Contract Amendment for BadgerCare Plus and SSI Medicaid Services

The agreement entered into for the period of February 1, 2008 through December 31, 2009 between the State of Wisconsin acting by or through the Department of Health Services, herein after referred to as the "Department" and ________, an insurer with a certificate of authority to do business in Wisconsin for the BadgerCare Plus and/or Medicaid SSI Medicaid Managed Care Program is hereby amended for the period of January 1, 2009 through December 31, 2009 as follows:

1. **Replace Table of Contents with updated version.**

2. **Article I**

Revise the first sentence of the definition of BadgerCare Plus to read as:

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.

Add the following as new as the last bullet point to the BadgerCare Plus definition:

Childless adults (ages 19 to 64) with income levels below 200 percent of the FPL (beginning April 1, 2009 pending federal approval).

Add the following definition as new:

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.

Add the following definition as new:

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.

Add the following definition as new:

Core Plan: The BadgerCare Plus benefit plan available to Childless Adults members beginning April 1, 2009, pending federal approval.

Add the following definition as new:

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.

Revise the first sentence of the definition for Enrollee, Member, Participant and Consumer to read as:

A BadgerCare Plus and/or Medicaid SSI 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.

Add the following definition as new:

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.

Add the following definition as new:

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 or Core Plans and ending on the last day of the 12th calendar month. Further information is available in the BadgerCare Plus All-Provider Updates.

Add the following definition as new:

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."

Add the following definition as new:

Health Needs Assessment (HNA): The HNA is a self-reported questionnaire designed to provide baseline health-status information for a population. Completion of the HNA will be mandatory for new Core Plan members. 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. The HNA was developed with input from physicians with experience in quality measurement and the development of HNAs.

Revise the definition of "Individually Identifiable Health Information (IIHI)" to read:

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).

Revise the definition of mandatory to read as:

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.

Add the following definition as new:

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**.**

Delete the following definition:

Member: Any individual entitled to benefits under Title XIX and XXI of the Social Security Act, under the Medicaid State Plan as defined in Wis. Stats., Chapter 49, and any individual covered by the Wisconsin state waiver for Medicaid expansion.

Add the following definition as new:

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 and/or Medicaid SSI program.

Add the following definition as new:

Outreach: Activities undertaken by the HMO to brand itself in the community and ensure name recognition without the purpose of soliciting members.

Delete the following definition of Protected Health Information:

Protected Health Information (PHI): The Privacy Rule protects all "individually identifiable health information: (IIHI) held or transmitted by a covered entity or its business associate, in any form or media, whtherh electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI), which is a subset of IIHI.

Add the following definition as new:

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.

Add the following definition as new:

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.

Add the following definition as new:

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

Add the following definition as new:

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.

Revise the definition of voluntary to read as:

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

3. Article III, C.3

Revise the last three sentences to read as:

This includes encounter data, AIDS/ventilator dependent member data, FQHC and RHC reports, provider and facility network submissions, comprehensive exam reports and health data indicators, SSI assessment reports 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 according to the submission schedule in Article VII, I.

4. Article III, C.10.f

Revise the first sentence to read as**:**

The HMO must interface with the case manager from the TCM agency to identify what BadgerCare Plus and/or Medicaid SSI covered services or social services are to be provided to a member.

5. Article III, D

Revise the first sentence to read as:

The HMO is responsible for the payment of all contract services provided to all BadgerCare Plus and/or Medicaid SSI members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage for BadgerCare Plus – Standard and Benchmark Plans, and for Medicaid SSI

Add the following as new as the second sentence:

For BadgerCare Plus – Core Plan members, HMOs will receive an Enrollment Report on the first and 15th of each month.

Replace Forward ID with Forward Health ID throughout paragraph.

6. Article III, D, 8, c.

Add the following as new as the last sentence:
Refer to Article VIII, F, 2, i. for the exemption criteria.

7. Article III, D.10

Revise title to read:

Enrollees Living in a Public Institution (BadgerCare Plus Standard, Benchmark, and Medicaid SSI Plans)

8. Article III, E.1

Revise the first paragraph and E.1.a to read as:

The HMO must promptly provide or arrange for the provision of all services required under Wis. Stats., s. 49.46(2), and Wis. Adm. Code HFS 107 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 Region 6 where HMOs must provide this service (Art. III, E, 7, a, 2).

Add the following as new after E.1.k:

Addendum V contains additional information on BadgerCare Plus and Medicaid SSI covered services.

9. Article III, E.3

Revise the title of E.3 to read as:

Physician and Other Health Services

Add the following as new after the first paragraph:

Note: Private duty nursing and personal care services are not covered for the Benchmark or Core Plan members, and home health services are not covered for Core 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.

Physician and lab services are covered under BadgerCare Plus Core Plan, regardless of whether the service is a family planning service. Additional family planning services provided in family planning clinics are covered on a fee-for-service basis under the Family Planning Waiver.

10. Article III, E.6

Revise the first paragraph to read as:

BadgerCare Plus Standard, Benchmark, and Medicaid SSI Plans:
The HMO must cover chiropractic services, or in the alternative, enter into a subcontract for chiropractic services with the State. State law mandates coverage.

Add the following as new under the first paragraph:

BadgerCare Plus Core Plan: Chiropractic services are not covered under the Core Plan.

11. Article III, E.7

Delete all of E.7.a.2 and replace with:

Enrollees in Milwaukee County
a) For dates of service on or after January 1, 2009: Common carrier transportation will be included in the capitation rate. HMOs will be required to submit common carrier reports according to the format in Addendum IV, J.

b) For dates of service prior to January 1, 2009: The Department will reimburse the HMO for Milwaukee County common carrier transportation for its members. Reimbursement will be subject to the HMO submitting a detailed report on CD ROM in an Excel file. The report must be submitted to the Bureau of Fiscal Management's Common Carrier Rate Analyst on a quarterly basis as specified in the submission schedule in Article VII, I and include all the data elements specified in Addendum IV, J. The Department will not reimburse the HMO for claims if data is not submitted according to these specifications. If the HMO is contracted to serve BadgerCare Plus and/or Medicaid SSI enrollees the reports must be submitted separately.

Revise E.7.b to read as:

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

Add the following as new under E.7.b:

c. BadgerCare Plus – Core Plan

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

12. Article III, E.8

Revise the title of E.8.a. to read as:

Dental Services Covered by the HMO Not Contracted to Provide Comprehensive Dental Services for BadgerCare Plus - Standard, Benchmark, Core, and Medicaid SSI Plans

Amend E.8 to read as follows, beginning with E.8.b.:

b. Dental Services Covered by the HMO Contracted to Provide Dental Care for BadgerCare Plus –Standard Plan and Medicaid SSI

1) All BadgerCare Plus and/or Medicaid SSI covered dental services as required under HFS 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 enrollees while they are enrolled in the HMO, except as required in Subsection c) following.

3) Completion of orthodontic or prosthodontic treatment begun while an enrollee was enrolled in the HMO if the enrollee became ineligible for BadgerCare Plus and/or Medicaid SSI 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 an enrollee 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.]

c. 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.

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

Dental coverage is limited to emergency services only for BadgerCare Plus – Core Plan members.

e. Reporting Requirements for HMOs that Cover Dental Services

HMOs that cover dental services must submit quarterly progress reports to the Department documenting the outcomes or current status of activities intended to increase utilization. These reports must be submitted to the HMO's Department Managed Care Analyst on a quarterly basis as specified in the submission schedule in Article VII, I.

As a result of this amendment, the Orthodontic and Prosthodontic Treatment responsibilities chart follows E.8.e.

13. Article III, E.9.a.3

Revise first paragraph to read as:

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.

14. Article III, E.10

Add the following as new as E.10.a:

a. BadgerCare Plus Standard, Benchmark, and Medicaid SSI Plan members:

As a result of this addition the former a becomes 1, b becomes 2 and c becomes 3

Add the following as new as E.10.b:

b. BadgerCare Plus Core Plan members:
Family planning physician and lab services are covered unless they are provided by a family planning clinic. Family planning clinic services will be covered separately under the Family Planning Waiver program.

15. Article III, E.12

Add the following as new:

12. <u>Pharmacy Coverage</u>

Pharmacy coverage, including provider-administered drugs under Art. III, E, 3, is carved out of the capitation rate for all BadgerCare Plus and/or Medicaid SSI members and will be paid on a fee-for-service basis.

16. Article III, F

Revise the last sentence of the first paragraph to read as:

Whether the service provided is a BadgerCare Plus and/or Medicaid SSI covered service or an alternative or replacement to a BadgerCare Plus and/or Medicaid SSI covered service, the HMO or HMO provider is not allowed to bill the enrollee for the service, other than an allowable co-payment.

17. Article III, F.1

Revise the first sentence to read as follows:

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

18. Article III, F.2

Revise the 6th paragraph of F.1 to become F.2 and read as:

2. BadgerCare Plus-Standard Plan or Medicaid SSI:
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.

19. Article III, F.3

Revise the 7th paragraph of F1 to become F.3 and read as:

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.

20. Article III, F.4

Add the following as new:

4. BadgerCare Plus Core Plan:

Outpatient mental health and substance abuse coverage is limited to services provided by a psychiatrist/physician only. The HMO will not be responsible for any costs relating to emergency detentions, crisis intervention, or court-ordered services (unless those services are outpatient mental health/substance abuse services provided by psychiatrists/physicians).

Due to the addition of new sections in Article III, F of the contract:

F2 becomes F5
F3 becomes F6
F4 becomes F7
F5 becomes F8

F6 becomes F9
F7 becomes F10
F8 becomes F11
F9 becomes F12
F10 becomes F13
F11 becomes F14

21. Article III, F.5

Revise the title of F5 (formerly F2) to read as:

5. Mental Health/Substance Abuse Assessment Requirements (BadgerCare Plus Standard, Benchmark, and Medicaid SSI)

22. Article III, F.6

Revise the title of F6 (formerly F3) to read as:

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

23. Article III, F.7

Revise the title of F7 (formerly F4) to read as:

7. Court-Related Children's Services (BadgerCare Plus – Standard and Benchmark Plans Only)

24. Article III, F.8

Revise the title of F8 (formerly F5) to read as:

8. Court-Related Substance Abuse Services (BadgerCare Plus – Standard, Benchmark, and Medicaid SSI).

Add the following as new after the first paragraph:

There are mental health and substance abuse coverage limitations as outlined in Addendum V.

25. Article III, F.9

Revise the title of F9 (formerly F6) to read as:

9. Crisis Intervention Benefit (BadgerCare Plus Standard and Medicaid SSI).

26. Article III, F.10

Revise the title of F10 (formerly F7) to read as:

10. Emergency Detention and Court-Related Mental Health Services (BadgerCare Plus Standard and Medicaid SSI)

Revise the first sentence of F.10.b to read as:

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.

27. Article III, F.11

Revise the title of F.11(formerly F8) to read as:

11. Institutionalized Individuals (BadgerCare Plus Standard, Benchmark, and Medicaid SSI)

Add as the last sentence to F.11.b.

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.

28. Article III, F.12

Revise the title of F12 (formerly F9) to read as:

12. Transportation Following Emergency Detention (BadgerCare Plus Standard, Benchmark, and Medicaid SSI)

Add as the third sentence of the first paragraph:

The county agency or law enforcement agency makes the decision whether the transfer requires a secured environment.

29. Article III, F.13

Revise the title of F13 (formerly F10) to read as:

13. Mental Health and/or Substance Abuse Exemptions (BadgerCare Plus Standard and Benchmark Plans Only)

30. Article III, H.2

Add the following as new after the third paragraph:

The HMO must ensure all members in the Core Plan have access to a comprehensive physical exam within the member's first certification period.

31. Article III, H.5.e

Add the following as new after the first paragraph:

The HMO must provide documentation and assurance of the above network adequacy criteria as required by the Department for pre-contract certification or upon request of the Department. The HMO must also submit an updated provider network and facility file to the State's FTP server 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))

Delete the following:

The HMO must provide documentation and assurance of the above network adequacy criteria as required by the Department for precontract certification or upon request of the Department. In addition, the HMO must update the documentation and assurance to the Department with respect to network adequacy whenever there has been a significant change, as defined by the Department, in the HMO's operations that would affect adequate capacity and services including changes in the HMOs benefits, geographic service areas, provider network, payments, or enrollment of a new population in the HMO.

32. Article III, I.4.e

Revise the first sentence to read as:

Systems to ensure the provision of a clinical determination of the medical necessity and appropriateness of the enrollee to continue with mental health and substance abuse providers who are not subcontracted with the HMO.

