting an appointment, receiving care, or on culturally appropriate care, including the provision of interpreter services in a timely manner.

2. Billing issues include the denial of a service or a member receiving a bill for a BadgerCare Plus covered service that the HMO is responsible for providing or arranging for the provision of that service.

3. Quality of care includes long waiting times in the reception area of providers' offices, rude providers or provider staff, or any other complaint related directly to patient care.

4. Denial of service includes any BadgerCare Plus covered service that the HMO denied.

5. Others as identified by the HMO.

Return the completed form to:

Bureau of Benefits Management
ATTN: Grievances, Managed Care Analyst, Room 350
P.O. Box 309
Madison, WI 53701-0309

I. Attestation Form

ATTESTATION

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

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

☐ Vent Report for (quarter)_____for (year) 20___.

☐ HMO Network Submission (submitted monthly) for (quarter) _____(year) 20__.

☐ Other _____ (Specify Report)

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____
(Signature) (Date)

_____ _____
(Print Name) (Print Date)

J. Common Carrier Detail Report

The detail report must be provided on disk CD ROM in an excel file format. The reports must include all of the following data elements.

	Data Elements
1.	HMO Name
2.	HMO #
3.	Member MA ID Number
4.	Member Last Name
5.	Member First Name
6.	Member's Date of Birth: mmddyyyy
7.	Members Gender: F (female) or M (male)
8.	Member's Medical Status Code
9.	Member's Medicare Status
10.	Vendor Name
11.	Date of Service: mmddyyyy
12.	Month of Service
13.	Invoice Date
14.	Loaded Miles
15.	Invoice Amount
16.	Administration Fees
17.	Total Charge
18.	Amount Billed: Include decimal (do not zero fill)
19.	Amount Paid: Include decimal (do not zero fill)
20.	Procedure Codes-HCPCS
21.	Modifier (if applicable)
22.	Type of Vehicle
23.	Comments

K. Summary Hospital Access Payment Report to Department of Health Services

This report will be provided to the HMO electronically for completion. Hospital Access Payments must be sent to the hospitals within 15 calendar days after the HMO receives the monthly amounts from the Department. HMOs must submit to the Department the following information for each paid hospital within 20 calendar days of receipt of payment from the Department:

Hospital Access Payment

HMO Name
Month, Year payment was received from the Department
Month, Year from which hospital discharge and visit data is being reported (i.e. previous month)
Date the last hospital access payment was sent
*** Grand Total Payment**

* Total payments made to all hospitals should be equal to the total amount the HMO received from the Department. The distribution of these funds by the HMO to hospitals shall be based on eligible discharges and visits in the prior month paid by the HMO to eligible hospitals.

1	2	3	4	5	6	7	8	9	10	11	12	13
MA ID	NPI	Hospital Name	Inpatient Funding Received from DHS	Number of Hospital Qualifying Inpatient Discharges Paid to the Individual Hospital	Number of Total Inpatient Discharges Paid by HMO to All Eligible Hospitals	Percent of the Hospital's Total Inpatient Discharges Paid by the HMO (Column 5 / Column 6)	Payment to Hospital for Inpatient Discharges (Column 4 x Column 7)	Outpatient Funding Received from DHS	Number of Hospital Qualifying Outpatient Visits Paid to the Individual Hospital	Number of Total Outpatient Discharges Paid by HMO to All Eligible Hospitals	Percent of the Hospital's Total Outpatient Visits Paid by HMO (Column 10 / Column 11)	Payment to Hospital for Outpatient Visits (Column 9 x Column 12)
		Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____

(Signature) (Date)

L. Summary Ambulatory Surgical Center (ASC) Access Payment Report to Department of Health Services

This report will be provided to the HMO electronically for completion. ASC Access Payments must be sent to the ambulatory surgical centers within 15 calendar days after the HMO receives the monthly amounts from the Department. HMOs must submit to the Department the following information for each paid ASC within 20 calendar days of payment from the Department:

Ambulatory Surgical Center (ASC) Access Payment

HMO Name
Month, Year payment was received from the Department
Month, Year from which claim is being reported (i.e. previous month)
Date the last ASC access payment was sent
*** Grand Total Payment**

* Total payments made to all ambulatory surgical centers (ASCs) should be equal to the total amount the HMO received from the Department. The distribution of these funds by the HMO to ASCs shall be based on eligible visits in the prior month paid by the HMO to eligible ASCs. If the HMO has no qualifying visits, the HMO shall return the payment to the Department and indicate this on this form.

