Contract for BadgerCare Plus and/or Medicaid SSI

HMO Services

Between

The HMO

and

The Wisconsin Department of Health and Family Services

February 1, 2008 through December 31, 2009

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CONTRACT FOR SERVICES

Between
The Wisconsin Department of Health and Family Services
and
HMO

ARTICLE I

The Wisconsin Department of Health and Family Services (the Department) and the HMO, an insurer with a certificate of authority to do business in Wisconsin, and an organization that makes available to enrolled participants, in consideration of periodic fixed payments, comprehensive health care services provided by providers selected by the organization and who are employees or partners of the organization or who have entered into a referral or contractual arrangement with the organization, for the purpose of providing and paying for BadgerCare Plus and/or Medicaid SSI and SSI-related Medicaid contract services to Members enrolled in the HMO under the State of Wisconsin BadgerCare Plus and/or Medicaid SSI program approved by the Secretary of the United States Department of Health and Human Services pursuant to the provisions of the Social Security Act and for the further specific purpose of promoting coordination and continuity of preventive health services and other medical care including prenatal care, emergency care, and HealthCheck services. The HMO is not required to contract for both programs, and if they are not contracted for both, only the provisions applicable to their program apply. The HMO does herewith agree:

I. DEFINITIONS

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

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

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

All In-Opt Out: The enrollment method for Medicaid SSI that allows enrollees to disenroll from the HMO and return to FFS following a 60 day trial of Managed Care enrollees identified as mandatory by Wisconsin's State Plan Amendment.

Appeal: A request for review of an action.

Assessment: An encounter where an appropriately qualified health care professional evaluates an enrollee's special health care needs using evaluation, examination or diagnostic tools, review of past medical history, records such as laboratory reports, patient interview, to adequately address the enrollee's health care and/or cultural needs in a multi-disciplinary treatment plan, plan of care or approach to delivery of care. The evaluation must include an encounter of care, not merely a telephone contact. Comprehensive physical examination is not required, unless it is necessary to fully assess the enrollee's health care needs. For the purposes of an assessment, qualified health care professional may include non-physician providers such as a psychologist for an enrollee with an identified mental health care need, or advanced practice nurse, physician assistant, registered nurse or social worker, where physician intervention is not required.

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

- All children (birth to age 19) with incomes above 185 percent of the federal poverty level (FPL).
- Pregnant women with incomes between 185 and 300 percent of the FPL.
- Parents and caretaker relatives with incomes between 185 and 200 percent of the FPL.
- Caretaker relatives with incomes between 44 and 200 percent of the FPL.
- Parents with children in foster care with incomes up to 200 percent of the FPL.
- Youth (ages 18 through 20) aging out of foster care.
- Farmers and other self-employed parents with incomes up to 200 percent of the FPL, contingent on depreciation calculations.

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

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

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

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

- Provided by a care coordinator for each enrollee, and

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

Care Coordination Includes:

Care Plan: As defined in this Article.

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

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

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

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

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

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

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

CFR: Code of Federal Regulations.

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

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

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

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

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

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

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

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

Continuing Care Provider: A provider who has an agreement with the BadgerCare Plus and/or Medicaid SSI program to provide:

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

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

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

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

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

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

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

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

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

Department: The Wisconsin Department of Health and Family Services.

Department Values: The Department's shared values include:

- An emphasis on a family centered approach.
- Enrollee involvement throughout the process.
- Building resources on natural and community supports.
- A strength based approach.
- Providing unconditional care.

- Collaborating across systems.
- Using a team approach across agencies.
- Being gender, age and culturally responsive.
- Promoting a self-sufficiency focus on education and employment where appropriate.
- A belief in growth, learning and recovery.
- Being oriented to outcomes.

Emergency Medical Condition:

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

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

   2. Serious impairment of bodily functions, or

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

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

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

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

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

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

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

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

Encounter:

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

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

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

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

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

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

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

Enrollee, Member, Participant and Consumer: 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 every month according to an established notification schedule. Children who are reported to the certifying agency within 100 days of birth shall be enrolled in the HMO their mother is enrolled in from their date of birth if the mother was an enrollee on the date of birth. Children who are reported to the certifying agency after the 100th day, but before their first birthday are eligible for BadgerCare Plus on a fee-for-service (FFS) basis.

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

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

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

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

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

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

HHS: The federal Department of Health and Human Services.

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

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

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

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

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

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

Mandatory: For the purpose of this contract mandatory refers to a service area where there are two or more HMOs available to the enrollee.

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

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

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

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

Newborn: An enrollee less than 100 days old.

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

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, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI), which is a subset of IIHI.

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

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

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

Member: Any individual entitled to benefits under Title XIX and XXI of the Social Security Act, and under the Medicaid State Plan as defined in Wis. Stats., Chapter 49.

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

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

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

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

State: The State of Wisconsin.

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

Trading Partner: Refers to a provider or HMO that transmits any health information in electronic form in connection with a transaction covered by 45 CFR

Parts 160 and 162, or a business associate authorized to submit health information on the Trading Partner's behalf.

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

Voluntary: As it relates to this contract is where there is a choice of only one HMO available to an enrollee.

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

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

ARTICLE II

II. DELEGATIONS OF AUTHORITY

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

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

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

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

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

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

ARTICLE III

III. FUNCTIONS AND DUTIES OF THE HMO

A. Statutory Requirement

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

B. Compliance with Applicable Law

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

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

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

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

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

C. Organizational Responsibilities and Duties

1. Ineligible Organizations

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

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

1) Been convicted of the following crimes:

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

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

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

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

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

2) Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person

described in C, 1, a, above from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

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

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

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

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

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

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

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

2. Contract Representative

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

3. Attestation

The HMO's Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or designee must attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department at the time of submission. This includes encounter data, AIDS/Vent, and any other data regarding claims the HMO paid. The encounter data form should be submitted to the Bureau of Benefits Management quarterly.