33. Article III, I.5

Add the following as new:

5. Comprehensive Physical Exam Requirements (Core Plan Only)

    1. Each HMO is responsible for ensuring that all members enrolled in the BadgerCare Plus Core Plan and who are enrolled in their health plan receive a comprehensive physical exam within the initial member certification period (which will normally be 12 months).

    2. HMOs are encouraged to have members complete the exam within 9 months to ensure the Department receives data that the member received an exam prior to the member's certification review.

    3. The Department defines a comprehensive physical exam, for purposes of this requirement, as exams that meet the definition of the following CPT codes: 99385, 99386, 99395, 99396, 99203, 99204, 99205, 99214, 99215, 99243, 99244, 99245, 99253, 99254, 99255, 99221, 99222, 99223, 99234, 99235, 99236, 99284, 99285, 99326, 99327, 99328, 99336, 99337, 99343, 99344, 99345, 99349 and 99350.

    4. The Department will review the HMO's encounter data to ensure that one of the recognized comprehensive physical exam CPT codes is included in the member's encounter record. (HMOs may submit a monthly file to the Department indicating if members received an exam; however, this is not mandatory.)

    5. HMOs will be able to assess which of their members the Department has a record of meeting the requirement by receipt of a monthly file from the Department to the HMO.

6. Beginning in 2010 with the recertification of Core Plan members, on a monthly basis, the Department will examine encounter data submitted by HMOs and eligibility reports to determine HMO compliance with the above requirement. While the Department will track compliance monthly, the Department will issue a recoupment of a portion of the HMO's capitation rate after compiling one year of recertification data (the Department estimates approximately April, 2010).

7. The Department will identify the total number of members enrolled in a HMO whose recertification was reviewed that month and the number of persons that lost eligibility (beginning in the following month) because of a failure to receive a physical exam.

8. If fewer than 20% of the members were disenrolled from the Core Plan for failure to receive a physical exam, then the HMO will be in compliance with the physical exam policy.

9. If more than 20% of members did not receive an exam and were subsequently disenrolled from the Core Plan, the Department will recoup $190 per member disenrolled from a HMO due to failure to comply with physical exam requirement.

10. The $190 recoupment will be applied to the number of non-complying members above the 20% noncompliance tolerance threshold.

11. The Department will recoup $380 for any member that did not have a physical exam but was able to prove that the HMO did not provide access to a physical exam and was subsequently allowed to remain enrolled in the Core Plan.

    T = Total number of HMO's members whose recertification was reviewed that month.
    P = Number of HMO's members that remain eligible for the Core Plan that month because they met the physical exam requirement.
    Y= Number of members still enrolled in the HMO and were granted exception because HMO did not provide access to exam

    If $(P/T) > 80\%$, then no recoupment
    If $(P/T) < 80\%$, then recoupment.

    $(.8T - P)(\$190) + (\$380Y) = \text{Recoupment}$

12. A member who moves within the last six months of his/her certification period which results in a change of HMOs will be taken out of the HMO's numerator and denominator.

13. Members who were previously enrolled in the GAMP program that received a comprehensive exam at any time during 2008 or the first three months of 2009 and prior to enrolling into the Core Plan and a HMO will be taken out of the HMO's numerator and denominator.

14. HMOs will be allowed to appeal member-specific physical exam recoupments to their Department Managed Care Analysts. The Department will review on a case by case basis. A HMO must be able to prove through documentation that they made a significant effort to ensure the member received an exam, but the member refused to complete the exam. The Department will assess HMOs as follows:
    a) In the event an HMO made contact with an individual where the HMO confirmed and the individual accepted an appointment to receive a comprehensive exam and the member does not show up for the exam, then the case will be counted as a complying case for purposes of this recoupment calculation.
    b) If a HMO made contact with an individual and the member refuses (the member verbally or in writing communicates to the HMO that they will **not** get an exam), then the case will be counted as a complying case for the purposes of this recoupment calculation.
    c) In all other cases, access is defined as the member both scheduling and receiving an exam prior to the annual recertification period.

15. The Department will communicate with members at the time of enrollment regarding scheduling a comprehensive exam through their HMO. The Department will inform members that if they contact their HMO within the first six months of being enrolled in the HMO, they are guaranteed an exam prior to their annual recertification review. If the Department does not have a record that the member received an exam at months six and nine during the member's first year of enrollment, the Department will send reminder notices to members regarding the importance of receiving an exam.

16. After compiling one year of recertification data, HMOs performing above the 80% compliance threshold for receipt of physical exams will receive the redistribution of recoupment funds from non-complying HMOs in an amount to be determined by the Department but not to exceed 10% of the HMO's Core Plan annual capitation rate payments for individuals within the compliance threshold.

17. In the event that no HMO achieves the 80% threshold or funds are still available after the redistribution to HMOs above 80%, all recoupment dollars will be redistributed based on performance ranking beginning with the top performers. The Department will not keep any of the recoupment revenues and HMOs in aggregate will not see a reduction in funding.

34. Article III, I.6

Add the following as new:

6. <u>Health Indicator Reporting Policy (Core Plan Only)</u>

1. HMOs will be required to submit health information, in a format identified by the Department, to the Department, for all Core Plan members who received a physical exam.

2. Mandatory data indicators: height, weight, blood pressure
   Optional indicators (as available): HbA1c results, LDL results

3. The Department will accept health indicator data that is self-reported by the HMO. Health indicator data does not necessarily need to be directly retrieved from the comprehensive exam; however, 80% of the members who received a physical exam should have reported health data.

4. HMOs (and/or their subcontractors) may submit health indicator data through the following mechanisms:
   a. By submitting a monthly submission file
   b. Via the interChange provider portal. Providers and HMOs can begin inputting data anytime after April, 2009.
   c. By submitting one file on an annual basis which includes all required health indicators by member. Initial data files must be submitted prior to April 1, 2010.

5. Following 12 months of recertification, HMOs are required to ensure that the Department has reported health information for at least 80% of members who received a physical exam.

6. If the HMO does not meet the 80% threshold, the Department will recoup $100 per member for failure to provide health information to the Department for members who received a comprehensive physical exam.

7. The $100 per member recoupment will be applied to the number of members whose health information was not reported above the 20% noncompliance tolerance threshold.

   X = Total number of members who received a physical exam during annual evaluation period.
   Y= Number of members with HMO reported health information during annual evaluation period

   If (Y/X) > 80%, then no recoupment
   If (Y/X) < 80%, then recoupment

   (.80X – Y) x $100 = Recoupment

8. While the Department will track compliance monthly, the Department will issue recoupments on HMOs after compiling one year of recertification data (the Department estimates approximately April, 2010).

9. After compiling one year of recertification data, HMOs performing above the 80% compliance threshold for submission of health indicators will receive the redistribution of recoupments from non-complying plans in an amount determined by the Department but not to exceed 10% of the HMO's Core Plan annual capitation rate payments for individuals within the compliance threshold.

10. In the event that no plan achieves the 80% threshold or funds are still available after the redistribution to HMOs above 80%, all recoupment dollars will be redistributed based on performance ranking beginning with the top performers. The Department will not keep any of the recoupment revenues and HMOs in the aggregate will not see a reduction in funding.

Due to the additions of new sections to Article III, I of the contract:

I.5 becomes I.7
I.6 becomes I.8
I.7 becomes I.9
I.8 becomes I.10
I.9 becomes I.11
I.10 becomes I.12

35. Article III, I.7

Add the following as new after the first paragraph:

HMOs should inform BadgerCare Plus Core Plan members that converting to private insurance due to loss of eligibility will affect a member's ability to become eligible for the Core Plan again for one year.

36. Article III, I.9

Revise I.9.a.7 to read as:

HealthCheck (not applicable to Core Plan member-specific handbooks).

Add the following as new as I.9.a.12:

SSI assessments (for Medicaid SSI members only).

Add the following as new as I.9.a.13

Comprehensive physical exam requirements (for Core Plan members).

Add the following as new after I.9.a.13

Health plans may either have a combined plan (for BadgerCare Plus – Standard, Benchmark, Core, and Medicaid SSI Plans) enrollee handbook, or plan-specific (such as creating a separate BadgerCare Plus Core Plan handbook to supplement the existing handbook); however, all of the above elements must be included.

Revise the first sentence of I.9.d to read as:

Enrollee handbooks (or other substitute enrollee 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 enrollees who are conversant only in those languages.

Revise the first sentence of I.9.g to read as:

Standard language on several subjects, including HealthCheck (not applicable for any Core Plan member-specific handbooks), family planning, grievance and appeal rights, conversion rights, and emergency and urgent care, must appear in all handbooks.

37. Article III, K

Revise the title of K to read as:

HealthCheck (Not applicable to Core Plan members)

Amend the last sentence of K, 1, d to read:

For example, for dates of service in 2009, the cut off date will be January 16, 2011).

38. Article III, K.2

Add the following as new after K.2.a:

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

Delete the following:

The HealthCheck, Blood Lead Test, and Childhood Immunization performance improvement incentive information is provided in Addendum VI and the methodology worksheets are provided in Addendum IV.

39. Article III, L

Replace all of Article, III L with the following:

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. 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 an initial description of its member communication plan and outreach plan it or its subcontractors plan to distribute to the Department for review on the second Friday of January of each calendar year. 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 approve, approve with modifications, or disapprove all member communication materials and outreach materials within ten business days. If the HMO does not receive a response from the Department within ten business days, the HMO must 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 and/or Medicaid SSI 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 and/or Medicaid SSI. 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 and/or Medicaid SSI managed care members. Member communication requirements are detailed in Article III, Section I "Responsibilities to Enrollees."

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 and/or Medicaid SSI 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 enrollees that are conversant only in those languages. The HMO must also arrange for translation into any other dialects appropriate for its enrollees.

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 and/or Medicaid SSI Members Accepted Here" or "BadgerCare Plus and/or Medicaid SSI 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 enrollees at health fairs or SSI town hall meetings.
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. 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 and/or Medicaid SSI managed care members and BadgerCare Plus and/or Medicaid SSI members who are not the HMO's members. The Department defines "marketing" as any unsolicited contact by the HMO, its employees, affiliated providers, subcontractors, or agents with a potential enrollee, 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 that could mislead, confuse, or defraud consumers.
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 enrollees. 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.

40. Article III, N

Revise the second sentence of N to read as:

The ForwardHealth cards will always determine the HMO enrollment, even where the HMO issues HMO ID cards.

41. Article IV, J

Replace Article IV, J with the following:

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.

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. The State has the authority to select a particular topic for the PIPs. For 2009 submission, plans must focus one of the PIPs on the following items:
   a) Pay for performance minimum thresholds-If the plan fails to meet one or more minimum threshold requirements for the Department's combined pay for performance program (Addendum VI, 2, d, i), the plan must submit at least one PIP to improve its performance in the focus area(s) where it has failed to meet the minimum threshold.
   b) Stretch performance goal-The plan designs an intervention targeted to meet its stretch performance goal in the focus area identified by DHS for its pay for performance program (Addendum VI, 2, d, iii). In this case, the plan will submit a study topic which includes an intervention to improve its performance in that focus area to meet the stretch performance goal.

2. Health plans can choose other study topics based on the Department's priority areas. 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
   i. HealthCheck
   ii. Tobacco cessation
   iii. Blood lead testing
   iv. Childhood immunizations
   v. Healthy birth outcomes
   vi. Diabetes management
   vii. Asthma management
   viii. Childhood obesity interventions

b) Non-Clinical
   i. SSI case management
   ii. Access and availability of services
   iii. Member satisfaction

3. All HMOs are required to submit two PIPs. Plans that serve both SSI and BadgerCare Plus members have the choice of submitting one PIP for each population (i.e. one PIP on SSI Case Management and another on Immunizations for the BadgerCare Plus members) or two PIPs where one focus area is relevant to both populations (i.e. Tobacco Cessation and Diabetes Management).

4. 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.

5. 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.

6. 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 January 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 January. 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.

7. 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.

8. Health plans must submit their completed PIPs by the first business day of December of the same contract 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.

9. 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.

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

11. 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 of the first business day of December of the year in which it's due.

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.

42. Article IV, K

Add the following as new:

K. Healthy Birth Outcomes

1. By April 2009, the Department will identify women at high risk of poor birth outcomes via a High-Risk Pregnancy Report, similar to the current Medicaid SI Predictive Risk Report, which will be sent to the HMO monthly.
2. The HMO must develop a Department-approved plan by April, 2009 for meeting the needs of members included in the High-Risk Pregnancy Report and members screened as being at high risk. The plan should articulate strategies for identifying high-risk members previously unknown to Medicaid, for interconception care to ensure the member is healthy prior to a new pregnancy, and for comprehensive prenatal care. The plan must also include strategies for getting the identified high-risk member into care. The plan must describe a program of infant care (for the first year of a baby's life). Where available, each component must meet national standards and/or guidelines.