1	2	3	4	5	6	7	8
MA ID	**NPI**	**ASC Name**	**Funding Received from DHS**	**Number of Claims Paid to the Individual ASC**	**Number of Total Claims by HMO to All Eligible ASCs**	**Percent of the ASC's Total Claims Paid by the HMO (Column 5 / Column 6)**	**Payment to ASC for Claims (Column 4 x Column 7)**
		Total:					

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____

(Signature) (Date)

M. Summary Critical Access Hospital (CAH) Access Payment Report to Department of Health Services

This report will be provided to the HMO electronically for completion. Payments must be sent to the hospitals within 15 calendar days after the HMO receives the monthly amounts from the Department. HMOs must submit to the Department the following information for each paid CAH:

Critical Access Hospital (CAH) Access Payment

HMO Name
Month, Year payment was received from the Department
Month, Year from which CAH discharge and visit data is being reported (i.e. previous month)
Date the last hospital access payment was sent
*** Grand Total Payment**

* Total payments made to all CAH(s) should be equal to the total amount the HMO received from the Department. The distribution of these funds by the HMO to CAH(s) shall be based on eligible discharges and visits in the prior month paid by the HMO to eligible CAH(s).

1	2	3	4	5	6	7	8	9	10	11	12	13
MA ID	NPI	Hospital Name	Inpatient Funding Received from DHS	Number of CAH Qualifying Inpatient Discharges Paid to the Individual CAH	Number of Total Inpatient Discharges Paid by HMO to All Eligible CAH(s)	Percent of the CAH's Total Inpatient Discharges Paid by the HMO (Column 5 / Column 6)	Payment to CAH for Inpatient Discharges (Column 4 x Column 7)	Outpatient Funding Received from DHS	Number of CAH Qualifying Outpatient Visits Paid to the Individual CAH	Number of Total Outpatient Discharges Paid by HMO to All Eligible CAH(s)	Percent of the CAH's Total Outpatient Visits Paid by HMO (Column 9 / Column 10)	Payment to CAH for Outpatient Visits (Column 9 x Column 12)
		Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

(Signature) (Date)

ADDENDUM V

SUMMARY OF BADGERCARE PLUS COVERED SERVICES

The BadgerCare Plus: Benefits and Cost Sharing Chart is available online at the following website with the title "BadgerCare Plus Covered Services Comparison Chart": https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/referenceAndTools.htm.spage

This document is for reference only and is subject to change over time. Please see the ForwardHealth Provider Updates for ongoing guidance on benefit policies.

ADDENDUM VI

PERFORMANCE REQUIREMENTS

A. Quality Performance Measures Requirements

Beginning with CY 2011, HMOs will be evaluated annually on their performance relative to the Department's performance benchmarks in seven focus areas. The seven focus areas are:

- Diabetes testing
- Blood lead testing
- Childhood immunization
- Asthma management
- Tobacco cessation
- Emergency Department utilization management
- Dental utilization

The Department will hold back payment of up to 3.25% of the HMO's capitation rate annually beginning in CY 2011 for failure by the HMO to meet the Department's benchmarks in each of these focus areas.

1. Diabetes testing, Blood lead testing, Childhood immunization, Asthma management, and Tobacco cessation

   a. For Diabetes testing, Blood lead testing, Childhood immunization, Asthma management, and Tobacco cessation, the following metrics will be used to evaluate performance:

      1) *HEDIS Measure: Child Immunization Status* – The percentage of children two years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio; one measles, mumps, and rubella (MMR); three H Influenza type B (HiB); three hepatitis B; and one chicken pox (VZV) vaccine (combination 2).

      2) *HEDIS-Like Measure: Lead Testing of One and Two Year Olds* – a) The percentage of one year olds (based on HEDIS methodology) having a lead screen performed when the child was 6-16 months; b) the percentage of two year olds (based on HEDIS methodology) having a lead screen performed when the child was 17-28 months.

      3) *HEDIS Measure*: *Use of Appropriate Medications for People with Asthma* – The percentage of members 5-50 years of age during the measurement year who had persistent asthma and who were appropriately prescribed medication during the measurement year.

4) *HEDIS Measure*: *Comprehensive Diabetes Care (Hba1c and LDL)* – Defined as the percentage of members 18-75 years of age with diabetes who had a hemoglobin A1C (HbA1c) test and LDL-C screen.

5) *MEDDIC Measure*: *Tobacco Cessation* – Defined as percentage of Medicaid members who were 11+ years of age and continuously enrolled during the measurement year, identified as having tobacco or nicotine addiction or current smoker status and cessation treatment. Refer to the MEDDIC-MS specifications for details on pharmacological and counseling cessation treatments.