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

The AA/CRC Plan contains three components: Affirmative Action, Civil Rights/Equal Opportunity, and Language Access. The HMO that has more than 25 employees and receives more than $25,000 must submit an Affirmative Action, Equal Opportunity, Civil Rights Compliance Plan and Language Access Plan. The HMO that has less than 25 employees and receives less than $25,000 must submit a Letter of Assurance and proof it is exempt from submitting Affirmative Action information in accordance with Wis. Stats., s.16.675, and Adm. Code 50. The HMO must submit language access information as part of the HMO certification application.

a. Affirmative Action Plan

1) For agreements where the HMO has 25 employees or more and will receive $25,000 or more, the HMO shall complete the AA, CRC and Language Access sections of the plan that may cover a two or three year period. The HMO with an annual work force of less than 25 employees or less than $25,000 may be exempt from submitting the AA component of the plan.

a) Exemptions from submitting AA Component requirements will be granted if:

(1) The HMO receives a State contract for less than $25,000;

(2) The HMO has less than 25 employees regardless of the dollar amount of the Contract;

(3) The HMO is a foreign company with a workforce of less than 25 employees in the U.S.;

(4) The HMO is a federal government agency or a Wisconsin municipality; and

(5) The HMO has a balanced workforce.

If the HMO is exempt from submitting an AA component because it has a balanced work force, the HMO must submit its "Work Force Analysis Form, a Request for Exemption from Submitting AA Component."

If the HMO is exempt from submitting an AA component for other reasons, the HMO must submit a "Request for Exemption from Submitting an AA Component." Exempt the HMO if it does not have a balanced work force in specific job groups that are required to develop and submit a recruitment strategy to address under-representation of that job group.

2) A component is written in detail and explains the HMO's program. The AA component must be prepared in accordance to the most recently revised AA, Equal Opportunity, CRC and Language Access Plan Instruction and Manual for the funding period covering January 1, 2007 to December 31, 2009.

3) In addition, for agreements of $25,000 or more and with 25 employees, the HMO shall conduct, keep on file, and update annually, a separate and additional accessibility self-evaluation of all programs and facilities, including employment practices for compliance with the Americans with Disabilities (ADA) Title I regulations, unless an updated self-evaluation under Section 503 of the Rehabilitation Act of 1973 exists that meets the ADA requirements. For technical assistance on all aspects of the Civil Rights Compliance, the HMO is to contact the Department's AA/CRC Office at:

The Department of Health and Family Services

1 W. Wilson Street, Room 555
P.O. Box 7850
Madison, WI 53707-7850
(608) 266-9472 (voice)
(888) 701-1251 TTY

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

The Department of Health and Family Services
Office of Affirmative Action and Civil Rights Compliance
P.O. Box 7850
Madison, WI 53707-7850

a) Civil Rights Compliance (CRC) Plan

(1) For agreements for the provision of services to enrollees, the HMO must comply with Civil Rights requirements. The HMO with an annual work force of less than 25 employees or receiving less than $25,000 is not required to submit a CRC plan, but must, at a minimum, submit a Letter of Assurance that the HMO will comply with all federal and state laws that address nondiscrimination in service delivery.

b) The HMO must submit to the Department's AA/CRC Office proof that it has complied with all the requirements in the revised AA, Equal Opportunity, CRC and Language Access Plan Instructions and Manual for Profit and Non-Profit Entities for meeting equal opportunity requirements under Title VI and VII of the Civil Rights Act of 1964; Sections 503 and 504 of the Rehabilitation Act of 1973; Title VI and XVI of the Public Health Service Act; the Age Discrimination Employment Act of 1967, the Age Discrimination Act of 1975, the Omnibus Reconciliation Act of 1981; the Americans with Disabilities Act of 1990; and the Wisconsin Fair Employment Act. If a plan was submitted and approved during the previous year, a plan update must be submitted for this Contract period.

(1) No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, or disability of age. This policy covers enrollment for and access to service delivery, and treatment in all programs and activities. All employees of the HMO are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

(2) No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race/ethnicity, color, sex, or sexual orientation, national origin or ancestry, disability (as defined in Section 504 of the Rehab Act, ADA), arrest or conviction record, marital status, political affiliation, military service, the use of legal products during non-work hours, non-job related genetic and honesty testing. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

(3) The HMO must post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and clients of services, and applicants for employment and employees. The complaint process will be according to Department standards as outlined in the AA/CRC Plan and made available in languages and formats understood by enrollees, applicants and employees. The Department will continue to provide appropriate translated program brochures and forms for distribution.

(4) The HMO agrees to comply with all of the requirements in the revised Department AA/CRC Plan for Profit and Non-Profit

Entities and their subcontractors during this Contract period.

(5) These requirements apply to any subcontracts or grants. The HMO has responsibility for ensuring that its subcontractors or sub-grantees also comply with all of the requirements of the plan.

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

(7) The HMO agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

5. Non-Discrimination in Employment

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

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

With respect to provider participation, reimbursement, or indemnification, the HMO will not discriminate against any provider who is acting with the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This shall not be construed to prohibit an HMO from including providers to the extent necessary to meet the needs of the BadgerCare Plus and/or Medicaid SSI population or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities.

6. Provision of Services to the HMO Enrollees

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

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

7. Access to Premises

The HMO must allow duly authorized agents or representatives of the state or federal government access to the HMO's or HMO subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the HMO's or subcontractor's contractual activities and shall produce all records requested as part of such review or audit within a reasonable time, but not more than 10 business days. Upon request for such right of access, the HMO or subcontractor must provide staff to assist in the audit or inspection effort, and adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits must be conducted in a manner as will not unduly interfere with the performance of HMO's or subcontractor's activities.

The HMO will have 30 business days to respond to any findings of an audit before the Department finalizes it. All information obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

8. Liability for the Provision of Care

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

9. Subcontracts

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

10. Coordination with Community-Based Health Organizations, Local Health Departments, Bureau of Milwaukee Child Welfare, Prenatal Care Coordination Agencies, School-Based Services Providers and Targeted Case Management Agencies

a. Community-Based Health Organizations

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

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

b. Local Health Departments

The Department encourages the HMO to contract with local health departments for the provision of care to BadgerCare Plus and/or Medicaid SSI enrollees in order to ensure continuity and culturally appropriate care and services. Local health departments can provide HealthCheck outreach and screening, immunizations,

blood lead screening services, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases (e.g., tuberculosis, HIV/AIDS, sexually transmitted diseases, hepatitis and others). WIC projects provide nutrition services and supplemental foods, breast feeding promotion and support; and immunization screening. Many projects screen for blood lead poisoning during the WIC appointment.