Suggested plan outline:

- Screening strategies, e.g., identification of high risk women
- Outreach strategies, e.g., approaches for getting the identified high risk member into medical care
- Medical prenatal care, e.g., assessment, care plans, and treatment
- Health promotion/patient education strategies or activities
- Interconception care, e.g., protection such as folic acid supplements; management of conditions, such as diabetes; and help in avoiding/reducing teratogens such as tobacco and alcohol
- Post-partum care, including depression screening and contraception options
- Infant care, e.g., medical care and parent education

43. Article V, A

Amend to read as:

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 members who are eligible for enrollment in the HMO as the result of eligibility under the following eligibility status codes:

BadgerCare Plus	
Med Stat	**Description**
Effective July 1, 2008	
BA	BC+ Standard Plan - Income equal or greater than 0% FPL and less than or equal to 100% of FPL for pregnant women
AB	BC+ Standard Plan – Income greater than 100% FPL and less than or equal to 200% of FPL for pregnant women
BE	BC+ Standard Plan – Income equal or greater than 0% FPL and less than or equal to 100% of FPL for child, under age 19
BJ	BC+ Standard Plan – Income greater than 100% of FPL and less than or equal to 150% of FPL for child, under age 6
BF	BC+ Standard Plan – Income greater than 100% of FPL and less than or equal to 150% of FPL for child, ages 6 through 18
BC	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 185% of FPL for child, under age 6
C1	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for child, under age 1
C3	BC+ Standard Plan – Income greater than 185% of FPL and less than or equal to 200% of FPL for child, ages 1 through 5
BG	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for child, ages 6 through 18
BL	BC+ Standard Plan – Income equal or greater than 0% FPL and less than or equal to 100% of FPL for parents/caretakers
BM	BC+ Standard Plan – Income greater than 100% of FPL and less than or equal to 130% of FPL for caretakers
5B	BC+ Standard Plan – Income greater than 130% of FPL and less than or equal to 150% of FPL for caretakers
BN	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for caretakers
B8	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for parents/caretakers, waiver eligible
BY	BC+ Standard Plan – Youths exiting out of home care
BP	BC+ Standard Plan – Income equal or greater than 0% of FPL and less than or equal to 130% of FPL for transitional grandfathering (prev. elig. under MA or BC up to 130%)
BQ	BC+ Standard Plan – Income greater than 130% of FPL and less than or equal to 200% of FPL for transitional grandfathering (prev. elig. under BC)
BR	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for transitional grandfathering (prev. elig. under BC)
B9	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for transitional grandfathering (prev. elig. under BC), waiver eligible
N1	BC+ Standard Plan – Income equal or greater than 0% of FPL and less than or equal to 100% of FPL for CEN – mom in SP or MA on DOB
N4	BC+ Standard Plan – Income greater than 100% of FPL and less than or equal to 200% of FPL for CEN – mom in SP or MA on DOB
1B	BC+ Standard Plan – Income greater than 100% of FPL and less than or equal to 130% of FPL for parents
2B	BC+ Standard Plan – Income greater than 130% of FPL and less than or equal to 150% of FPL for parents
3B	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for parents

BadgerCare Plus	
Med Stat	**Description**
X6	BC+ Standard Plan – Income equal or greater than 0% of FPL and less than or equal to 100% of FPL for earnings extension – 12 months for adults age 19 or greater
X8	BC+ Standard Plan – Income greater than 0% of FPL and less than or equal to 100% of FPL for earnings extension – 12 months for children under age 19
X7	BC+ Standard Plan – Income equal or greater than 0% of FPL and less than or equal to 100% of FPL for child support extension – 4 months for adults age 19 or greater
X9	BC+ Standard Plan – Income equal or greater than 0% of FPL and less than or equal to 100% of FPL for child support extension – 4 months for children under age 19
BO	BC+ Benchmark Plan – Income greater than 200% of FPL for caretakers (self-employed and farmers) – No dental benefit
4B	BC+ Benchmark Plan – Income greater than 200% of FPL for parents (self-employed & farmers) – No dental benefit
BB	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL and less than or equal to 250% of FPL for pregnant women
AA	BC+ Benchmark Plan + Dental – Income greater than 250% of FPL and less than or equal to 300% of FPL for pregnant women
PM	BC+ Benchmark Plan + Dental – Income greater than 300% of FPL for pregnant minor, under age 19
TP	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL and less than or equal to 250% of FPL for pregnant minor, under age 19 – tribal member
TB	BC+ Benchmark Plan + Dental – Income greater than 250% of FPL and less than or equal to 300% of FPL for pregnant minor, under age 19 – tribal member
BH	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL and less than or equal to 250% of FPL for children ages through 18
C2	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL and less than or equal to 250% of FPL for child, under age 1
TC	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL and less than or equal to 250% of FPL for child, under age 19, tribal member
TK	BC+ Benchmark Plan + Dental – Income greater than 250% of FPL and less than or equal to 300% of FPL for child, under age 19, tribal member
BI	BC+ Benchmark Plan + Dental – Income greater than 250% of FPL for child, under age 19
N3	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL for CEN – mom in BMP on DOB
T1	BC+ Benchmark Plan– HCTC, adults
T2	BC+ Benchmark Plan– HCTC, pregnant woman
T3	BC+ Benchmark Plan– HCTC, child under age 19
TF	BC+ Standard Plan – Income greater than 185% of FPL and less than 200% of FPL for children ages 1 through 5, tribal member
TG	BC+ Standard Plan – Income greater than 150% of FPL and less than 200% of FPL for children ages 6 through 18, tribal member
The following Med Stat Codes will be implemented in interChange effective 1/1/09.	
HC	BC+ Standard Plan for Drugs Only, BC+ Benchmark Plan for all other services – Income greater than 150% of FPL and less than or equal to 185% of FPL for children ages 1 through 5

BadgerCare Plus	
Med Stat	**Description**
HG	BC+ Standard Plan for Drugs Only, BC+ Benchmark Plan for all other services – Income greater than 150% of FPL and less than or equal to 200% of FPL for children ages 6 through 18
HI	BC+ Standard Plan for Drugs Only, BC+ Benchmark Plan for all other services – Income greater than 200% FPL for children under age 19
GT	BC+ Core Plan – Income less than or equal to 100% FPL for GAMP transition members.
The following Med Stat Codes will be implemented in interChange effective 4/1/09.	
CU	BC+ Core Plan – Income less than or equal to 100% FPL
CO	BC+ Core Plan – Income greater than 100% and less than or equal to 200% FPL
CN	BC+ Core Plus – Income less than 100% FPL
CP	BC+ Core Plus – Income greather than 100% and less than or equal to 200% FPL

MEDICAID SSI AND SSI-RELATED MEDICAID

Identify Medicaid SSI members who are eligible for enrollment in the HMO as the result of eligibility under the following eligibility status codes:

MEDICAID SSI AND SSI-RELATED MEDICAID	
Med Stat	**Description**
01	SSI; Aged; Not in nursing home
04	SSI Aged; Decline cash, Not in nursing home
05	SSI Aged; Med-Ndy; No cash, Not in nursing home
10	County 503 Cases; SSI ineligible ABD-disregard SSI-CLA
11	SSI; Blind; Not in nursing home
14	SSI; Blind; Decline cash; Not in nursing home
15	SSI; Blind; Med-Ndy; Not in nursing home
19	SSI, Employed
20	SSI; Essential; Spouse of disabled person; No $
21	SSI; Disabled; Not in nursing home
22	SSI; Disabled; Decline cash; Not in nursing home
23	SSI; Disabled; Med-Ndy
AD	County Aged; Med-Ndy; Deductible; SSI >65 income >185% FPL
BD	County Blind; Med-Ndy; Deductible; SSI >65 income >185% FPL
DC	County Disabled; SSI Inelig; Due to SSA-CLA disabled adult children living with parents
DD	County Disabled; Med-Ndy; Deductible; SSI >185% income FPL
L1	County Widow(ers); SSI ineligible due to increase disability benefits early receipt of Social Security
L3	County Widow(ers); SSI ineligible due to increase disability benefits early receipt of Social Security
L5	County Widow(ers); SSI ineligible due to increase disability benefits early receipt of Social Security
L7	County Widow(ers); SSI ineligible due to increase disability benefits early receipt of Social Security
M3	MAPP, >150% (FPL)
M4	MAPP, to 150% (FPL) no premium
ZZ	SSI Zebley Decision
5C	County 503 Case; Member Med-Ndy
5D	Disabled Adult/Child Med-Ndy

44. Article V, B

Revise the third sentence of the first paragraph to read as:

All members listed as an ADD or CONTINUE on either the Initial or Final HMO Enrollment Report (BadgerCare Plus Standard and Benchmark Plans and Medicaid SSI) or the twice monthly HMO Enrollment Reports (Core) are members of the HMO during the enrollment month.

45. Article V, C

Add the following as new after the first paragraph:

BadgerCare Plus Core Plan disenrollment reports will be sent to HMOs on a twice-monthly basis on the first and 15th of each month.

46. Article V, E

Add the following as new as the third sentence of the first paragraph:

(HMOs will receive twice-monthly enrollment reports for the Core Plan).

47. Article V, E.1

Add the following title to E.1:

BadgerCare Plus Standard and Benchmark Plans and Medicaid SSI:

E.1 becomes E.1.a.

E.2 becomes E.1.b.

Add the following as new after E.1.b:

2. BadgerCare Plus Core Plan:

Language describing the twice-monthly file submission process will be added by contract amendment prior to April 1, 2009 implementation.

48. Article V, J

Revise the title of J to read as:

Vaccines for Family (BadgerCare Plus Standard and Benchmark Plans Only)

49. Article V, P

Add the following as new:

Health Needs Assessment/Health Indicators/Comprehensive Exam Report

The Department will provide the HMO with a report including member specific health needs assessment/physical exam/health indicators data collected by the health plan, providers, and Department for members in the Core Plan. The Department will provide this report to the HMO on a twice-monthly basis at the time the HMO receives the Core Plan enrollment reports.

50. Article VI, A

Revise the first bullet point to read as:

The Department's enhanced funding policies include NICU risk sharing and ventilator dependent enrollees. The HMO cannot submit a request for enhanced funding under more than one of the two funding policies for the same enrollee for the same date(s) of service.

Revise the third bullet point to read as:

Phase-in of the rate realignment and CDPS adjusters will be 25% in 2008 and 50% in 2009 for BadgerCare Plus – Standard Plan members.

Add the following as new after the third bullet point:

For individuals enrolled in a HMO with a pregnancy-related medical status code prior to January 1, 2009, the Department will pay the Healthy Start Pregnant Woman rate per member on a monthly basis. For individuals first enrolled in a HMO with a pregnancy-related medical status code on or after January 1, 2009, 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.

51. Article VI, E

Revise the first sentence of the fourth paragraph to read as:

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.

52. Article VI, F

Amend first sentence to read as:

The HMO must actively pursue, collect and retain all monies from all available resources for services to enrollees 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 HIV/AIDS and ventilator dependent patients).

Amend the last sentence of the first paragraph of VI, F, 2 to read as:

The HMO must also seek to coordinate benefits before claiming reimbursement from the Department for the HIV/AIDS and ventilator dependent enrollees:

53. Article VI, H.3

Revise H.3.a.1 to read as:

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, 2008, through December 31, 2008, must be submitted on or before April 1, 2009).

Revise H.3.a.2 to read as:

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, 2008, through December 31, 2008, must be submitted on or before April 1, 2010).

Revise H.3.b to read as:

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.

54. Article VI, I

Replace I.1.a and b with the following:

a. AIDS

1. For services dated on or after January 1, 2009, the Department will no longer reimburse HMOs for members with a confirmed diagnosis of AIDS outside the capitation rate. AIDS reimbursement will be included in the 2009 capitation rates. HMOs must submit encounter data for these services.

2. For services dated prior to January 1, 2009, the Department will reimburse HMOs for members with a confirmed diagnosis of AIDS outside of the capitation rate. AIDS services for qualified members must be submitted in accordance with the following criteria:

   a) Criteria Requirement

      1) Enhanced Funding Criteria Requirement for Members with AIDS (except newborns)

         For those enrollees with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code, the 100% reimbursement is effective on the first day of the month in which they were diagnosed as having AIDS.