These specifications are subject to change based on revised HEDIS recommendations. Performance metrics will be measured using the most current HEDIS specifications available at time of the Department's evaluation.

b. Performance for each calendar year will be measured using all encounter data for that calendar year submitted to the Department by June 21 of the following year. The Department will use data from the following sources: DHS Encounter Data, Wisconsin Immunization Registry, and Wisconsin Childhood Lead Poisoning Prevention Program. The Department will use data submitted as of June 21 of each year to calculate measures. Any encounter data which is populated by the HMO conducting its own internal (and audited) chart reviews which complies with HEDIS-hybrid methodology and the requirements in the encounter data manual to supplement their administrative data for a given year will be accepted as long as data is submitted by June 21 of that year.

c. HMOs must perform at or above the following benchmarks in CY 2011, CY 2012, and CY 2013. Separate benchmarks are set for performance in Milwaukee County and for average performance across Washington, Ozaukee, Waukesha, Racine and Kenosha counties. For Washington, Ozaukee, Waukesha, Racine and Kenosha counties, the HMO will not have to meet the established benchmark in each county individually; rather the HMO will be evaluated based on its combined performance across these five counties.

d. The Department will provide updated benchmarks to the HMO using 2008 data for the below performance measures.

	Milwaukee County			Washington, Ozaukee, Waukesha, Racine and Kenosha counties		
Performance Measure	CY 2011 benchmark	CY 2012 benchmark	CY 2013 benchmark	CY 2011 benchmark	CY 2012 benchmark	CY 2013 benchmark

Childhood immunization	54.5%	58.4%	62.2%	61.6%	61.9%	62.2%
Diabetes testing—HbA1c	70.3%	71.1%	72.0%	71.5%	71.8%	72.0%
Diabetes testing—LDL	63.5%	64.2%	65.0%	64.8%	64.9%	65.0%
Blood lead testing— 1 year old	59.1%	62.0%	64.8%	67.2%	67.2%	67.2%
Blood lead testing—2 year old	57.1%	57.1%	57.1%	54.5%	54.5%	54.5%
Asthma management	77.0%	77.0%	77.0%	74.0%	74.6%	75.1%
Tobacco cessation	43.5%	48.8%	54.0%	48.9%	51.4%	54.0%

d. Financial assessment

The Department will hold back payment of up to 2.5% of the HMO's capitation rate for failure to meet the performance benchmarks. Although the Department will determine the HMO's full capitation rate, 2.5% of that rate will not be paid out to the HMO unless the HMO meets the performance benchmarks as indicated in this section.

The Department will issue the HMO a payment for any monies owed after the Department has completed calculating the HMO's performance for the previous year. The Department estimates this payment will be made during the third quarter following the year for which performance was calculated. For example, the Department estimates that it will issue an HMO payment by September 2012 for the HMO's performance in CY 2011.

The 2.5% amount will be distributed across the performance measures as follows:

Performance Measure	Percent of capitation rate
Childhood immunization	.6%
Diabetes testing—HbA1c and LDL	.5%
Blood lead testing— 1 and 2 year olds	.5%
Asthma management	.5%
Tobacco cessation	.4%
TOTAL	2.5%

The HMO will be eligible for the 2.5% payment amount according to the following criteria:

1) Meets benchmarks: For each calendar year, if the benchmark for a measure is met in BOTH Milwaukee county and across Washington, Ozaukee, Waukesha, Racine and Kenosha counties, the HMO will be eligible for the payment amount associated with that measure.

2) Does not meet benchmark: For each calendar year, if the benchmark for a measure is NOT met in BOTH Milwaukee County and across Washington, Ozaukee, Waukesha, Racine and Kenosha counties, the HMO will not be eligible for the payment amount associated with that measure.

3) Blood lead testing and Diabetes testing exception: Blood lead testing and diabetes testing each have two measures associated with them; therefore, benchmarks must be met for both measures in both Milwaukee county and across Washington, Ozaukee, Waukesha, Racine and Kenosha counties. Otherwise, the HMO will not be eligible for the payment amount associated with that measure.

e. Performance Bonus

For each calendar year, up to $3 million will be allocated among the HMOs that meet or exceed the benchmarks in all measures. This amount is in addition to the 2.5% payment amount. If an HMO declines in performance in any measure from the previous year—even if the HMO is performing above the benchmark—the HMO will not be eligible for this payment.

f. Auto-assignment allocation

The Department will implement the following auto-assignment allocation based on the HMO's performance:

1) Declines in performance. Beginning with performance in CY 2011, if an HMO declines in performance for any measure in any year from the prior year in either Milwaukee county or across Washington, Ozaukee, Waukesha, Racine and Kenosha counties, the HMO will NOT receive auto-assignments for the number of months equal to the number of performance measures for which a decline occurred (example: decline in 1 measure equals no auto-assignments for 1 month; decline in 2 measures equals

no auto-assignments for 2 months). The HMO must also submit a corrective action plan to DHS.