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

c. A Milwaukee County HMO must designate at least one individual to serve as a contact person for the Bureau of Milwaukee Child Welfare (BMCW). If the HMO chooses to designate more than one contact person the HMO should identify the service area for which each contract person is responsible. The HMO must provide all BadgerCare Plus and/or Medicaid SSI covered mental health and substance abuse services to individuals identified as clients of BMCW. Disputes regarding the medical necessity of services identified in the Family Treatment Plan will be adjudicated using the dispute process, except that the HMO must provide court-ordered services.

d. Prenatal Care Coordination (PNCC) Agencies

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

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

e. School-Based Services (SBS) Providers

The HMO must use its best effort to sign a MOU with all SBS providers in the HMO service area to ensure continuity of care and to avoid duplication of services. School based services are paid FFS when provided by a BadgerCare Plus certified SBS provider. However, in situations where an enrollee's course of treatment is interrupted due to school breaks, after school hours or during the summer months, the HMO is responsible for providing and paying for all BadgerCare Plus covered services.

f. Targeted Case Management (TCM) Agencies

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

11. Clinical Laboratory Improvement Amendments (CLIA)

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

D. Payment Requirements/Procedures

The HMO is responsible for the payment of all contract services provided to all BadgerCare Plus and/or Medicaid SSI members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage. The HMO is also responsible for the provision, or authorizing the provision of, services to all enrollees with valid Forward cards indicating HMO enrollment, without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the enrollment reports must be reported to the Department for resolution. The HMO must continue to provide and authorize provision of all contract services until the discrepancy is resolved, including members who were PENDING on the Initial Report and held a valid Forward card indicating HMO enrollment, but did not appear as a CONTINUE on the Final Report. The payment for services to all newborns meeting the criteria described in the section "Capitation Payment for Newborns."

1. Claims Retrieval

The HMO must maintain a claim retrieval system that can upon request identify date of receipt, action taken on all provider claims (i.e., paid, denied, other), and when action was taken. The HMO must have procedures in place that will show the date a claim was received whether the claim is a paper copy or an electronic submission. In addition, the HMO must maintain a claim retrieval system that can identify, within the individual claim, the services provided and the diagnoses of the enrollees using nationally accepted coding systems: HCPCS including Level I CPT codes and Level II and Level III HCPCS codes with modifiers,

ICD-9-CM diagnosis and procedure codes, and other national code sets such as place of service, type of service, and EOB codes. Finally, the claim retrieval system must be capable of identifying the provider of services by the appropriate BadgerCare Plus and/or Medicaid SSI provider ID number and/or National Provider Identifier (NPI), if applicable, assigned to all in-plan providers.

2. Thirty Day Payment Requirement

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

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

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

4. Payment of HMO Referrals to Non-Affiliated Providers

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

5. Health Professional Shortage Area (HPSA) Payment Provision

The following provision refers to payments made by the HMO. HMO covered primary care and emergency care services provided to a member living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA must be paid at an enhanced rate of 20% above the rate the HMO would otherwise pay for those services. Specified HMO-covered obstetric or gynecological services (see Wisconsin Health Care Programs Online Handbooks) provided to a member living in a HPSA or by a provider practicing in a HPSA must be paid at an enhanced rate of 25% above the rate the HMO would otherwise pay providers in HPSAs for those services.

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

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

If an HMO contracts with a BadgerCare Plus and/or Medicaid SSI certified FQHC or RHC for the provision of services to its enrollees, the HMO must negotiate payment rate for that FQHC or RHC on the same basis it negotiates with other clinics and primary providers. An HMO that contracts with an FQHC or RHC must annually submit to the Department a signed Attestation form (Addendum IV, I).

7. Immunization Program

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

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

8. Transplants

Transplant coverage is as follows:

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

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

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

Enrollees who have had one or more of the transplant surgeries referenced in 9, b, above will be permanently exempted from HMO enrollment.

9. Hospitalization at the Time of Enrollment or Disenrollment

The HMO will not assume financial responsibility for enrollees who are hospitalized at the time of enrollment (effective date of coverage) until an appropriate hospital discharge. The Department is responsible for paying on a FFS basis all BadgerCare Plus and/or Medicaid SSI covered services for such hospitalized enrollees during hospitalization.

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

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

a) Loss of BadgerCare Plus or Medicaid SSI enrollment occurs.

b) Disenrollment occurs because there is a voluntary disenrollment from the HMO as a result of one of the conditions in Article III, F in which case the HMO's liability shall terminate upon disenrollment being effective.

c) Disenrollment is due to a medical status change in code which includes:

- SSI for BadgerCare Plus members only.
- 503 case (503 cases are SSI cases that continue Medicaid SSI eligibility when Social Security cost of living increases cause an SSI member to lose SSI enrollment).
- Institutionalized enrollment.

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

10. Enrollees Living in a Public Institution

The HMO is liable for the cost of providing all medically necessary services to enrollees who are living in a public institution during the month in which they first enter the public institution. Enrollees who remain in a public institution after the last day of the month are no longer eligible for BadgerCare Plus or Medicaid SSI and the HMO is not liable for providing care after the end of the first month.

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

E. Covered BadgerCare Plus and/or Medicaid SSI Services

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

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

1. Provision of Contract Services

The HMO must promptly provide or arrange for the provision of all services required under Wis. Stats., s. 49.46(2), and Wis. Adm. Code HFS 107 as further clarified in all Wisconsin Health Care Programs Online Handbook and HMO Contract Interpretation Bulletins, and as otherwise specified in this Contract except:

a. Common Carrier Transportation.

b. Dental, unless provided by the HMO.

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

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

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

f. Milwaukee Childcare Coordination (BadgerCare Plus Only).

g. Tuberculosis-related Services.

h. Crisis Intervention Benefit.

i. Community Support Program (CSP) services.

j. Comprehensive Community Services (CCS).

k. Pharmacy Coverage

2. Medical Necessity

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

3. Physician Services

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

4. Pre-Existing Medical Conditions

The HMO must assume responsibility for all covered pre-existing medical conditions of each enrollee as of the effective date of coverage under the

Contract. The aforementioned responsibility does not apply in the case of persons hospitalized at the time of initial enrollment.