      2) Enhanced Funding Criteria Requirement for Newborns

         Newborns with a confirmed diagnosis of AIDS reimbursement will be effective on their date of birth.

   b) Enhanced Funding End Date for All Members

      The period of enhanced funding will end on the enrollee's date of death, the date the enrollee loses BadgerCare Plus and/or Medicaid SSI enrollment, or the date the enrollee is exempted from HMO enrollment. In addition, the period of enhanced funding will end on the date the enrollee's medical status code (Article V) changes to a non-contracted medical status code.

   c) Documentation Requirement (for dates of service prior to January 1, 2009)

      For those enrollees with a confirmed diagnosis of AIDS the HMO must submit a signed statement from a physician that indicates a confirmed diagnosis of AIDS and the diagnosis date must accompany each new request.

b. HIV-Positive

1. For services dated on or after January 1, 2009, the Department will no longer reimburse HMOs for members with a confirmed diagnosis of HIV and who are on an anti-retroviral drug treatment approved by the federal Food and Drug Administration outside the capitation rate. HIV reimbursement will be included in the 2009 capitation rates. HMOs must submit encounter data for these services.

2. For services dated prior to January 1, 2009, the Department will reimburse HMOs for members with a confirmed diagnosis of HIV and who are on an anti-retroviral drug treatment approved by the federal Food and Drug Administration outside the capitation rate. HIV services for qualified members must be submitted in accordance with the following criteria:

   a) Enhanced Funding Criteria Requirement for Members with HIV

      For those enrollees who are HIV-positive and on anti-retroviral drug treatment approved by the federal Food and Drug Administration, qualify for reimbursement. The 100% reimbursement is effective on the first day of the month that the first anti-retroviral medication was dispensed.

   b) Enhanced Funding Criteria Requirement for Newborns

      Newborns with a confirmed diagnosis of HIV reimbursement will be effective on their date of birth.

   c) Enhanced Funding End Date for All Members

      The period of enhanced funding will end on the enrollee’s date of death, the date the enrollee loses BadgerCare Plus and/or Medicaid SSI enrollment, or the date the enrollee is exempted from HMO enrollment. In addition, the period of enhanced funding will end on the date the enrollee’s medical status code (Article V) changes to a non-contracted medical status code.

   d) Documentation Requirement

      For those enrollees with a confirmed diagnosis of HIV a signed statement must be submitted from the physician that the enrollee is HIV-positive and on anti-retroviral medications, the name of the drug and the date it was started must accompany each new request.

As a result of these changes, re-number the remaining section headings in Article VI, I as follows:

c. Ventilator Dependent Enrollees

1. General Information
2. Criteria Requirement
   a.) BadgerCare Plus
   b.) Medicaid SSI
3. Enhanced Funding
   a.) Newborns (BadgerCare Plus only)
   b.) All Other Enrollees
4. Documentation Requirements
   a) BadgerCare Plus
   b) Medicaid SSI

2. Payment Requirements for All Policies

a. Reporting
b. Payment Adjustments
c. Payment Dispute Resolution

55. Article VI, J

Delete J.1. and J.2.
Replace with the following:

Incentive payments will be made at the sole discretion of the Department and will be based on criteria communicated to the HMO through a contract amendment.

4. Rural Expansion Incentives implemented by amendment as Article VI, J, 4. will remain in effect as contracted policy through December 31, 2009. The terms and conditions of the incentive are applicable for the populations when the amendment was signed by the HMO and DHS. The childless adults population (members enrolled in Core Plan) are not eligible for the expansion incentive.

56. Article VII, H.

Replace H with the following:

Provider and Facility Network Data Submissions

1. The HMO that contracts with the Department to provide BadgerCare Plus and/or Medicaid SSI 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. A separate provider network and facility file must be submitted for both BadgerCare Plus and Medicaid SSI populations

(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 and Medicaid SSI members. The provider network and facility data submission must be completed by the first Monday of every month. Reporting dates are included in Article VII, I

3. HMO 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.

The provider and facility data file that must be submitted by the first Monday of October, 2009 will be used for 2010 service area certification determinations.

57. Amend Article VII, I to read:

I. Contract Specified Reports and Due Dates

2009 REPORTS AND DUE DATES

Type of Report	**Frequency**	**Report Period**	**Reporting Unit**	**Report Format**
Encounter Data File	Within 30 days	Previous Month	Fiscal Agent	Electronic Media
HMO Provider and Facility Network	On 20th of every month, or for significant changes	Next month	DHS	Electronic Media
Dental Progress Report **	Quarterly	Previous Quarter	BBM	Hardcopy
Assessment Report	Monthly, on 20th	Previous Month	Enrollment Specialist	Electronic Media
Formal/Informal Grievance Experience Summary Report	Quarterly (within 30 days of end of quarter)	Previous Quarter	BBM	Hardcopy
Attestation Form	Quarterly	Previous Quarter	BBM	Hardcopy
Common Carrier Data	Quarterly	Previous Quarter	BFM – Rate Section	CD-Rom
AIDS/Ventilator Dependent Report	Quarterly	DOS prior to January 1, 2009	BFM	CD-Rom & Hardcopy
Federally Qualified	February 15	Annual	BBM	Hardcopy – no form

Health Centers & Rural Health Centers				
Coordination of Benefits Report	Quarterly (within 45 days of end of quarter)	Previous Quarter	BBM	Electronic Media
Neonatal ICU Patient Care Data	April 1	Annual	BFM	Hardcopy
Initial Performance Improvement Project Topic Selection Summary	First business day of January	Annual	BBM & EQRO	Electronic Media
Member Communication and Outreach Plan	Second Friday of January	Annual	BBM	Electronic Media
High-risk Pregnancy Plan	First business day of April	Annual	BBM	Electronic Media
Performance Improvement Project Final Report	First business day of December	Annual	BBM & EQRO	Electronic Media

58. Article VIII, A

Add a title to the third paragraph which reads as:

BadgerCare Plus Standard and Benchmark Plans

Revise the third paragraph to read as:

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.

Add the following as new after the third paragraph:

BadgerCare Plus Core Plan:
BadgerCare Plus Core Plan members are required to enroll in a HMO if one or more HMOs are available for enrollment.

Revise the fifth paragraph (formerly fourth paragraph) to read as:

Medicaid SSI:
The current State Plan Amendment requires an all-in opt-out enrollment in the HMO for enrollment areas where there are two or more HMOs with sufficient slots for the eligible populations.

59. Article VIII, D1

Add the following as new after the third paragraph:

Voluntary HMO disenrollment is not applicable to BadgerCare Plus Core Plan. Core Plan members have the right to disenroll from one HMO if they enroll in another HMO that is available in the service area.

60. Article VIII, D.2

Add the following as new after the first sentence of the first paragraph:

(The Department may approve involuntary disenrollment requests for BadgerCare Plus Core Plan members on an individual basis.)

61. Article VIII, E.2

Add the following as new after the first paragraph:

If a BadgerCare Plus Core Plan member becomes eligible for these waiver programs or other managed care programs, the member will lose BadgerCare Plus Core Plan eligibility and therefore be disenrolled from the HMO.

62. Article VIII, E, 3

Replace “looses” with “loses.”

63. Article VIII, F.2

Add the following as new as the last sentence of the first paragraph:

Even if a BadgerCare Plus member meets the exemption criteria, the Department may in its sole discretion, deny an exemption.

Revise the title of F.2.a to read as:

AIDS or HIV-Positive (BadgerCare Plus Standard, Benchmark, and Core Plans)

Revise the tile of F.2.b to read as:

Certified Nurse Midwives or Nurse Practitioners (Not applicable to Core Plan)

Revise the title of F.2.c to read as:

Commercial HMO Insurance (Not applicable to Core Plan)

Revise the title of F.2.e to read as:

Mental Health and Substance Abuse Exemption (BadgerCare Plus Standard and Benchmark Plans Only)

Revise the title of F.2.f to read as:

Ninth Month Pregnancy (BadgerCare Plus Standard and Benchmark Plans Only)

Revise the title of F.2.g to read as:

Medicaid SSI Families (Not applicable to BadgerCare Plus)

Revise the title of F.2.h to read as:

Third Trimester Pregnancy (BadgerCare Plus Standard and Benchmark Plans Only)

Revise F.2.i to read as:

Transplant (BadgerCare Plus Standard, Benchmark, Core and SSI Medicaid Plans).
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.

a. 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.

b. In the case of autologous bone marrow transplants, the person will be permanently exempted from HMO enrollment the date the bone marrow was extracted.

c. Enrollees 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.

Revise the title of F.2.j to read as:

Admission to a Birth-to-3 Exemption (BadgerCare Plus Standard and Benchmark Plans Only)

64. Article VIII, G

Amend to read as:

System Based Disenrollments

1. Listed below are the reasons for disenrollment by medical status category:

Exemption Type	BadgerCare Plus (Standard, Benchmark, and Core)	Medicaid SSI/SSI Related
Loss of BadgerCare Plus and/or Medicaid SSI Enrollment	Yes	Yes
Out-of-State or Out-of-Service Area Move	Yes	Yes
CIP, COP, or Other Home and Community Based Waivers or Family Care	Yes	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)	Medicaid SSI/SSI Related	BadgerCare Plus Core Plan
Ninth Month Pregnancy	Yes	Yes	No
Third Trimester Pregnancy	Yes	Yes	No
SSI Family Member	Yes	No	No
Nurse Midwife/Certified Nurse Practitioner	Yes	Yes	No
FQHC	Yes	Yes	No
Mental Health and/or Substance Abuse	Yes	No	No
HIV/AIDS	Yes	Yes	Yes
Commercial HMO	Yes	Yes	No
Native American	Yes	Yes	Yes
Birth-to-3	Yes	No	No

3. The HMO may request the following disenrollments by medical status categories:

Disenrollment Type	BadgerCare Plus (Standard and Benchmark)	Medicaid SSI/SSI Related	BadgerCare Plus (Core Plan)
Just Cause	Yes	Yes	Yes
CIP, COP, Family Care Waivers	Yes	Yes	No
Infants with Low Birth Weight	Yes	No	No
Transplants	Yes	Yes	Yes
Nursing Homes	No	Yes	No
Inability to Complete Patient Plan of Care	No	Yes	No
Living in a Public Institution	Yes	Yes	No
Medicare Beneficiaries	Yes	No	No

65. Article VIII, H.1

Revise the title of H.1 to read as:

BadgerCare Plus Standard, Benchmark, and Core Plans

66. Article X, A.13

Revise the last sentence of the first paragraph to read as:

However, BadgerCare Plus – Benchmark and Core Plan enrollees can be billed for missed appointments, also if an enrollee agrees in writing to pay for a non-covered service, then the HMO, HMO provider, or HMO subcontractor can bill.

67. Article X, E.1

Add the following as new after the last bullet point:

This Department notification must be through the submission of an updated provider network to the FTP server.

68. Article X, E.2

Add the following as new as the last sentence of the first paragraph:

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.

Add the following as new after the second paragraph:

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.

69. Article X, E.3

Delete all of E.3

E.4 becomes E.3

70. Article XIV

Replace XIV with the following:

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., HFS 108.01, Wis. Adm. Code, 42 CFR 431 Subpart F and 42 CFR 438 Subpart F. 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:

(i) is part of the public domain without any breach of this Agreement by Contractor;
(ii) is or becomes generally known on a non-confidential basis, through no wrongful act of Contractor;
(iii) was known by Contractor prior to disclosure hereunder without any obligation to keep it confidential;
(iv) was disclosed to it by a third party which, to the best of Contractor's knowledge, is not required to maintain its confidentiality;
(v) was independently developed by Contractor; or
(vi) 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 Manager/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.

71. Article XVII

Add as new:

L. Media Contacts

The HMO agrees to forward to the Department all media contacts regarding BadgerCare Plus and/or Medicaid SSI programs or members.

72. Article XVIII, C

Revise C.6 to read as:

Future Adjustments: These rates may be changed to reflect legislative changes in BadgerCare Plus and/or Medicaid SSI reimbursement or changes in approved services.

73. Article XVIII

Create section XVIII, D by revising the first sentence of the second paragraph of C.7 to read:

D. Other terms of the contract include (Medicaid SSI only):

Amend Art. XVIII, D, 1 to read as follows:

1. Case Mix Adjustment:
Region 5 and Region 6: The Department will make case mix adjusted payments to the HMO 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 Exhibit Section, 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.

Regions 1-4: The Department will conduct an analysis comparing actual Medicaid SSI HMO member's diagnosis and service usage intensity (utilization and cost) with the comparable FFS equivalent population using the Chronic Illness and Disability Payment System (CDPS).

The Department will make case mix adjusted payments to HMOs operating in Regions 1-4 if the CDPS-based adjustment method is approved by CMS. The payment rates for members will be adjusted based upon the final outcome of the CDPS analysis as applied to the rate schedule in the Exhibit Section, subject to CMS approval. This retrospective reconciliation of the composite CDPS weight based on actual enrollment will be calculated within 60 days following the end of each calendar year within the Contract period.