2) Exceeds benchmark. If an HMO exceeds a benchmark for any measure in any year, the HMO will receive an increase in auto-assignments equal to the auto-assignments forfeited by any HMO that declines in performance in 'i' above. If more than one HMO exceeds a benchmark, the increase in auto-assignments will be allocated equally among those HMOs that exceeded the benchmark.

3) Alternative scenario. If no HMO exceeds a benchmark and auto-assignments are forfeited, the auto-assignments will be distributed evenly among the HMOs that did not decline in performance.

4) Diabetes testing and blood lead testing: Each of the two measures associated with diabetes testing and blood lead testing count as individual performance measures; therefore if an HMO declines in performance for Diabetes testing—HbA1c, Diabetes testing—LDL, Blood lead testing—1 year old, or Blood lead testing—2 year old, in either Milwaukee county or across Washington, Ozaukee, Waukesha, Racine and Kenosha counties, the HMO will NOT receive auto-assignments for the number of months equal to the number of performance measures for which a decline occurred. Also, if an HMO exceeds a benchmark for Diabetes testing—HbA1c, Diabetes testing—LDL, Blood lead testing—1 year old, or Blood lead testing—2 year old, the HMO will receive an increase in auto-assignments equal to the auto-assignments forfeited by any HMO that declines in performance in 'i' above. If more than one HMO exceeds a benchmark, the increase in auto-assignments will be allocated equally among those HMOs that exceeded the benchmark.

Any freezing or increased allocation of auto-assignments will begin with the month following the month during which the Department completed its calculation of the HMO's performance for the previous year. The Department estimates that it will complete its calculation of the HMO's performance in August following the year for which performance was calculated; therefore, the Department estimates implementing a freeze or increase in auto-assignments in September.

2. Emergency Department utilization management

a. The Department will hold back payment of up to .5% of the HMO's capitation rate annually for failure to meet both of the following criteria:

1) The HMO must not exceed the statewide rate of Emergency Department (ED) visits per continuously enrolled member in the HMO. For CY 2011, the HMO's rate must be no greater than 0.59 visits per continuously enrolled member. The Department will use data submitted as of June 21, 2011 to calculate the statewide rate for the CY 2012 benchmark and data as of June 21, 2012 to calculate the statewide rate for the CY 2013 benchmark. The Department estimates that it will inform the HMO of their benchmark for the following year in July of 2012 and 2013.

2) The HMO must not exceed the statewide percentage of continuously enrolled members with 3 or more ED visits and no primary care visit in that measurement year. For CY 2011, the HMO's percentage must be no greater than 3.40% of their continuously enrolled population. The Department will use data submitted as of June 21, 2011 to calculate the statewide percentage for the 2012 benchmark and data as of June 21, 2012 to calculate the statewide percentage for the CY 2013 benchmark. The Department estimates that it will inform the HMO of their benchmark for the following year in July of 2012 and 2013.

The HMO must meet both of the above criteria each year in order to be eligible for release of the .5% payment. If an HMO declines in performance in either of these measures from the previous year—even if they exceed the threshold—the HMO will not be eligible for this released amount.

b. The Department will measure the rate of emergency department visits for an Ambulatory Sensitive Condition based on AHRQ's Prevention Quality Indicator measures (PQIs) for each HMO on an annual basis. Beginning in CY 2011, if the HMO's PQI emergency department visit rate is greater than that of the statewide rate for that calendar year, the HMO must submit to the Department a corrective action plan to reduce the rate below the State average. If after the next calendar year, the HMO's PQI emergency department visit rate remains above the Statewide rate, the Department will withhold the entire payment of .5% of the HMO's capitation detailed in 'a' above regardless of whether the HMO has met the benchmarks detailed in 1 and 2 above.

c. Although the Department will determine the HMO's full capitation rate, .5% of that rate will not be paid out to the HMO annually unless the HMO meets the performance benchmarks as indicated in this section. The Department will issue the HMO a payment for any monies owed after the Department has completed calculating the HMO's performance for the previous year. The Department estimates this payment will be made during the third quarter following the year for which performance was calculated. For example, the Department estimates that it will issue an HMO payment by September 2012 for the HMO's performance in CY 2011.