5. Ambulance Services

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

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

b. Pay for emergency ambulance services based on established BadgerCare Plus and/or Medicaid SSI criteria for claims payment of these services.

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

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

6. Chiropractic Services

The HMO must cover chiropractic services, or in the alternative, enter into a subcontract for chiropractic services with the State. State law mandates coverage.

7. Common Carrier Transportation

a. BadgerCare Plus – Standard Plan and Medicaid SSI

1) Enrollees Outside of Milwaukee County

The HMO must arrange for transportation for HealthCheck screenings. When authorized by the Department, the HMO may provide non-emergency transportation by common carrier or private motor vehicle for these visits and be reimbursed by the county.

The HMO may negotiate arrangements with local county Department of Health and Social Services for common carrier or private vehicle transportation for HMO services in general and not just for HealthCheck screenings.

2) Enrollees in Milwaukee County

The HMO must provide or arrange for common carrier transportation in accordance with the BadgerCare Plus and/or Medicaid SSI transportation guidelines included in the Medicaid Enrollment Handbook (online at www.emhandbooks.wi.gov/meh/). Common carrier transportation includes, but is not limited to, taxi, van, or bus as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus and/or Medicaid SSI covered services, including those not covered by the HMO such as chiropractic and family planning services. Common carrier transportation also includes coverage of meals and lodging in accordance with the Medicaid Enrollment Handbook.

The HMO must submit a detailed report on CD ROM in an Excel file. The report must be submitted to the HMO's Department Managed Care Analyst on a quarterly basis as specified in Article VII and include all the data elements specified in Addendum IV. If the HMO is contracted to serve BadgerCare Plus and/or Medicaid SSI enrollees the reports must be submitted separately.

b. BadgerCare Plus – Benchmark Plan

1) Common carrier transportation is not a covered service under the Benchmark Plan.

8. Dental Services

a. Dental Services Covered by all HMOs

1) Emergency Dental Care

The HMO must cover emergency dental care. The only exception is the dentist's or oral surgeon's direct charges.

2) Dental Surgeries Performed in a Hospital

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

charges. The only exception is the dentist's or oral surgeon's direct charges. If the HMO is unable to arrange for the dental surgery to be performed within their own provider network then the HMO must authorize the service(s) to be performed out of plan.

3) Prescription Drugs Prescribed by a Dental Provider

Fee-for-Service is liable for the cost of all medically necessary prescription drugs when ordered by a certified BadgerCare Plus and/or Medicaid SSI dental provider.

b. Dental Services Covered by HMO Contracted to Provide Dental Care

1) BadgerCare Plus – Standard Plan and Medicaid SSI

a) 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.

b) 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.

c) 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.

2) BadgerCare Plus – Benchmark Plan

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

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

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

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

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

9. Emergency and Post-Stabilization Services

a. 24-Hour Coverage

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

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

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

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

3) Notify the Department of any changes to this toll-free telephone number for emergency calls within seven business days of the change.

b. Provision/Payment Requirements

The HMO must promptly provide or pay for needed contract services for emergency medical conditions and post-stabilization services, regardless of whether the provider that furnishes the service has a contract with the entity. Nothing in this requirement mandates the HMO to reimburse for non-authorized post-stabilization services. Payment and liability requirements include but are not limited to:

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

2) Paying for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.

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

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

(2) Specific subcontract agreements.

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

The HMO may have a contract or an MOU with hospitals or urgent care centers within the HMO's service area to ensure prompt and appropriate payment for emergency services. Unless a contract or MOU specifies otherwise, the HMO is liable to the extent that FFS would have been liable for a situation that meets the definition of emergency. The Department reserves the right to resolve disputes between the HMO, hospitals and urgent care centers regarding emergency situations based on the emergency

definition. For situations where a contract or MOU is not possible, the HMO must identify for hospitals and urgent care centers procedures that ensure prompt and appropriate payment for emergency services.

10. Family Planning Services and Confidentiality of Family Planning Information

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

    b. The enrollee may choose to receive family planning services at any BadgerCare Plus certified family planning clinic. Family planning services provided at BadgerCare Plus certified family planning clinics are paid FFS for HMO enrollees including pharmacy items ordered by the family planning provider.

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

11. Fertility Drugs

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

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

The HMO must provide BadgerCare Plus and/or Medicaid SSI covered services, but the HMO is not restricted to providing only those services. The HMO may provide additional or alternative treatments if the other treatment modalities are more appropriate and result in better outcomes than BadgerCare Plus and/or Medicaid SSI covered services. 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.

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

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

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

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

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

Regardless of whether a. or b., above, is chosen, such treatment facilities and/or providers must provide arrangements for covered transitional treatment in addition to other outpatient mental health and/or substance abuse services. Such transitional treatment arrangements may include but are not limited to adult mental health day treatment, child/adolescent day treatment and substance abuse day treatment.

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

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

Under the 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.

Information on mental health and substance abuse covered services under the BadgerCare Plus – Benchmark Plan can be found in Addendum V.

2. Mental Health/Substance Abuse Assessment Requirements

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

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

3. Assurance of Expertise for Child Abuse, Child Neglect and Domestic Violence (BadgerCare Plus Only)

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

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

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

4. Court-Related Children's Services (BadgerCare Plus Only)

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

5. Court-Related Substance Abuse Services

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

6. Crisis Intervention Benefit

The HMO must assign a medical representative to coordinate with the designees of crisis intervention agencies certified under Wis. Adm. Code HFS 34 to provide services within the HMO's service area. The HMO must work with the certified Crisis Intervention Agency to coordinate the transition from crisis intervention care to ongoing BadgerCare Plus and/or Medicaid SSI covered mental health and substance abuse care within the HMO's network. The HMO is not responsible for payment for services provided to their enrollees by certified Crisis Intervention Agencies. Those services are to be billed directly to FFS. In addition, the HMO is not required to pay for services directed by the certified Crisis

Intervention Agency outside the HMO network, unless the HMO has authorized those services.