74. Article XVIII, D.3

Revise the first sentence of the second paragraph to read as:

Each year quarterly payments will be based on the number of member months for Milwaukee County attributable to the HMO for the quarter as determined by the Department multiplied by $1.75.

Add the following as new after the second paragraph:

Total combined payment to the Milwaukee County HMO in the Medicaid SSI Managed Care Program for external advocate services will not exceed $300,000 for services provided in the period October 1, 2008, through September 30, 2009, and paid in calendar year 2009. If total payments to the External Advocate are projected to exceed $300,000, the final quarterly payment to the External Advocate will be adjusted so that no more than $300,000 is paid to the External Advocate. The HMO's charge for that final quarterly payment will be prorated based on its member months for that quarter. Total payments to the HMO in excess of $300,000 will be subject to reconciliation with a final adjusting reconciliation no later than March 31, 2010.

75. Article XVIII, D.6

Delete the title and first sentence of D.6 which reads as:

6. Pharmacy Coverage
Pharmacy is carved out of the capitation rate for all BadgerCare Plus and/or Medicaid SSI eligibles and will be paid on a fee for service basis.

After D.5, add as new:

E. Contracted Populations

76. Addendum II

Revise YOUR FORWARDHEALTH OR FORWARD ID CARD to read as:

YOUR FORWARDHEALTH ID CARD

Revise the first sentence of the paragraph under YOUR FORWARDHEALTH ID CARD to read as:

Always carry your ForwardHealth card with you, and show it every time you get care.

Add the following as new under 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.

Revise the third paragraph under BILLING ENROLLEES to read as:

Under BadgerCare Plus – Benchmark and Core Plans, the HMO and its providers and subcontractors may bill you for deductibles for covered services that are provided by a BadgerCare Plus certified provider.

Revise the first paragraph under SERVICES COVERED BY [HMO NAME] to read as:

The HMO is responsible to provide all medically necessary covered services under BadgerCare Plus Standard and Benchmark Plans (specific covered services and co-payments amounts for the Benchmark and Core Plans are listed in Addendum V) and/or Medicaid SSI. (The HMO must provide information for these sections that are approved by the Department.)

Revise the MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES title to read as:

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (language may be different based on which plan you are talking about in the handbook – see the Benchmark and Core Plan covered services and co-payments in Addendum V.)

Revise the FAMILY PLANNING SERVICES title to read as:

FAMILY PLANNING SERVICES (language may be different based on which plan you are talking about in the handbook - – see the Benchmark and Core Plan covered services and co-payments in Addendum V.)

Revise the last sentence of the second paragraph under FAMILY PLANNING SERVICES to read as:

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).

Revise the DENTAL SERVICES title to read as:

DENTAL SERVICES (The following language applies to BadgerCare Plus Standard Plan and Medicaid SSI members. The Benchmark Plan has a limited dental benefit for certain populations. The Core Plan covers only emergency dental services. See covered services and co-payments in Addendum V.)

Revise the first sentence of #2 under DENTAL SERVICES to read as:

You may get dental services from any dentist who will accept your ForwardHealth ID card.

Revise #1 under CHIROPRACTIC SERVICES to read as:

[HMO NAME] provides covered chiropractic services for BadgerCare Plus Standard, Benchmark, and Medicaid SSI Plan 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. Chiropractic services are not covered for BadgerCare Plus Core Plan members.

Revise #2 under CHIROPRACTIC SERVICES to read as:

You may get chiropractic services from any chiropractor who will accept your Forward Health ID card if you are a BadgerCare Plus Standard, Benchmark, or Medicaid SSI member. Your chiropractic services are provided by the State, not [HMO NAME]. Chiropractic services are not covered for BadgerCare Plus Core Plan members.

Revise the first paragraph under HEALTHCHECK to read as:

HealthCheck is a preventive health checkup program for enrollees under the age of 21 (not covered for BadgerCare Plus Core Plan members). 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.

Revise BadgerCare Plus – Benchmark Plan Members under TRANSPORTATION to read as:

BadgerCare Plus – Benchmark and Core Plan Members

Revise BadgerCare Plus – Benchmark Members under SPECIAL MEDICAL VEHICLE (SMV) to read as:

BadgerCare Plus – Benchmark and Core Plan Members

Revise the third paragraph under PHARMACY BENEFITS to read as:

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.

Add the following as new following PHARMACY BENEFITS:

CARE EVALUATION (SSI Medicaid members only)

As a member of [HMO NAME], you will be asked to speak with a trained staff member about your health care needs. Your case manager/care coordinator will contact you within the first 60 days of being enrolled with [HMO NAME] to schedule a time to talk about your medical history and the care you need. It is very important that you talk with your case manager/care coordinator. If you have questions or would like to contact [HMO NAME] directly to schedule a care evaluation session, please call XXX-XX-XXXX.

COMPREHENSIVE PHYSICAL EXAM (Core Plan members only)

As a member of the Core Plan, it is your responsibility to schedule and receive a physical exam with your doctor within the first year of being enrolled in the Core Plan. This is very important because if you do not get a physical exam, **you will lose your health care benefits.** You will receive notification from [HMO NAME] about scheduling this exam. If you need help to schedule your physical exam, please contact XXX-XXX-XXXX.

If you are unable to schedule and receive a physical exam through [HMO NAME], please call Medicaid Member Services at the State of Wisconsin at 1-800-362-3002.

Add the following as new after the first paragraph under HEALTH INSURANCE AFTER YOUR ELIGIBILITY ENDS:

BadgerCare Plus Core Plan members: If you choose to buy insurance from [HMO NAME] when your eligibility ends, this may affect your ability to enroll in the Core Plan again if you become eligible.

77. Addendum III, A.3

Add the following as new after the first sentence:

In the mental health/substance abuse benefit area, a request for an assessment must be accepted in all situations.

78. Addendum III, A.5

Add the following as new after the first sentence of the first bullet point:

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.

79. Addendum IV, A

Revise the AIDS COST SUMMARY to read as:

AIDS COST SUMMARY (Services prior to January 1, 2009)

Revise the first sentence under AIDS and Ventilator Dependent Detail Report to read as:

The detail report must be provided on CD-Rom in an Excel file format as well as a paper copy.

80. Addendum IV, C

Revise the second sentence of the first paragraph to read as:

NICU reports must be submitted to the Department's Bureau of Fiscal Management on or before April 1 of the following year.

Revise title of HMO Detailed NICU Data Format worksheet to read:
D. HMO DETAILED NICU DATA FORMAT

81. Addendum IV, F
Revise IV, F, 1 (Report instructions) to read as:

1.	HMO Name:	In this field enter the name of the HMO reporting.
	HMO NPI Number:	In this field enter the BadgerCare Plus and/or Medicaid SSI 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.

Revise IV, F, 1 (Report) to read as:

1. HMO Name ____

HMO Provider NPI Number ________________________________

Taxonomy Code ____

Telephone Number ____

82. Addendum IV, G

Amend to read as follows:

HealthCheck Worksheet

HEALTHCHECK WORKSHEET
Note: Does not include BadgerCare Plus Core Plan members
HMO: ___________

			Age Groups					
		Calculation	**< = 1**	**1 – 2**	**3 – 5**	**6 – 14**	**15 – 20**	**Total**
1	# of eligible months for enrollees under age 21	Entered (Total is sum of age groups)						
2	# of unduplicated enrollees under age 21	Entered						
3	Ratio of recommended	Given	5	1.5	1.0	0.56	0.5	

	screens per age group member							
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.

83. Addendum IV, H.

H.1 Add the following as new after the first sentence:

The log must distinguish between the BadgerCare Plus and Medicaid SSI members, if the HMO serves both populations. If the HMO does not have a separate log for BadgerCare Plus and/or Medicaid SSI and their commercial members, the log must distinguish between the programs.

H.2 Edit years to read 2008 and 2009

84. Addendum IV, I

Amend to read as:

Attestation Form

ATTESTATION

I, ____________________________, have reviewed the following data:
(Name and Title)

☐ Encounter Data for (quarterly)________(year) 200__.

☐ AIDS/Vent Report for (quarter)______________for (year) 200__.

☐ FQHC/RHC Report (annually)________________(year).

☐ HMO Network Submission for (quarter) _________(year) 200__.

☐ Physical Exam Report and Indicators for (quarter) _________(year) 200__.

☐ SSI Assessment Report for (quarter) _________(year) 200__.

☐ 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)

85. Addendum IV, K

Delete K

86. Addendum IV, L

Delete L

87. Addendum V
Amend to read as:

ADDENDUM V

Summary of BadgerCare Plus Covered Services

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	BadgerCare Plus Core Plan***
Chiropractic Services		
Full coverage	Full coverage	No coverage
$.50 to $3 co-payment per	$15 co-payment per visit	

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	BadgerCare Plus Core Plan***
service		
Dental Services		
Full coverage	Limited coverage of preventive, diagnostic, simple restorative, periodontics, and extractions for pregnant women and children Coverage limited to $750 per enrollment year.	Coverage limited to emergency services only
$.50 to $3 co-payment per service	A $200 deductible applies to all services except preventive and diagnostic. Cost-sharing equal to 50% of allowable fee on all services	No co-payment
Disposable Medical Supplies (DMS)		
Full coverage	Coverage of syringes, diabetic pens and DMS that is required with the use of a durable medical equipment (DME) item.	Coverage of syringes, diabetic pens and DMS that is required with the use of a DME item.
$0.50 co-payment per item	No co-payment	$0.50 co-payment per item
Drugs		
Comprehensive drug benefit with coverage of generic and brand name prescription drugs, and some over-the-counter (OTC) drugs	Generic drug-only formulary with a few generic OTC drugs Members will be automatically enrolled in the Badger Rx Gold plan. This is a separate program administered by Navitus, which provides for a discount on the cost of drugs.	Generic-only formulary drug benefit with a few generic OTC drugs *Brand name mental health drugs are only covered for individuals previously covered under the General Assistance Medical Program.* Members will be automatically enrolled in the Badger Rx Gold plan. This is a separate program administered by Navitus, which provides for a discount on the cost of drugs.

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	BadgerCare Plus Core Plan***
Co-payments: - $0.50 for OTC drugs - $1.00 for generic drugs - $3.00 for brand Co-payments are limited to $12.00 per member, per provider, per month. OTCs are excluded from this $12.00 maximum.	$5 co-payment with no limits	$5 co-payment with a $20 limit per month, per provider
Durable Medical Equipment (DME)		
Full coverage	Full coverage up to $2,500 per enrollment year	Full coverage up to $2,500 per enrollment year
$0.50 to $3 co-payment per item Rental items are not subject to co-payment	$5 co-payment per item Rental items are not subject to co-payment but count toward the $2,500 annual limit.	$0.50 to $3 co-payment per item Rental items are not subject to co-payment but count toward the $2,500 annual limit.
Health Screenings for Children		
Full coverage of HealthCheck screenings and other services for individuals under age 21 years	Full coverage of HealthCheck screenings HealthCheck “Other” services and Interperiodic services for individuals under age 21 years are not covered.	Not applicable
$1 co-payment per screening for 18, 19, and 20 year olds only	No co-payment	
Hearing Services		
Full coverage	Limited coverage of services provided by an audiologist. Hearing aids, hearing aid batteries, cochlear implants and bone-anchored hearing devices are not covered.	No coverage
$.50 to $3 per procedure No co-payment for hearing aid batteries	$15 per procedure, regardless of the number of procedures performed during one visit	
Home Care Services (Home Health, Private Duty Nursing and Personal Care)		
Full coverage of private	Full coverage of home health	

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	BadgerCare Plus Core Plan***
duty nursing, home health services, and personal care	services Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care are not covered.	No coverage
No co-payment	$15 co-payment per visit	
Hospice Services		
Full coverage	Full coverage, up to 360 days per lifetime	No coverage
No co-payment	$2 co-payment per day	
Inpatient Hospital Services		
Full coverage	Full coverage, with the following dollar amount limits per enrollment year: - $6,300 for stays in a general acute care hospital for substance abuse - $7,000 for stays in an IMD (Institutes for Mental Disease) for substance abuse treatment Hospital stays for mental health and substance abuse services have a 30-day limit	Full coverage (not including inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital)
$3 co-payment per day with a $75 cap per stay	Co-payment: - $100 stay for medical stays - $50 co-payment per stay for mental health and/or substance abuse treatment	$3 co-payment per day for members with income up to 100% FPL with a $75 cap per stay $100 co-payment per stay for members with income from 100% to 200% FPL There is a $300 total co-payment cap per year for inpatient and outpatient hospital services for all income levels.
Mental Health and Substance Abuse Treatment*		
Full coverage (not including room and board)	Coverage of this service is based on the Wisconsin State Employee Health Plan.	Coverage limited to mental health therapy services provided by