3. Dental Utilization

The Department will hold back payment of up to .25% of the HMO's capitation rate annually for failure to meet the following criteria:

The following metrics will be used to evaluate performance:

1) *Overall dental utilization by continuously enrolled children:* Percent of members 18 years and younger who were enrolled in the HMO for at least 11 months that year and received a D-code encounter.
2) *Overall dental utilization by continuously enrolled adults:* Percent of members 19 years and older who were enrolled in the HMO for at least 11 months that year and received a D-code encounter.
3) *Comprehensive dental exam utilization by continuously enrolled children:* Percent of members 18 years and younger who were enrolled in the HMO for at least 11 months that year who received either codes D0120 or D0150.
4) *Comprehensive dental exam utilization by continuously enrolled adults:* Percent of members 19 years and older who were enrolled in the HMO for at least 11 months that year who received either codes D0120 or D0150.

Metrics 1 and 2 exclude the following CDT codes: D5911 – D5999, D6210 – D6999.

a. For CY 2011, the HMO must perform at or above the following benchmarks:

Overall dental utilization by continuously enrolled children: Benchmark will be available on approximately October 1, 2010. *Overall dental utilization by continuously enrolled adults*: Benchmark will be available approximately on October 1, 2010. *Comprehensive dental exam utilization by continuously*

enrolled children: 24.0%*Comprehensive dental exam utilization by continuously enrolled adults:* 15.7%

b. For CY 2012 and CY 2013, the HMO must increase its utilization rate for all four measures by at least 10% from the HMO's previous calendar year's performance. For example, if an HMO's CY 2011 overall dental utilization rate by continuously enrolled children is 28.0%, it must have a utilization rate of at least 30.8% in CY 2012 in order to be eligible for the .25% payment amount.

At a minimum, the HMO's utilization rates must be no less than the following levels for each calendar year:

1) *Overall dental utilization by continuously enrolled children:* Benchmarks for CY2012 and CY 2013 will be available on approximately October 1, 2010.
2) *Overall dental utilization by continuously enrolled adults:* Benchmarks for CY2012 and CY 2013 will be available on approximately October 1, 2010.
3) *Comprehensive dental exam utilization by continuously enrolled children:* 26.4% (CY 2012); 29.0% (CY 2013)
4) *Comprehensive dental exam utilization by continuously enrolled adults:* 17.3% (CY 2012); 19.0% (CY 2013)

c. The HMO must meet all the benchmarks for all four measures in a given year in order to be eligible for release of the .25%. If an HMO declines in performance in any one measure from the previous year—even if the HMO has exceeded that year's benchmark—the HMO will not be eligible for this released amount.

d. Although the Department will determine the full capitation rate, .25% of that rate will not be paid out to the HMO annually unless the HMO meets the performance benchmarks as indicated in this section. The Department will issue the HMO a payment for any monies owed after the Department has completed calculating the HMO's performance for the previous year. The Department estimates this payment will be made during the third quarter following the year for which performance was calculated. For example, the Department estimates that it will issue an HMO payment by September 2012 for the HMO's performance in CY 2011.

B. Poor Birth Outcome Assessment

HMOs will be evaluated annually on whether they provided comprehensive care to adolescents and women known to be at high risk for a poor birth outcome. Members participating in the Medical Home pilot will be excluded from this evaluation.

1. Performance Guidelines

The Department will determine the HMOs performance based on the following guidelines:

a. The denominator is all female members that gave birth in the measurement year, were enrolled in the HMO for at least five months and;
   - Were on the Department's High Risk Pregnancy Report for women with a prior poor birth outcome; or
   - Were below 18 years of age.

   Members participating in the Medical Home pilot will be removed from the denominator.

b. The numerator is the number of female members in the denominator who had a poor birth outcome and did not receive satisfactory care.

c. Satisfactory care is defined as care that meets national guidelines established by the American College of Obstetricians and Gynecologists (ACOG) and other best practices for high risk women as determined by the Department.

d. A chart review will be conducted by the Department to determine whether the care provided meets the criteria for satisfactory care. Care that meets all of the ACOG guidelines and at least 7 out of 9 of the best practices for high risk women will be considered to receive satisfactory care.

2. Assessment Structure

Performance will be reported as a rate for comparison purposes, however the assessment will be calculated based on the absolute number of female members in the denominator that had a poor birth outcome and did not receive satisfactory care. The HMO will be assessed $2,000 per birth for each member meeting these criteria.