7. Emergency Detention and Court-Related Mental Health Services

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

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

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

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

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

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

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

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

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

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

8. Institutionalized Individuals

a. Institutionalized Children

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

b. Institutionalized Adults

The HMO is not liable for expenditures for any service to a person 21 to 64 years of age who is a resident of an institution for mental disease (IMD), except to the extent that expenditures for a service to an individual on convalescent leave from an IMD are reimbursed by FFS.

9. Transportation Following Emergency Detention

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

10. Mental Health and/or Substance Abuse Exemptions (BadgerCare Plus Only)

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

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

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

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

MOUs must be signed every two years as part of certification. If no changes have occurred then both the county and the HMO must sign off that no changes have occurred and documentation must be submitted to the Bureau of Benefits Management to this effect.

G. Provider Appeals

All BadgerCare Plus and Medicaid SSI providers must appeal first to the HMO and then to the Department if they disagree with the HMO's payment or nonpayment of a claim. The HMO must respond to the appeal within 45 days.

1. The HMO must inform providers in writing of the HMO's decision to pay or deny the original claim.

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

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

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

    d. An explanation of the process the provider should follow when appealing the HMO's decision.

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

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

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

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

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

    e. A statement advising the provider of the provider's right to appeal to the Department if the HMO fails to respond to the appeal within 45 days or if the provider is not satisfied with the HMO's response to the request for reconsideration. Appeals to the Department must be submitted in writing within 60 days of the HMO's final decision or, in the case of no response, within 60 days from the 45 day timeline allotted the HMO to respond. Appeals should be sent to:

        BadgerCare Plus and Medicaid SSI
        Managed Care Unit
        P.O. Box 6470
        Madison, WI 53716-0470

2. The HMO must accept written appeals from providers submitted within 60 days of the HMO's initial payment and/or nonpayment notice. The

HMO must respond in writing within 45 days from the date of receipt of the request for reconsideration. If the HMO fails to respond within 45 days, or if the provider is not satisfied with the HMO's response, the provider may seek a final determination from the Department.

3. After a provider has appealed to the HMO according to the terms described in Subsection 1 above and the provider disputes the determination, the provider may appeal to the Department for the final determination. Appeals must be submitted to the Department within 60 days of the date of written notification of the HMO's final decision resulting from a request for reconsideration or, if the HMO fails to respond, within 60 days from the 45 day timeline allotted the HMO to respond. In exceptional cases, the Department may override the HMO's time limit for the submission of claims and appeals. The Department will not exercise its authority in this regard unreasonably. The Department will accept written comments from all parties to the dispute prior to making a final decision. The Department has 45 days from the date of receipt of all written comments to inform the provider and the HMO of the final decision. If the Department's decision is in favor of the provider, the HMO will pay provider(s) within 45 days of receipt of the Department's final determination. The HMO must accept the Department's determinations regarding appeals of disputed claims.

H. Provider Network and Access Requirements

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

1. Use of BadgerCare Plus and/or Medicaid SSI Certified Providers

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

2. Protocols/Standards to Ensure Access

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

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

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

3. Written Standards for Accessibility of Care

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

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

The HMO must take corrective action if its standards are not met.

4. Access to Selected BadgerCare Plus and/or Medicaid SSI Providers and/or Covered Services

a. Dental Providers

The HMO that covers dental services must have a dental provider within a 35-mile distance from any enrollee residing in the HMO service area or no further than the distance for non-enrolled members residing in the service area. If there is no certified provider within the specified distance, the travel distance shall be no more than for a non-enrolled member. The HMO must also consider whether the dentist accepts new patients, and whether full or part-time coverage is available.

b. Mental Health or Substance Abuse Providers

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

c. High Risk Prenatal Care Services (BadgerCare Plus Only)

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

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

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

e. Primary Care Providers

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

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

This access standard does not prevent a member from choosing an HMO when the member resides in a zip code that does not meet the 20-mile distance standard. However, the member will not be automatically assigned to that HMO. If the member has been assigned to the HMO or has chosen the HMO and becomes

dissatisfied with the access to medical care, the member may disenroll from the HMO because of distance.

f. Second Medical Opinions

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

g. Women's Health Specialists

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

5. Network Adequacy Requirements

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

a. The anticipated BadgerCare Plus and/or Medicaid SSI enrollment.

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

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

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

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

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

I. Responsibilities to Enrollees

1. Advocate Requirements

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

a. Functions of the BadgerCare Plus and/or Medicaid SSI HMO Advocate(s)

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

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

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

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

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

6) Participate in the Department's advocacy program for Managed Care. Such participation includes working with DHCAA Managed Care staff assigned to the HMO on

issues of access to medical care, quality of medical care, and working with the enrollment specialist, ombudsmen, and the Department's approved external advocate on issues of access to medical care, quality of medical care, and enrollment and disenrollment.

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

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

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

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

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

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

b. Staff Requirements and Authority of the BadgerCare Plus and/or Medicaid SSI HMO Advocate

At a minimum, the HMO must have one HMO Advocate for BadgerCare Plus and one for Medicaid SSI depending on HMO certification. The advocate(s) must be located in the organizational structure so that they have the authority to perform the functions and duties listed in Section 1, a, 1)-12) above.

The HMO certification application requires the HMO to state the staffing levels to perform the functions and duties listed in Subsection 1, a, 1)-12) above in terms of number of full and part time staff and total full time equivalents (FTEs) assigned to these

tasks. The Department assumes that an HMO acting as an Administrative Service Organization (ASO) for another HMO will have at least one advocate or FTE position for each ASO contract as well as maintain their own internal advocate(s). The HMO may employ less than a FTE advocate position, but must justify to the satisfaction of the Department why less than one FTE position will suffice for the HMO's enrollee population. The HMO must also regularly evaluate the advocate position, work plan(s), and job duties and allocate an additional FTE advocate position or positions to meet the duties listed in Subsection 1, a, 1)-12) above if there is significant increase in the HMO's enrollee population or in the HMO service area. The Department reserves the right to require the HMO to employ an FTE advocate position if the HMO does not demonstrate the adequacy of a part-time advocate position.