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	BadgerCare Plus Core Plan***
	Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment for adults, substance abuse day treatment for adults and children, and child/adolescent mental health day treatment and inpatient hospital stays for mental health and substance abuse. Services not covered are crisis intervention, community support program (CSP), Comprehensive Community Services (CCS), outpatient services in the home and community for adults, and substance abuse residential treatment. Mental health services have no dollar maximums. Substance abuse services are limited to $7,000. Costs of mental health services, including inpatient stays, apply to this overall limit. Also, there are separate dollar limits for specific substance abuse services: - $4,500 for outpatient substance abuse services including $2,700 for outpatient services (including narcotic treatment) for substance abuse day treatment. - $6,300 for inpatient hospital stays in a general acute care hospital.	a psychiatrist only.
$.50 to $3 co-payment per service, limited to the first 15 hours or $500 of services, whichever comes first, provided per calendar year. Co-payment not required	$10 to $15 co-payment per visit for all outpatient services: - $10 per day for all day treatment services - $15 per visit for narcotic treatment services (no co-payment for lab tests)	$.50 to $3 co-payment per service, limited to $30 per provider, per calendar year

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	BadgerCare Plus Core Plan***
when services provided in hospital setting	- $15 per visit for outpatient mental health diagnostic interview exam, psychotherapy − individual or group (no co-payment for electroconvulsive therapy and pharmacological management) - $15 per visit for outpatient substance abuse services	
Nursing Home Services		
Full coverage	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year.	No coverage
No co-payment	No co-payment	
Outpatient Hospital - Emergency Room		
Full coverage	Full coverage	Full coverage
No co-payment	$60 co-payment per visit *(waived if member admitted to hospital)*	No co-payment for members with income up to 100% FPL $60 co-payment per visit for members with income from 100% to 200% FPL *(waived if member admitted to hospital)*
Outpatient Hospital Services		
Full coverage	Full coverage	Full coverage
$3 co-payment per visit	$15 co-payment per visit	$3 co-payment per visit for members with income up to 100% FPL $15 co-payment per visit for members with income from 100% to 200% FPL $300 total co-payment cap per year for inpatient and outpatient hospital services for all income levels.

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	BadgerCare Plus Core Plan***
Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)		
Full coverage	Full coverage, limited to 20 visits per therapy discipline per enrollment year Also covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. (The cardiac rehabilitation visits do not count towards the 20 PT visits.)	Full coverage, limited to 20 visits per therapy discipline per enrollment year
$.50 to $3 co-payment per service Co-payment obligation limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year (co-payment limits calculated separately for each discipline)	$15 co-payment per visit, per provider. There are no monthly or annual co-payment limits.	$.50 to $3 co-payment per service. Co-payment obligation limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year (co-payment limits calculated separately for each discipline)
Physician Services		
Full coverage, including laboratory and radiology	Full coverage, including laboratory and radiology	Full coverage, including laboratory and radiology
$.50 to $3 co-payment per service limited to $30 per provider per calendar year. No co-payment for emergency services, anesthesia or clozapine management	$15 co-payment per visit No co-payment for emergency services, preventive care, anesthesia or clozapine management	$.50 to $3 co-payment per service, limited to $30 per provider per calendar year. No co-payment for emergency services, preventive care, anesthesia or clozapine management
Podiatry Services		
Full Coverage	Full coverage	No coverage
$.50 to $3 co-payment per service; limited to $30 per provider per calendar year.	$15 co-payment per visit	
Prenatal /Maternity Care		
Full coverage, including prenatal care coordination,	Full coverage, including prenatal care coordination, and preventive	Not Applicable

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	BadgerCare Plus Core Plan***
and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems	mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems	
No co-payment	No co-payment	
Reproductive Health Services		
Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization	Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization	Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver program.
No co-payment for family planning services	No co-payment for family planning services	
Routine Vision		
Full coverage including coverage of eyeglasses	One eye exam every two years, with refraction	No Coverage
$0.50 to $3 co-payment per service	$15 co-payment per visit	
Smoking Cessation Services		
Coverage includes prescription and OTC tobacco cessation products.	Coverage includes prescription generic and OTC tobacco cessation products.	Coverage includes prescription generic and OTC tobacco cessation products.
Refer to the drug benefit for information on copayments	Refer to the drug benefit for information on copayments	Refer to the drug benefit for information on copayments
Transportation – Ambulance, Specialized Medical Vehicle (SMV), Common Carrier		
Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service.	Coverage limited to emergency transportation by ambulance.	Coverage limited to emergency transportation by ambulance.
- $2 co-payment for non-emergency ambulance trips - $1 co-payment per trip for transportation by SMV - No co-payment for transportation by common carrier or emergency ambulance	$50 co-payment per trip	No co-payment

88. Addendum VI

Replace all of Addendum VI with the following:

The total incentive amounts in aggregate paid to the HMO under this contract per calendar year will not exceed total capitation revenues by more than 5%.

New HMOs are not eligible for receipt of a pay for performance incentive until the Department has one year of baseline data available to measure initial performance.

The Department has allocated $4,500,000 for CY09 pay for performance incentives of which $250,000 will be allocated to the SSI case management incentive and $4,250,000 will be allocated to the combination pay for performance incentive.[1]

1. Case Management (Medicaid SSI HMOs only)

a. SSI HMOs will be eligible for two financial incentives structured to improve both the rate and content of SSI case management assessments. The incentive is based on the combined (non-weighted) average rate of timeliness of initial assessments and comprehensiveness of initial assessments.

b. The Department will determine a performance goal, to be the same for all participating HMOs, following the January, 2009 MetaStar case management chart review.

c. The Department's two-tier incentive will reward incremental improvement for improvement in meeting the performance goal as well as a larger reward for HMOs who reach the performance goal.

   i. Incremental Improvement Incentive
      1. 60 percent of the available funds will be allocated based on the incremental increase by each HMO, towards meeting the Department-established performance goal, using 2009 chart review data as a base.

   ii. Lump Sum Performance Goal Incentive
      1. 40 percent of the available funds will be available to HMOs that meet the Department-established performance goal.

d. The Department will allocate $250,000 for the CY 2009 SSI Case Management Incentive. The Department maintains discretion for allocating both the lump sum and incremental improvement incentive.

2. Combination Pay for Performance Incentive (BadgerCare Plus – Benchmark, Standard Plan HMOs only)

[1] Combination Pay for Performance Incentive is designed to assess and compare measures of performance for a combined grouping of the P4P areas within each HMO. The Department will determine a specific area for improvement and a performance goal for each HMO.

a. The Department will use seven performance metrics in five focus areas using 2005-2007 data to identify targeted performance goal, minimum thresholds and maintenance-of-effort requirements.

   The focus areas and metrics using HEDIS 2008 specifications to evaluate 2007 performance data include:

   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 hepatits 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 5-56 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) testing and LDL-C screening.
   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.

b. 2009 performance metrics will be measured using the HEDIS 2010 specifications.

c. The Department will inform the HMO by January, 2009 on the performance metrics it has identified that the HMO must target in CY 2009 for 1) stretch performance improvement goal, 2) minimum threshold targets, and 3) maintenance-of-effort.

d. The Department's stretch performance goal will be scaled to the individual health plan's performance. The Department will publish the goals for all HMOs.

e. To receive an incentive, the HMO must meet all three targets:

   i. The HMO must meet the identified CY09 minimum thresholds for all seven performance metrics.

   ii. The HMO must maintain maintenance of effort in performance metrics in which they perform above the minimum threshold. Performance in a particular metric must be the same (with a 95% confidence interval) as its prior three-year average performance (or fewer years depending on available data).

   iii. The HMO must meet the targeted stretch performance goal for the Department-identified focus area. A 95% confidence interval will be applied to determine if an HMO meets the stretch goal.

f. If the HMO fails to meet a minimum threshold in any performance metric, it must submit a corrective action plan to the Department indicating how it plans on improving its performance during the following contract year in that particular performance metric.

g. The Department has allocated $4,250,000 for the combination pay for performance incentive. The available $4,250,000 will be allocated based on the following data for BadgerCare Plus – Standard and Benchmark Plan members:

   i. The total number of CY09 member months in plans qualifying for the incentive will be determined.

   ii. The $4,250,000 will be divided by the total number of member months of plans that qualify for the incentive.

   iii. Each qualifying HMO will receive the lesser of the sum of their total allocation based on member months or 1% of their total capitation revenue for the year.

h. The Department will calculate the incentive based on HMO performance improvement during CY 2009. Improvement in CY 2009 will be measured using all CY 2009 encounter data submitted to the Department by June 30, 2010. 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, 2010 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 to supplement their administrative data for 2010 will be accepted as long as data is submitted by June 21, 2010. The HMO cannot use chart reviews to alter the 2005, 2006, and 2007 base data.

i. This incentive payment will not become part of the HMO’s base rate.

3. Childhood Obesity Reporting (BadgerCare Plus)

a. The HMO shall work with providers to ensure V85 CPT diagnosis codes are included in health check and physician exam claims for children ages two-seventeen.

b. The Department anticipates an incentive targeting childhood obesity will be forthcoming in the 2010-2011 contract based on a decrease in the number and/or percent of overweight and obese children with V85.53 and V85.54 (overweight and obese) CPT codes.

4. Tobacco Cessation

a. The HMO must maintain and populate a tobacco registry (electronic database of information about members with identified tobacco or nicotine addition or current smoker status).

6. Region 4 Expansion Incentive

Region 4 Expansion Incentives implemented by amendment as Addendum VI, 6. will remain in effect as contracted policy through December 31, 2009. The terms and conditions of the incentive are applicable for the populations when the amendment was signed by the HMOs and DHS. The childless adults population (members enrolled in Core Plan) are not eligible for the expansion incentive.

89. Amend Exhibit as follows:

EXHIBIT

Wisconsin Department of Health Services
2009 MCE and Capitation Rate Development for BadgerCare Plus Standard Plans

2009 Capitation Rates - BadgerCare Plus Standard Plan

All Service Capitation Rate by Age/Gender and Rate Region

Age Range	Gender	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Age 0	All	$ 298.61	$ 315.41	$ 260.91	$ 292.67	$ 301.53	$ 391.27
Ages 1 - 5	All	72.14	62.32	61.82	66.93	72.23	87.84
Ages 6 - 14	All	68.92	57.07	55.95	64.23	59.77	60.15
Ages 15 - 20	Female	133.38	118.14	118.80	116.08	117.74	118.84
Ages 15 - 20	Male	80.68	72.80	76.45	86.91	84.67	74.88
Ages 21 - 34	Female	195.00	182.22	176.26	177.68	199.82	191.77
Ages 21 - 34	Male	122.69	111.91	123.03	131.79	139.61	129.72
Ages 35 -44	Female	244.21	263.99	246.33	239.54	275.31	268.14
Ages 35 -44	Male	180.26	210.81	156.46	195.62	205.10	205.62
Ages 45 & Over	Female	342.34	319.62	298.50	325.47	319.21	354.13
Ages 45 & Over	Male	240.87	336.91	245.90	201.48	273.58	359.54

Medical & Dental Service Capitation Rate by Age/Gender and Rate Region

Age Range	Gender	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Age 0	All	$ 297.64	$ 315.10	$ 260.00	$ 291.91	$ 301.29	$ 391.23
Ages 1 - 5	All	71.28	62.03	61.16	66.45	72.01	87.81
Ages 6 - 14	All	67.57	56.48	54.81	63.35	59.35	60.09
Ages 15 - 20	Female	130.54	116.90	116.33	114.56	117.01	118.74
Ages 15 - 20	Male	78.93	71.92	74.89	85.64	84.09	74.81
Ages 21 - 34	Female	189.85	179.95	171.92	174.02	198.42	191.47
Ages 21 - 34	Male	119.07	110.10	119.99	128.60	138.20	129.21
Ages 35 -44	Female	237.69	260.63	240.33	234.70	273.19	267.74
Ages 35 -44	Male	175.10	208.30	151.97	191.34	203.44	205.13
Ages 45 & Over	Female	336.49	315.56	292.51	320.24	316.98	353.54
Ages 45 & Over	Male	235.96	334.06	241.51	197.44	271.86	359.06