EXHIBIT 1: STANDARD PLAN CAPITATION RATES AND MATERNITY KICK PAYMENT

Wisconsin Department of Health Services
2010 Capitation Rates for Southeast Wisconsin RFP
BadgerCare Plus Standard Program

		Medical and Dental Base Rate		Chiropractic Capitation Rate	
Age Range	Gender	Region 5	Region 6	Region 5	Region 6
Age 0	All	$ 241.17	$ 313.35	$ 0.19	$ 0.03
Ages 1 - 5	All	57.53	70.24	0.17	0.03
Ages 6 - 14	All	47.34	47.99	0.34	0.04
Ages 15 - 20	Female	92.93	94.76	0.58	0.09
Ages 15 - 20	Male	66.93	59.75	0.46	0.05
Ages 21 - 34	Female	156.23	151.63	1.12	0.24
Ages 21 - 34	Male	108.87	102.27	1.13	0.40
Ages 35 -44	Female	214.24	211.10	1.68	0.32
Ages 35 -44	Male	159.36	161.53	1.32	0.39
Ages 45 & Over	Female	248.73	278.62	1.78	0.46
Ages 45 & Over	Male	213.51	281.57	1.37	0.39

Medical/Dental Administration by HMO:

UnitedHealthcare of Wisconsin, Inc.	$ 12.71
Abri Health Plan, Inc.	13.99
Children's Community Health Plan, Inc.	14.00
Community Connect Health Plan	17.50

Wisconsin Department of Health Services
2010 Capitation Rates for Southeast Wisconsin RFP
BadgerCare Plus Standard Program

Medical and Dental Capitation Rates

Age Range	Gender	Region 5				Region 6			
		UnitedHealthcare of Wisconsin, Inc.	Abri Health Plan, Inc.	Children's Community Health Plan, Inc.	Community Connect Health Plan	UnitedHealthcare of Wisconsin, Inc.	Abri Health Plan, Inc.	Children's Community Health Plan, Inc.	Community Connect Health Plan
Age 0	All	$ 253.88	$ 255.16	$ 255.17	$ 258.67	$ 326.06	$ 327.34	$ 327.35	$ 330.85
Ages 1 - 5	All	70.24	71.52	71.53	75.03	82.95	84.23	84.24	87.74
Ages 6 - 14	All	60.05	61.33	61.34	64.84	60.70	61.98	61.99	65.49
Ages 15 - 20	Female	105.64	106.92	106.93	110.43	107.47	108.75	108.76	112.26
Ages 15 - 20	Male	79.64	80.92	80.93	84.43	72.46	73.74	73.75	77.25
Ages 21 - 34	Female	168.94	170.22	170.23	173.73	164.34	165.62	165.63	169.13
Ages 21 - 34	Male	121.58	122.86	122.87	126.37	114.98	116.26	116.27	119.77
Ages 35 -44	Female	226.95	228.23	228.24	231.74	223.81	225.09	225.10	228.60
Ages 35 -44	Male	172.07	173.35	173.36	176.86	174.24	175.52	175.53	179.03
Ages 45 & Over	Female	261.44	262.72	262.73	266.23	291.33	292.61	292.62	296.12
Ages 45 & Over	Male	226.22	227.50	227.51	231.01	294.28	295.56	295.57	299.07

All Services (Medical, Dental, and Chiropractic) Capitation Rates

Age Range	Gender	Region 5				Region 6			
		UnitedHealthcare of Wisconsin, Inc.	Abri Health Plan, Inc.	Children's Community Health Plan, Inc.	Community Connect Health Plan	UnitedHealthcare of Wisconsin, Inc.	Abri Health Plan, Inc.	Children's Community Health Plan, Inc.	Community Connect Health Plan
Age 0	All	$ 254.07	$ 255.35	$ 255.36	$ 258.86	$ 326.09	$ 327.37	$ 327.38	$ 330.88
Ages 1 - 5	All	70.41	71.69	71.70	75.20	82.98	84.26	84.27	87.77
Ages 6 - 14	All	60.39	61.67	61.68	65.18	60.74	62.02	62.03	65.53
Ages 15 - 20	Female	106.22	107.50	107.51	111.01	107.56	108.84	108.85	112.35
Ages 15 - 20	Male	80.10	81.38	81.39	84.89	72.51	73.79	73.80	77.30
Ages 21 - 34	Female	170.06	171.34	171.35	174.85	164.58	165.86	165.87	169.37
Ages 21 - 34	Male	122.71	123.99	124.00	127.50	115.38	116.66	116.67	120.17
Ages 35 -44	Female	228.63	229.91	229.92	233.42	224.13	225.41	225.42	228.92
Ages 35 -44	Male	173.39	174.67	174.68	178.18	174.63	175.91	175.92	179.42
Ages 45 & Over	Female	263.22	264.50	264.51	268.01	291.79	293.07	293.08	296.58
Ages 45 & Over	Male	227.59	228.87	228.88	232.38	294.67	295.95	295.96	299.46