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

The Medicaid SSI advocate must be knowledgeable and have experience working with disabled persons and shall have adequate time to advocate for the target Medicaid SSI populations.

2. Advance Directives

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

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

1) The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right

to accept or refuse medical or surgical treatment and the right to formulate advance directives; and

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

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

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

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

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

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

3. Choice of Health Care Professional

The HMO must offer each enrollee covered under this Contract the opportunity to choose a primary health care professional affiliated with the HMO, to the extent possible and appropriate. If the HMO assigns members to primary care providers, then the HMO must notify members of the assignment. The HMO must permit enrollees to change primary providers at least twice in any year, and to change primary providers more often than that for just cause, just cause being defined as lack of access to quality, culturally appropriate, health care. Such just cause will be handled as a formal grievance. If the HMO has reason to lock in an enrollee to one primary provider in cases of difficult case management, the HMO must submit a written request in advance of such lock-in to the Department's Bureau of Fiscal Management. Culturally appropriate care in this section means care by a provider who can relate to the enrollee and who can provide care with sensitivity, understanding, and respect for the enrollee's culture.

4. Coordination and Continuation of Care

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

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

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

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

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

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

f. Specific Requirements for Medicaid SSI Only:

The HMO must ensure that the care of new enrollees is not disrupted or interrupted. The HMO must ensure continuity of care for new enrollees receiving health care under FFS prior to their enrollment in the HMO. The HMO must:

1) Authorize coverage of services with the enrollee's current providers for the first 60 days of enrollment or until the first of the month following completion of the initial assessment and care plan, whichever is later.

a) Mandatory Medicaid SSI

After the first 60 days, the enrollee may choose disenrollment or may change to a different HMO if s/he is not satisfied with provider offered by the HMO. The Enrollment Specialist will obtain provider information from new enrollees whenever possible and share the information with the assigned HMO. Exceptions to the 60 day requirement will be allowed in situations where the HMO can document a history of quality concerns with the provider.

b) Voluntary Medicaid SSI

If the care plan is not completed within the first 90 days after enrollment, the enrollee must be given at least 30 days from the development of the care plan to decide whether to opt out of the HMO. The HMO will be provided with a comprehensive list of the existing FFS providers for each enrollee via the predictive model, to enable recruitment of those providers into the managed care provider network. Any HIPAA issues that arise during this process must be addressed. The Enrollment Specialist will obtain provider information from new enrollees whenever possible and share that information with the HMO.

(1) The first 60 days will allow the HMO to contact existing providers and to conduct the assessment. If the care plan is not completed within the first 90 days after enrollment, the enrollee has 30 days following notification of the care plan to disenroll.

2) Honor FFS authorizations for therapies and personal care at the level authorized by FFS for 60 days or until the first of the month following completion of the initial assessment and care plan, whichever is later. Exceptions to the 60 day requirement will be allowed in situations where the enrollee agrees to change providers, the enrollee agrees to a lower level of care, or if the HMO can document that continuing the care would result in abuse, safety or quality concerns. This does not extend authorizations beyond the time or visits approved under FFS.

3) The HMO must have a detailed automated system for collecting all information on enrollee contacts by care coordinators, case managers, and any other staff that has a direct impact on the enrollee's access to services.

4) The HMO shall assist members who wish to receive care through another HMO or return to the FFS system by making appropriate referrals and by assisting in the transfer of medical records to new providers.

5. Conversion Privileges

The HMO must offer any enrollee covered under this Contract, whose enrollment is subsequently terminated due to loss of BadgerCare Plus and/or Medicaid SSI eligibility, the opportunity to convert to private

insurance without underwriting. The time period for conversion following BadgerCare Plus and/or Medicaid SSI termination notice must comply with Wis. Stats. 632.897 regarding conversion rights.

6. Cultural Competency

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

(1) Recognizing members' beliefs,

(2) Addressing cultural differences in a competent manner, and

(3) Fostering in its staff and providers behaviors that effectively address interpersonal communication styles that respect enrollees' cultural backgrounds.

The HMO must have specific policy statements on these topics and communicate them to subcontractors.

The HMO must encourage and foster cultural competency among providers. When appropriate the HMO must permit enrollees to choose providers from among the HMO's network based on linguistic/cultural needs. The HMO must permit enrollees to change primary providers based on the provider's ability to provide services in a culturally competent manner. Enrollees may submit grievances to the HMO and/or the Department regarding their inability to obtain culturally appropriate care, and the Department may, pursuant to such a grievance, permit an enrollee to disenroll from that HMO and enroll into another HMO, or into FFS in a county where HMOs do not enroll all eligibles.

7. Enrollee Handbook, Education and Outreach for Newly Enrolled Members

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

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

2) Information on contract services offered by the HMO.

3) Location of facilities.

4) Hours of service.

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

6) Grievance appeal procedures.

7) HealthCheck.

8) Family planning policies.

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

10) Providers and whether the provider is accepting new "enrollees."

11) Changing HMOs.

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

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

d. 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 in at least: Spanish, Russian, and Hmong if the HMO has enrollees who are conversant only in those languages. The handbook must tell enrollees how to obtain a copy of the handbook in those languages. The Department will translate the standard handbook language into the three specified languages. The HMO may use the translated standard handbook language as appropriate to its service area. However, the HMO must have local resources review the final handbook language to ensure that the appropriate dialect(s) is/are used in the standard translation. The HMO must also arrange for translation into any other dialects appropriate for its enrollees.

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

f. The HMO must submit their enrollee handbook for review and approval within 60 days of signing the Contract for 2008-2009.

g. Standard language on several subjects, including HealthCheck, family planning, grievance and appeal rights, conversion rights,

and emergency and urgent care, must appear in all handbooks. Any exceptions to the standard must be approved in advance by the Department, and will be approved only for exceptional reasons. If the standard language changes during the course of the Contract period, due to changes in federal or state laws, rules or regulations, the HMO must insert the new language into the enrollee handbooks as of the effective date of any such change.

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

8. Health Education and Disease Prevention

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

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

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

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

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

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

reasonable efforts to locate and use culturally appropriate health-related material.