Medical & Chiropractic Service Capitation Rate by Age/Gender and Rate Region

Age Range	Gender	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Age 0	All	$ 298.52	$ 315.39	$ 260.84	$ 292.53	$ 301.51	$ 391.18
Ages 1 - 5	All	64.44	59.23	54.93	59.46	69.12	83.48
Ages 6 - 14	All	56.62	49.15	44.75	50.47	54.14	52.68
Ages 15 - 20	Female	121.06	112.45	107.89	104.60	112.17	112.86
Ages 15 - 20	Male	69.49	66.80	66.95	75.82	79.50	69.75
Ages 21 - 34	Female	183.80	177.62	166.50	167.80	193.38	183.46
Ages 21 - 34	Male	112.40	107.64	113.95	121.43	133.17	122.22
Ages 35 -44	Female	233.00	258.13	236.31	229.40	268.88	259.12
Ages 35 -44	Male	169.72	205.27	146.18	187.23	199.44	197.40
Ages 45 & Over	Female	329.83	312.91	285.59	313.77	311.25	341.76
Ages 45 & Over	Male	227.07	329.18	234.38	190.10	265.39	346.86

Medical Only Service Capitation Rate by Age/Gender and Rate Region

Age Range	Gender	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Age 0	All	$ 297.55	$ 315.08	$ 259.93	$ 291.77	$ 301.28	$ 391.14
Ages 1 - 5	All	63.58	58.94	54.27	58.97	68.90	83.45
Ages 6 - 14	All	55.26	48.56	43.61	49.59	53.72	52.62
Ages 15 - 20	Female	118.22	111.21	105.42	103.08	111.44	112.76
Ages 15 - 20	Male	67.74	65.92	65.40	74.55	78.92	69.68
Ages 21 - 34	Female	178.65	175.35	162.15	164.14	191.98	183.16
Ages 21 - 34	Male	108.78	105.83	110.90	118.24	131.76	121.72
Ages 35 -44	Female	226.48	254.77	230.31	224.57	266.77	258.72
Ages 35 -44	Male	164.56	202.76	141.69	182.95	197.78	196.92
Ages 45 & Over	Female	323.98	308.85	279.60	308.53	309.01	341.18
Ages 45 & Over	Male	222.16	326.33	230.00	186.07	263.67	346.38

Wisconsin Department of Health Services

2009 MCE and Capitation Rate Development for BadgerCare Plus Standard and Benchmark Plans

2009 Maternity Case Rate Development - BadgerCare Plus Standard & Benchmark Plan

	Region					
	1	2	3	4	5	6
Capitation Payments for Women Identified as Pregnant Before January 1, 2009						
All Services	$ 863.48	$ 786.55	$ 669.09	$ 819.43	$ 896.42	$ 1,083.83
Medical & Dental	856.12	784.36	663.41	813.23	894.55	1,083.31
Medical & Chiro	856.10	783.72	663.31	810.55	893.11	1,078.74
Medical Only	848.74	781.53	657.62	804.35	891.23	1,078.22
Kick Payments for Women Identified as Pregnant On or After January 1, 2009						
Kick Payment	$5,197.47	$4,225.59	$4,305.49	$4,617.61	$4,645.58	$5,788.39

Wisconsin Department of Health Services

2009 Capitation Rate Development for BadgerCare Plus Benchmark Plans

2009 Capitation Rates - BadgerCare Plus Benchmark Plan

All Service MCE rate by Age/Gender and Rate Region

Age Range	Gender	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Age 0	All	$ 236.43	$ 263.91	$ 206.55	$ 231.84	$ 239.17	$ 310.52
Ages 1 - 5	All	57.05	52.13	48.94	53.13	57.32	69.87
Ages 6 - 14	All	54.39	47.75	44.18	51.00	47.41	47.99
Ages 15 - 20	Female	104.68	98.39	93.27	91.68	93.23	94.49
Ages 15 - 20	Male	63.45	60.66	60.14	68.66	67.06	59.58
Ages 21 - 34	Female	174.48	174.38	157.96	159.72	181.88	175.09
Ages 21 - 34	Male	n/a	n/a	n/a	n/a	n/a	n/a
Ages 35 -44	Female	218.71	252.65	221.11	215.67	250.68	245.05
Ages 35 -44	Male	n/a	n/a	n/a	n/a	n/a	n/a
Ages 45 & Over	Female	309.12	305.94	268.75	294.13	290.76	323.55
Ages 45 & Over	Male	n/a	n/a	n/a	n/a	n/a	n/a

Medical & Dental Service MCE Rate by Age/Gender and Rate Region

Age Range	Gender	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Age 0	All	$ 236.23	$ 263.84	$ 206.36	$ 231.68	$ 239.12	$ 310.51
Ages 1 - 5	All	56.87	52.07	48.80	53.02	57.27	69.86
Ages 6 - 14	All	54.10	47.62	43.93	50.81	47.32	47.98
Ages 15 - 20	Female	104.08	98.11	92.74	91.36	93.08	94.47
Ages 15 - 20	Male	63.08	60.47	59.81	68.39	66.94	59.57
Ages 21 - 34	Female	173.28	173.82	156.95	158.87	181.56	175.02
Ages 21 - 34	Male	n/a	n/a	n/a	n/a	n/a	n/a
Ages 35 -44	Female	217.19	251.83	219.71	214.54	250.18	244.95
Ages 35 -44	Male	n/a	n/a	n/a	n/a	n/a	n/a
Ages 45 & Over	Female	307.76	304.94	267.35	292.91	290.24	323.41
Ages 45 & Over	Male	n/a	n/a	n/a	n/a	n/a	n/a

Medical & Chiro Service MCE Rate by Age/Gender and Rate Region

Age Range	Gender	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Age 0	All	$ 236.36	$ 263.89	$ 206.49	$ 231.73	$ 239.16	$ 310.44
Ages 1 - 5	All	50.65	49.42	43.21	46.91	54.73	66.24
Ages 6 - 14	All	44.15	40.79	34.86	39.54	42.72	41.78
Ages 15 - 20	Female	94.43	93.39	84.19	82.14	88.60	89.51
Ages 15 - 20	Male	54.13	55.39	52.23	59.43	62.76	55.32
Ages 21 - 34	Female	165.17	170.34	149.83	151.50	176.52	168.17
Ages 21 - 34	Male	100.68	102.92	102.49	109.27	121.26	111.83
Ages 35 -44	Female	209.38	247.51	212.77	207.23	245.33	237.54
Ages 35 -44	Male	152.23	196.94	131.09	168.90	181.91	180.84
Ages 45 & Over	Female	298.71	300.05	258.01	284.39	284.13	313.26
Ages 45 & Over	Male	205.04	316.68	212.11	171.71	242.39	318.01

Medical Only Service MCE Rate by Age/Gender and Rate Region

Age Range	Gender	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Age 0	All	$ 236.15	$ 263.82	$ 206.30	$ 231.57	$ 239.11	$ 310.43
Ages 1 - 5	All	50.46	49.35	43.07	46.81	54.68	66.23
Ages 6 - 14	All	43.86	40.66	34.61	39.35	42.64	41.76
Ages 15 - 20	Female	93.83	93.12	83.66	81.81	88.44	89.49
Ages 15 - 20	Male	53.76	55.20	51.90	59.16	62.64	55.30
Ages 21 - 34	Female	163.97	169.78	148.82	150.64	176.19	168.10
Ages 21 - 34	Male	99.84	102.47	101.78	108.52	120.93	111.71
Ages 35 -44	Female	207.86	246.68	211.37	206.10	244.83	237.45
Ages 35 -44	Male	151.03	196.32	130.04	167.91	181.52	180.73
Ages 45 & Over	Female	297.34	299.05	256.61	283.17	283.60	313.13
Ages 45 & Over	Male	203.90	315.97	211.09	170.77	241.99	317.90

Wisconsin Department of Health Services

2009 Capitation Rate Development for Childless Adults Plans

2009 Capitation Rates - Childless Adults - GAMP Population

Childless Adults - GAMP Capitation Rates							
		Region					
Age Range	Gender	1	2	3	4	5	6
Ages 21 - 34	Female	-	-	-	-	-	239.96
Ages 21 - 34	Male	-	-	-	-	-	160.14
Ages 35 -44	Female	-	-	-	-	-	338.13
Ages 35 -44	Male	-	-	-	-	-	257.84
Ages 45 & Over	Female	-	-	-	-	-	445.26
Ages 45 & Over	Male	-	-	-	-	-	452.02
Composite		-	-	-	-	-	326.88

Wisconsin Department of Health Services

2009 Capitation Rate Development for Childless Adults Plans

2009 Capitation Rates - Childless Adults < 100% of the FPL

Other Childless Adults <= 100% FPL Capitation Rates							
		Region					
Age Range	Gender	1	2	3	4	5	6
Ages 21 - 34	Female	165.16	170.95	150.09	151.90	177.33	169.27
Ages 21 - 34	Male	101.35	103.97	103.28	109.99	122.33	113.16
Ages 35 -44	Female	208.83	247.47	212.33	207.09	245.63	238.28
Ages 35 -44	Male	152.29	197.36	131.40	169.08	182.63	181.84
Ages 45 & Over	Female	297.88	299.58	257.35	283.78	284.21	313.59
Ages 45 & Over	Male	204.89	316.42	212.05	171.93	242.80	318.34
Composite		189.51	228.40	179.69	180.21	209.57	230.37

Wisconsin Department of Health Services

2009 Capitation Rate Development for Childless Adults Plans

2009 Capitation Rates - Childless Adults > 100% of the FPL

Other Childless Adults > 100% FPL Capitation Rates							
		Region					
Age Range	Gender	1	2	3	4	5	6
Ages 21 - 34	Female	158.56	164.12	144.10	145.84	170.24	162.51
Ages 21 - 34	Male	97.33	99.85	99.19	105.62	117.47	108.67
Ages 35 -44	Female	200.47	237.55	203.83	198.80	235.78	228.73
Ages 35 -44	Male	146.21	189.46	126.17	162.33	175.33	174.57
Ages 45 & Over	Female	285.92	287.55	247.03	272.39	272.80	300.99
Ages 45 & Over	Male	196.69	303.71	203.56	165.06	233.07	305.55
Composite		181.93	219.25	172.50	173.00	201.18	221.14

Wisconsin Department of Health Services

Exhibit 9

2009 MCE and HMO Capitation Rate Development for SSI Program

2009 Managed Care Equivalents/CAP Development - SSI Program CAP Rates by Rate Cell - Medical Services

No Dental and Chiro CAP rate by Age/Gender and Rate Region

		Med Stat Code 21 - Medicaid Only						**Med Stat Code 21 - Dual Elig**					
		Region						Region					
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
19-29	Male	$ 355.79	$ 392.77	$ 282.97	$ 349.83	$ 412.92	$ 431.19	$ 96.78	$ 72.19	$ 64.05	$ 115.83	$ 121.16	$ 97.83
19-29	Female	528.04	435.65	462.17	421.42	453.82	544.53	142.13	78.20	86.12	148.79	109.34	234.66
30-39	Male	470.96	500.36	384.86	606.18	515.45	498.86	90.52	58.46	50.24	124.85	76.08	223.36
30-39	Female	496.19	478.46	511.47	489.43	658.79	604.71	102.52	117.90	87.57	108.34	169.71	238.31
40-64	Male	635.20	637.04	496.59	607.22	624.49	845.06	104.97	140.61	121.16	124.96	151.83	325.47
40-64	Female	612.28	610.51	578.57	579.21	755.66	949.33	139.47	146.15	118.69	145.73	182.86	393.14
65+	Male	451.06	596.49	251.16	206.23	1,425.60	764.30	171.49	251.70	189.20	136.90	241.50	317.09
65+	Female	704.24	631.30	761.64	497.72	946.65	726.95	210.49	291.27	212.99	184.30	191.80	330.54
Composite CAP		561.26	549.17	493.49	526.47	613.96	753.44	136.50	154.80	126.53	139.75	159.42	318.69

		SSI Related Med Stat Codes - Medicaid Only						**SSI Related Med Stat Codes - Dual Elig**					
		Region						Region					
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
19-29	Male	$ 723.62	$ 630.45	$ 1,144.66	$ 697.72	$ 753.25	$ 609.67	$ 84.00	$ 70.00	$ 42.25	$ 98.18	$ 50.31	$ 187.07
19-29	Female	748.70	353.39	1,193.94	598.46	473.01	578.90	141.64	319.07	161.21	94.68	112.40	218.02
30-39	Male	2,148.55	491.06	766.56	581.15	690.70	486.47	66.45	96.24	111.15	144.29	116.43	215.02
30-39	Female	694.03	1,042.77	551.44	842.93	894.82	736.32	115.26	105.24	122.17	154.46	184.05	181.52
40-64	Male	2,162.23	1,942.23	1,516.69	1,897.87	1,799.36	1,137.39	155.87	159.13	105.46	164.21	137.46	264.37
40-64	Female	1,408.14	1,224.11	1,068.16	1,526.24	1,322.23	1,134.80	153.32	119.39	121.34	149.19	154.29	317.96
65+	Male	826.11	946.23	710.34	385.10	442.81	776.26	147.26	179.19	158.80	150.41	110.98	240.13
65+	Female	776.69	1,026.80	870.06	422.33	437.03	675.35	170.95	180.23	143.15	157.65	121.19	242.52
Composite CAP		1,464.16	1,167.59	1,123.73	1,194.79	1,040.53	895.11	156.53	161.09	134.16	152.93	128.51	257.54