Maternity Kick Payment No Administrative Allowance		$ 3,659.71	$ 3,659.71	$ 3,659.71	$ 3,659.71	$ 4,596.43	$ 4,596.43	$ 4,596.43	$ 4,596.43

EXHIBIT 2: BENCHMARK PLAN CAPITATION RATES AND MATERNITY KICK PAYMENT

Wisconsin Department of Health Services

2010 Capitation Rates for Southeast Wisconsin RFP

BadgerCare Plus Benchmark Program

		Medical and Dental Base Rate		Chiropractic Capitation Rate	
Age Range	Gender	Region 5	Region 6	Region 5	Region 6
Age 0	All	$ 201.94	$ 262.37	$ 0.04	$ 0.01
Ages 1 - 5	All	48.27	58.95	0.03	0.01
Ages 6 - 14	All	39.83	40.42	0.08	0.01
Ages 15 - 20	Female	77.99	79.54	0.13	0.02
Ages 15 - 20	Male	56.21	50.20	0.10	0.01
Ages 21 - 34	Female	151.26	146.80	0.28	0.06
Ages 21 - 34	Male	100.45	93.25	0.28	0.10
Ages 35 -44	Female	207.43	204.39	0.41	0.08
Ages 35 -44	Male	149.94	150.08	0.32	0.09
Ages 45 & Over	Female	240.82	269.76	0.44	0.11
Ages 45 & Over	Male	200.42	262.88	0.34	0.09

Medical/Dental Administration by HMO:

UnitedHealthcare of Wisconsin, Inc.	$ 12.71
Abri Health Plan, Inc.	13.99
Children's Community Health Plan, Inc.	14.00
Community Connect Health Plan	17.50

Wisconsin Department of Health Services
2010 Capitation Rates for Southeast Wisconsin RFP
BadgerCare Plus Benchmark Program

Medical and Dental Capitation Rates

Age Range	Gender	Region 5				Region 6			
		UnitedHealthcare of Wisconsin, Inc.	Abri Health Plan, Inc.	Children's Community Health Plan, Inc.	Community Connect Health Plan	UnitedHealthcare of Wisconsin, Inc.	Abri Health Plan, Inc.	Children's Community Health Plan, Inc.	Community Connect Health Plan
Age 0	All	$ 214.65	$ 215.93	$ 215.94	$ 219.44	$ 275.08	$ 276.36	$ 276.37	$ 279.87
Ages 1 - 5	All	60.98	62.26	62.27	65.77	71.66	72.94	72.95	76.45
Ages 6 - 14	All	52.54	53.82	53.83	57.33	53.13	54.41	54.42	57.92
Ages 15 - 20	Female	90.70	91.98	91.99	95.49	92.25	93.53	93.54	97.04
Ages 15 - 20	Male	68.92	70.20	70.21	73.71	62.91	64.19	64.20	67.70
Ages 21 - 34	Female	163.97	165.25	165.26	168.76	159.51	160.79	160.80	164.30
Ages 21 - 34	Male	113.16	114.44	114.45	117.95	105.96	107.24	107.25	110.75
Ages 35 -44	Female	220.14	221.42	221.43	224.93	217.10	218.38	218.39	221.89
Ages 35 -44	Male	162.65	163.93	163.94	167.44	162.79	164.07	164.08	167.58
Ages 45 & Over	Female	253.53	254.81	254.82	258.32	282.47	283.75	283.76	287.26
Ages 45 & Over	Male	213.13	214.41	214.42	217.92	275.59	276.87	276.88	280.38

All Services (Medical, Dental, and Chiropractic) Capitation Rates

Age Range	Gender	Region 5				Region 6			
		UnitedHealthcare of Wisconsin, Inc.	Abri Health Plan, Inc.	Children's Community Health Plan, Inc.	Community Connect Health Plan	UnitedHealthcare of Wisconsin, Inc.	Abri Health Plan, Inc.	Children's Community Health Plan, Inc.	Community Connect Health Plan
Age 0	All	$ 214.69	$ 215.97	$ 215.98	$ 219.48	$ 275.09	$ 276.37	$ 276.38	$ 279.88
Ages 1 - 5	All	61.01	62.29	62.30	65.80	71.67	72.95	72.96	76.46
Ages 6 - 14	All	52.62	53.90	53.91	57.41	53.14	54.42	54.43	57.93
Ages 15 - 20	Female	90.83	92.11	92.12	95.62	92.27	93.55	93.56	97.06
Ages 15 - 20	Male	69.02	70.30	70.31	73.81	62.92	64.20	64.21	67.71
Ages 21 - 34	Female	164.25	165.53	165.54	169.04	159.57	160.85	160.86	164.36
Ages 21 - 34	Male	113.44	114.72	114.73	118.23	106.06	107.34	107.35	110.85
Ages 35 -44	Female	220.55	221.83	221.84	225.34	217.18	218.46	218.47	221.97
Ages 35 -44	Male	162.97	164.25	164.26	167.76	162.88	164.16	164.17	167.67
Ages 45 & Over	Female	253.97	255.25	255.26	258.76	282.58	283.86	283.87	287.37
Ages 45 & Over	Male	213.47	214.75	214.76	218.26	275.68	276.96	276.97	280.47