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

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

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

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

h. Systematic referrals of potentially eligible women, infants, and children to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and relevant medical information to the WIC program. More information about the WIC program as well a list of the local WIC agencies can be found on the WIC website (www.dhfs.state.wi.us/wic).

9. HMO Care Management Services (Medicaid SSI Only)

a. Care Management Model

The HMO will provide Medicaid SSI care coordination and case management services according to the definition of care coordination. As part of this model, the HMO will employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a person. Upon the effective date of this contract, the HMO will implement its guidelines for Medicaid SSI care

management that must have received prior Department approval. The HMO must receive Department approval for any subsequent changes to the guidelines prior to the implementation of such changes.

b. Care Management

The care coordinators and case managers will work together with the primary care providers as teams to provide appropriate services for HMO enrollees. At a minimum, the following must be provided for each enrollee:

1) A comprehensive assessment for each enrollee. Comprehensive assessment guidelines must be pre-approved by the Department. Departmental approval of subsequent changes is required before they are implemented by the HMO. The guidelines include the development of a care plan. The care plan must include both appropriate medical and social services and be consistent with the primary care provider's clinical treatment plan and medical diagnoses, be member-centric, reflect the principles of recovery, and be culturally sensitive. The assessment process shall incorporate, to the greatest extent possible, the enrollee's unique perspective and own words about how he/she views his/her recovery, experience, challenges, strengths, resources, and needs in each of the domains included in the assessment process.

2) The assessment shall be comprehensive and consistent with the following:

- Be based upon known facts and recent information and evaluations and include assessment for co-existing mental health disorders, substance use disorders, physical or mental impairments and medical problems.
- Be updated as new information becomes available.
- Address the strengths, needs, recovery goals, priorities, preferences, values and lifestyle described by the enrollee.
- Address age and developmental factors that influence appropriate outcomes, goals, and methods for addressing them where applicable.

- Identify the cultural and environmental supports as they affect identified goals and desired outcomes and preferred methods for achieving the identified goals.

- Identify the enrollee's recovery goals and understanding of options for treatment.

- The assessment process shall address all of the following:

    a) Diagnosis and health related services.
    b) Mental health and substance use.
    c) Demographic information (including ethnicity, education, living situation/housing, legal status).
    d) Activities of daily living (including bathing, dressing, and eating).
    e) Instrumental activities of daily living (including medication management, money management, and transportation).
    f) Overnight care and employment.
    g) Communication and cognition (ability to communicate memory).
    h) Indirect supports (family, social, and community network).
    i) General health and life goals.
    j) Any other health-related domain identified by the Department.

c. The HMO must contact the enrollee to schedule the comprehensive assessment as soon as possible after receiving the enrollment report. The HMO shall submit a monthly detailed report of assessments to the Department, electronically (as provided by the Department). The report will include enrollee's name, Medicaid SSI ID number, and not yet scheduled assessments, pending assessments, and completed assessments along with the HMO's notification dates, effective enrollment dates, and date of completed care plan. The report must be submitted no later than the twentieth of each month to the Enrollment Specialist (Addendum VI, I).

d. Conduct patient status and care plan reviews and updates as medically indicated but at least annually as part of monitoring both clinical and non-clinical standards of care to ensure the development and implementation of current care plans for each enrollee.

A member who voluntarily disenrolls from the HMO can re-enroll if the member meets the covered population enrollment criteria as

specified in this Contract. The need for the HMO to perform a comprehensive assessment on the re-enrolling member depends on how long the member remained disenrolled from the HMO:

1) If the member becomes re-enrolled less than six months after the member's last disenrollment from the HMO, then the HMO does not have to perform a comprehensive assessment. The HMO may use the previously developed care plan for that member.

2) If the member becomes re-enrolled at least six months after the member's last disenrollment from the HMO, then the HMO must perform a comprehensive assessment for the member.

e. The care plan must be developed in consultation with the enrollee and the enrollee's legal guardian, if appropriate, with opportunity for the enrollee to provide input. Enrollee participation in the care plan process must be documented by the HMO, as well as a judgment of the enrollee's understanding of the care plan. Agreement between the HMO and enrollee regarding the care plan is a desired goal. When such agreement is not possible, the areas of disagreement, the reasons for disagreement and how the care plan will be implemented given the disagreement must be documented in the care plan. The initial care plan must be shared verbally with the enrollee and an offer made to provide a written copy of the initial care plan or summary. The HMO must develop a process to ensure that relevant information from the care plan is available and easily accessible in place and time to the enrollee. The HMO is responsible for delivery of all covered services deemed medically necessary except as may be subject to prior authorization, utilization management, clinical practice guidelines or other evidence-based criteria and the enrollee's right to refuse care or treatment. In the event that Medicaid SSI covered services specified in the care plan do not occur, the HMO records must reflect the reasons why care specified in the care plan was not provided." For non-covered services, the HMO must assure that the members are referred to appropriate or community resources.

10. Interpreter Services

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

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

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

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

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

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

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

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

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

J. Billing Enrollees

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

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

The HMO and its providers and subcontractors must not bill a BadgerCare Plus- or Medicaid SSI enrollee for medically necessary covered services provided during the enrollee's period of HMO enrollment, except for allowable copayments and premiums established by the Division of Health Care Access and Accountability (DHCAA) for covered services provided during the enrollee's period of enrollment in BadgerCarePlus-Standard and Benchmark Plans.

The HMO and its providers and subcontractors may not bill a Medicaid SSI enrollee for co-payments and/or premiums for medically necessary services provided during the enrollee's period of HMO enrollment.

K. HealthCheck

1. HMO Responsibilities

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

    b. Provide Comprehensive HealthCheck screens upon request. The HMO must provide a HealthCheck screen within 60 days (if a screen is due according to the periodicity schedule) for enrollees over one year of age for which a parent or guardian of an enrollee requests a Comprehensive HealthCheck screen. If the screen is not

due within 30 days, then the HMO must schedule the appointment in accordance with the periodicity schedule.