		MAPP - Medicaid Only						**MAPP - Dual Elig**					
		Region						Region					
		1	2	3	4	5	6	1	2	3	4	5	6
Composite CAP		$ 993.82	$ 993.82	$ 993.82	$ 993.82	$ 1,048.48	$ 1,049.25	$ 145.75	$ 145.75	$ 145.75	$ 145.75	$ 153.77	$ 164.19

* Region 6 includes $1.75 External Advocate Rate
* MCE-CAP increase was from DHS

Wisconsin Department of Health Services

Exhibit 9

2009 MCE and HMO Capitation Rate Development for SSI Program

2009 Managed Care Equivalents/CAP Development - SSI Program CAP Rates By Rate Cell - Including Dental, No Chiro

Dental; No Chiro CAP rate by Age/Gender and Rate Region

		Med Stat Code 21 - Medicaid Only						**Med Stat Code 21 - Dual Elig**					
		Region						Region					
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
19-29	Male	$ 364.75	$ 397.23	$ 291.22	$ 355.35	$ 416.51	$ 435.00	$ 105.89	$ 76.81	$ 73.26	$ 120.05	$ 127.06	$ 103.84
19-29	Female	538.55	440.25	474.08	427.26	459.19	552.22	151.36	83.13	96.20	155.41	115.98	241.42
30-39	Male	481.43	504.67	394.96	610.82	520.82	506.39	99.25	64.43	60.23	130.94	80.45	230.87
30-39	Female	509.87	484.67	521.95	499.21	664.96	618.31	114.48	124.64	97.68	116.94	175.08	245.98
40-64	Male	646.15	641.30	506.25	615.00	630.39	852.84	115.44	146.25	129.78	131.20	157.77	334.87
40-64	Female	622.34	617.57	589.73	587.45	763.77	959.78	150.06	153.28	127.36	153.12	189.70	403.69
65+	Male	455.91	598.98	253.61	213.07	1,425.89	773.81	176.24	255.22	193.64	140.68	246.84	326.30
65+	Female	710.68	635.08	767.18	502.87	959.88	738.94	215.20	295.38	217.69	188.79	197.09	338.44
Composite CAP		571.75	554.69	503.82	533.84	620.28	762.38	145.53	160.55	134.56	146.07	165.38	327.63

		SSI Related Med Stat Codes - Medicaid Only						**SSI Related Med Stat Codes - Dual Elig**					
		Region						Region					
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
19-29	Male	$ 732.45	$ 633.97	$ 1,157.78	$ 702.84	$ 756.97	$ 623.65	$ 85.52	$ 75.42	$ 48.62	$ 108.87	$ 54.22	$ 190.55
19-29	Female	755.42	359.19	1,202.54	601.73	478.24	585.05	161.77	326.85	168.07	110.27	163.94	220.44
30-39	Male	2,158.20	496.92	772.96	587.33	694.65	495.98	78.70	109.50	124.98	145.49	127.90	230.74
30-39	Female	702.67	1,052.42	562.47	857.28	900.36	739.51	129.70	119.30	129.16	181.09	191.69	238.60
40-64	Male	2,169.59	1,947.80	1,530.67	1,907.22	1,810.47	1,150.39	161.78	165.30	112.46	168.53	142.86	270.00
40-64	Female	1,418.52	1,231.68	1,075.89	1,532.96	1,329.71	1,143.82	162.29	124.08	134.94	158.60	165.55	327.34
65+	Male	839.33	951.81	720.01	391.31	448.51	787.96	152.20	182.18	162.45	153.54	112.03	251.03
65+	Female	786.93	1,032.22	876.84	426.43	440.91	684.26	176.29	183.12	147.44	160.14	123.68	244.81
Composite CAP		1,473.19	1,173.81	1,133.87	1,201.89	1,047.43	905.36	162.82	165.79	140.43	158.57	134.89	266.70

		MAPP - Medicaid Only						**MAPP - Dual Elig**					
		Region						Region					
		1	2	3	4	5	6	1	2	3	4	5	6
Composite CAP		$ 1,005.36	$ 1,005.36	$ 1,005.36	$ 1,005.36	$ 1,060.65	$ 1,060.79	$ 154.96	$ 154.96	$ 154.96	$ 154.96	$ 163.48	$ 173.77

* Region 6 includes $1.75 External Advocate Rate
* CAP-CAP increase was from DHS

Wisconsin Department of Health Services

Exhibit 9

2009 MCE and HMO Capitation Rate Development for SSI Program

2009 Managed Care Equivalents/CAP Development - SSI Program CAP Rates By Rate Cell - Including Chiro, No Dental

Chiro; No Dental CAP rate by Age/Gender and Rate Region

		Med Stat Code 21 - Medicaid Only						**Med Stat Code 21 - Dual Elig**					
		Region						Region					
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
19-29	Male	$ 358.14	$ 393.62	$ 285.42	$ 350.58	$ 413.27	$ 431.47	$ 97.23	$ 72.39	$ 64.17	$ 116.31	$ 121.23	$ 97.89
19-29	Female	530.37	437.46	464.58	423.01	454.68	544.76	143.80	78.51	87.24	149.16	109.57	234.71
30-39	Male	475.93	502.29	386.41	608.14	516.27	499.10	90.76	58.80	50.68	125.05	76.25	223.46
30-39	Female	503.21	480.68	516.21	492.26	660.94	605.60	103.77	118.36	88.00	108.60	169.88	238.56
40-64	Male	638.04	637.91	499.03	608.79	625.34	845.73	105.38	140.85	121.48	125.21	151.93	325.52
40-64	Female	616.33	613.09	583.69	581.89	757.61	950.60	140.03	146.50	119.27	146.14	183.12	393.25
65+	Male	451.49	596.81	251.16	206.23	1,426.15	764.30	171.77	251.84	189.39	137.33	241.65	317.11
65+	Female	705.56	632.53	762.36	498.32	946.79	731.45	210.69	291.45	213.29	184.52	191.89	330.61
Composite CAP		564.90	550.96	497.06	528.46	615.24	754.26	137.03	155.08	126.96	140.07	159.58	318.78

		SSI Related Med Stat Codes - Medicaid Only						**SSI Related Med Stat Codes - Dual Elig**					
		Region						Region					
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
19-29	Male	$ 725.73	$ 630.64	$ 1,146.23	$ 698.31	$ 753.85	$ 609.67	$ 84.07	$ 70.26	$ 42.63	$ 98.64	$ 50.42	$ 187.09
19-29	Female	752.13	354.35	1,196.63	600.35	473.41	578.90	142.48	319.45	161.62	95.35	113.88	218.04
30-39	Male	2,152.69	493.13	768.69	582.49	692.70	486.96	66.96	96.88	111.97	144.34	116.76	215.12
30-39	Female	698.38	1,045.90	554.84	844.94	896.40	737.87	115.86	105.92	122.59	155.59	184.27	181.90
40-64	Male	2,164.32	1,944.70	1,519.54	1,899.53	1,799.57	1,137.56	156.12	159.43	105.88	164.39	137.62	264.41
40-64	Female	1,411.56	1,227.21	1,071.70	1,529.61	1,323.47	1,135.02	153.69	119.62	122.15	149.59	154.61	318.03
65+	Male	826.11	946.43	711.53	385.10	442.81	776.26	147.47	179.33	159.02	150.55	111.01	240.20
65+	Female	776.75	1,027.23	871.11	422.33	437.03	675.35	171.17	180.37	143.40	157.76	121.26	242.53
Composite CAP		1,466.86	1,169.59	1,126.41	1,196.64	1,041.21	895.30	156.79	161.31	134.54	153.17	128.69	257.59

	MAPP - Medicaid Only						**MAPP - Dual Elig**					
	Region						Region					
	1	2	3	4	5	6	1	2	3	4	5	6
Composite CAP	$ 997.68	$ 997.68	$ 997.68	$ 997.68	$ 1,052.55	$ 1,053.11	$ 146.23	$ 146.23	$ 146.23	$ 146.23	$ 154.27	$ 164.69

* Region 6 includes $1.75 External Advocate Rate

* CAP-CAP increase was from DHS

Wisconsin Department of Health Services

Exhibit 9

2009 MCE and HMO Capitation Rate Development for SSI Program

2009 Managed Care Equivalents/CAP Development - SSI Program CAP Rates By Rate Cell- All Services

All Services CAP rate by Age/Gender and Rate Region

		Med Stat Code 21 - Medicaid Only						Med Stat Code 21 - Dual Elig					
		Region						Region					
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
19-29	Male	$ 367.10	$ 398.09	$ 293.67	$ 356.10	$ 416.86	$ 435.28	$ 106.35	$ 77.01	$ 73.39	$ 120.52	$ 127.13	$ 103.90
19-29	Female	540.87	442.06	476.49	428.85	460.05	552.44	153.03	83.44	97.32	155.78	116.21	241.47
30-39	Male	486.40	506.60	396.50	612.78	521.64	506.63	99.49	64.76	60.67	131.13	80.62	230.97
30-39	Female	516.89	486.89	526.69	502.04	667.12	619.19	115.73	125.10	98.11	117.20	175.25	246.24
40-64	Male	648.99	642.18	508.69	616.57	631.24	853.51	115.86	146.49	130.09	131.44	157.87	334.92
40-64	Female	626.40	620.14	594.85	590.13	765.72	961.05	150.62	153.63	127.94	153.53	189.95	403.79
65+	Male	456.34	599.30	253.61	213.07	1,426.44	773.81	176.52	255.35	193.83	141.11	247.00	326.32
65+	Female	712.00	636.31	767.91	503.47	960.02	743.44	215.40	295.56	217.99	189.01	197.17	338.51
Composite CAP		575.39	556.48	507.39	535.83	621.56	763.20	146.06	160.83	134.99	146.39	165.54	327.72

		SSI Related Med Stat Codes - Medicaid Only						SSI Related Med Stat Codes - Dual Elig					
		Region						Region					
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
19-29	Male	$ 734.55	$ 634.15	$ 1,159.36	$ 703.43	$ 757.57	$ 623.65	$ 85.58	$ 75.68	$ 49.00	$ 109.32	$ 54.33	$ 190.57
19-29	Female	758.84	360.14	1,205.23	603.62	478.63	585.05	162.61	327.23	168.48	110.94	165.43	220.46
30-39	Male	2,162.35	498.99	775.09	588.67	696.64	496.47	79.21	110.14	125.80	145.55	128.23	230.84
30-39	Female	707.02	1,055.55	565.87	859.28	901.94	741.06	130.30	119.98	129.58	182.23	191.91	238.98
40-64	Male	2,171.68	1,950.27	1,533.51	1,908.88	1,810.67	1,150.55	162.02	165.59	112.88	168.71	143.01	270.04
40-64	Female	1,421.95	1,234.78	1,079.43	1,536.33	1,330.94	1,144.03	162.66	124.30	135.76	159.00	165.87	327.41
65+	Male	839.33	952.01	721.20	391.31	448.51	787.96	152.41	182.33	162.67	153.67	112.06	251.10
65+	Female	786.99	1,032.65	877.88	426.43	440.91	684.26	176.51	183.26	147.69	160.25	123.75	244.83
Composite CAP		1,475.89	1,175.80	1,136.55	1,203.74	1,048.11	905.55	163.08	166.01	140.80	158.81	135.07	266.75

	MAPP - Medicaid Only						MAPP - Dual Elig					
	Region						Region					
	1	2	3	4	5	6	1	2	3	4	5	6
Composite CAP	$ 1,009.22	$ 1,009.22	$ 1,009.22	$ 1,009.22	$ 1,064.72	$ 1,064.65	$ 155.44	$ 155.44	$ 155.44	$ 155.44	$ 163.99	$ 174.27

* Region 6 includes $1.75 External Advocate Rate
* CAP-CAP increase was from DHS

All terms and conditions of the February 1, 2008 through December 31, 2009 contract and any prior amendments that are not affected by this amendment shall remain in full force and effect.

HMO Name	**Department of Health Services**
Official Signature	Official Signature
Printed Name	Printed Name Jason Helgerson
Title	Title Medicaid Director Division of Health Care Access and Accountability
Date	Date