Maternity Kick Payment No Administrative Allowance		$ 3,659.71	$ 3,659.71	$ 3,659.71	$ 3,659.71	$ 4,596.43	$ 4,596.43	$ 4,596.43	$ 4,596.43

EXHIBIT 3: BADGERCARE PLUS STANDARD AND BENCHMARK HOSPITAL ACCESS PAYMENT

Wisconsin Department of Health Services
2010 MCE and Capitation Rate Development for BadgerCare Plus
Capitation Rate Add-On for the Hospital Assessment

Existing HMOs	January - December 2010		
HMO	Total	Inpatient	Outpatient
Abri	$ 65.26	$ 36.85	$ 28.41
CCHP	63.74	32.05	31.69
CompCare	26.56	18.82	7.74
Dean	49.73	34.55	15.18
Dean Southeast	63.86	32.08	31.78
GHC-SCW	43.68	23.72	19.96
GHC-EC	34.60	24.57	10.03
Health Tradition	38.59	28.18	10.41
MercyCare	57.56	28.58	28.98
MHS	57.63	29.60	28.03
Network	57.90	32.37	25.53
Security	45.70	30.89	14.81
UHC	63.76	32.71	31.05
Unity	71.91	31.87	40.04

New HMOs	January - December 2010		
Region	Total	Inpatient	Outpatient
1	$ 28.30	$ 19.66	$ 8.64
2	58.57	32.52	26.05
3	44.54	30.57	13.97
4	56.84	31.65	25.19
5	66.81	32.75	34.06
6	61.28	31.50	29.78

Notes:
Base managed care utilization and enrollment data period is October 2006 through September 2007
The funding between the BCP and SSI programs was determined based on the proportion of managed care visits / discharges incurred in a program's base data
For HMOs that do not have credible data, average regional utilization data is used
To the extent enrollment significantly shifts between fee-for-service and managed care, the allocation by service setting may be exhausted earlier than anticipated or may not be depleted, and is subject to review and change by DHS.

EXHIBIT 4: BADGERCARE PLUS STANDARD AND BENCHMARK ASC ACCESS PAYMENT

Wisconsin Department of Health Services

2010 MCE and Capitation Rate Development for BadgerCare Plus

Capitation Rate Add-On for the Ambulatory Surgical Center Assessment

Existing HMOs

HMO	January - June 2010	July - December 2010
Abri	$ 1.56	$ 0.78
CCHP	1.62	0.81
CompCare	0.04	0.02
Dean	5.80	2.90
Dean Southeast	1.68	0.84
GHC-SCW	0.38	0.19
GHC-EC	0.14	0.07
Health Tradition	0.18	0.09
MercyCare	0.18	0.09
MHS	1.86	0.93
Network	1.82	0.91
Security	5.70	2.85
UHC	1.40	0.70
Unity	1.46	0.73
CCHP Central	1.90	0.95
Gundersen Lutheran	1.82	0.91
Physicians Plus	1.90	0.95

New HMOs

Region	January - June 2010	July - December 2010
1	$ 2.50	$ 1.25
2	0.62	0.31
3	2.26	1.13
4	2.90	1.45
5	1.18	0.59
6	2.00	1.00

Notes:

DHS provided the SFY10 and SFY11 allotments for the BCP and SSI managed care programs of $6,664,735 in each SFY.

Base managed care utilization and enrollment data period is CY2006 and CY2007.

The funding between the BCP and SSI programs was determined based on the proportion of managed care visits incurred in a program's base data

For HMOs that do not have credible data, average regional utilization data is used

For HMOs that do not have base utilization, a 10% threshold on the average regional utilization data is used

To the extent enrollment significantly shifts between fee-for-service and managed care, the allocation by program may be exhausted earlier than anticipated or may not be depleted, and is subject to review and change by DHS.

EXHIBIT 5: BADGERCARE PLUS STANDARD AND BENCHMARK CRITICAL ACCESS HOSPITAL (CAH) ACCESS PAYMENT

This exhibit will be published at a later date.