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

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

d. A performance improvement incentive system will be put in place to increase the number of age appropriate Blood Lead Toxicity, test and age appropriate immunizations. The Department and the HMO will work closely on the measurement methodologies for these incentives. The Department will initiate the incentive through a contract amendment.

e. The rate of Comprehensive HealthCheck screens will continue to be determined by the calculation in the HealthCheck Worksheet. Comprehensive HealthCheck data provided by the HMO must agree with its medical record documentation. For the purpose of the HealthCheck recoupment process, the Department will not include any additional HealthCheck encounter records that are received after January 16, 2009 for the year under consideration. (Please note: This date marks the end of the twelve and one half month period of time from the end of the year under consideration. For example, for dates of service in 2008 the cut-off date will be January 16, 2010).

2. Department Responsibilities

The Department will provide quarterly reports to inform the HMO of their progress in meeting the HealthCheck requirements. Quarterly reports will be provided 90 days following the end of the quarter.

If the HMO provides fewer screens in the Contract year than 80%, the Department will:

a. Recoup the funds provided to the HMO for the provision of the remaining screens. The following formula will be used:

(0.80 x A - B) x (C - D), where:

A = Expected number of screens (Line 6 of HealthCheck Worksheet, Addendum IV).

B = Number of screens paid in the Contract year as reported in the HMO's Encounter Data Set as of January 16, 2006, and January 16, 2007. (The end of the 12 1/2 half month period following the year under consideration.)

C = FFS maximum allowable fee (Line 11 of the HealthCheck Worksheet). The FFS maximum allowable fee is the average maximum fee for the year. For example, if the maximum allowable fee for HealthCheck is $50 from January through June, and $52 from July through December in one year, then the average maximum allowable fee for the year is $51.

D = HMO discount, if applicable.

b. Determine the amount of the HMO's HealthCheck recoupment by Rate Region, excluding Dane, Eau Claire, Kenosha, Milwaukee and Waukesha counties, which will be determined separately.

c. Determine the actual number of screens completed during the calendar year, for the recoupment calculation (Line 8 of the Worksheet, Addendum IV), by using the number of screens reported in the HMO's Encounter Database for calendar years prior to 2008 by Rate Region, except for Dane, Eau Claire, Kenosha, Milwaukee and Waukesha counties which will be determined separately. The Department will identify and retrieve the HealthCheck screening data from the encounter database.

When assigning HealthCheck screens to an age category, the Department will use the member's age on the first day of the month in which the screening occurred.

For BadgerCare Plus if a newborn enrollee is screened in the month of their birth, the newborn's screen will be assigned to the under one age category.

d. Determine the number of eligible months and unduplicated enrollees (Lines 1 and 2 of the Worksheet, Addendum IV) per HMO per year by using the Wisconsin Health InterChange according to the specifications contained in this Contract. When calculating member months for each age category, the Department will use the member's age on the first day of the month except for newborns for BadgerCare Plus when calculating member months

for each age category. Newborns enrolled in an HMO in the month of their birth will be counted as eligible from their date of birth.

Inform the HMO in writing of its preliminary analysis of the HealthCheck data and allow the HMO 30 business days to review and respond to the calculations. If the HMO responds within 30 business days, the Department will review the HMO's concerns and notify the HMO of its final decision. If the HMO does not respond within 30 business days, the Department will send a "Notice of Intent to Recover" letter 40 days after the initial letter.

L. Marketing Plans and Informing Materials

As used in this section, "marketing materials, other marketing activities, and informing materials" include the production and dissemination of any informing materials, marketing plans, marketing materials and other marketing activities that refer to BadgerCare Plus, Medicaid SSI, Title XIX, or Title XXI and are intended for members. This requirement includes marketing or informing materials that are produced by providers under contract to the HMO or owned by the HMO in whole or in part. 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, or 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.

1. Approval of Marketing and Informing Materials

   The HMO must submit to the Department for prior written approval all informing member materials, marketing plans, and all marketing materials and other marketing activities that refer to BadgerCare Plus, Medicaid SSI, Title XIX, or Title XXI. This requirement includes marketing or informing materials that are produced by providers under contract to the HMO or owned by the HMO in whole or in part.

   Marketing plans and informing materials must be written at a "sixth grade comprehension level." The Department will review them in a manner that does not unduly restrict or inhibit the HMO's informing or marketing plans. When applying this provision to specific marketing plans, informing materials and/or activities, the entire content and use of the informing/marketing materials or activities will be taken into consideration. The Department will review all materials as follows:

   a. The Department will review and either approve, approve with modifications, or deny all marketing or informing materials within 10 business days of receipt of the informing materials. If the HMO

does not receive a response from the Department within 10 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 marketing or informing materials must be clearly marked time-sensitive by the HMO and will be approved, approved with modifications or denied by the Department within three business days. The Department reserves the right to determine whether the material is, 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 it deems 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. Problems and errors the Department subsequently identifies must be corrected by the HMO when they are identified. 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)].

2. Prohibited Practices

a. Practices that are discriminatory.

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

c. Direct and indirect cold calls, either door-to-door or telephonic.

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

e. Activities and material that could mislead, confuse or defraud consumers.

f. Materials that contain false information.

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

3. The HMO Agreement to Abide by Marketing/Informing Criteria

The HMO agrees to engage only in marketing activities and distribute only those informing and marketing materials that are pre-approved in writing. Any activities must occur in its entire service area and only as indicated in the agreement. The HMO that fails to abide by these marketing requirements may be subject to any and all sanctions. In determining any sanctions, the Department will take into consideration any past unfair marketing practices, the nature of the current problem and the specific implications on the health and well being of the enrollees. In the event that the HMO's affiliated provider fails to abide by these requirements, the Department will evaluate whether the HMO should have had knowledge of the marketing issue and the HMO's ability to adequately monitor ongoing future marketing activities of the subcontractor(s).

M. Reproduction/Distribution of Materials

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

N. HMO ID Cards

The HMO may issue its own HMO ID cards. The HMO may not deny services to an enrollee solely for failure to present the HMO issued ID card. The Forward Health and Forward cards will always determine the HMO enrollment, even where the HMO issues HMO ID cards.

O. Open Enrollment

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

P. Selective Reporting Requirements

1. Communicable Disease Reporting

As required by Wis. Stats. 252.05, 252.15(5)(a)6 and 252.17(7)(9b), physicians, physician assistants, podiatrists, nurses, nurse midwives, physical therapists, and dietitians affiliated with a BadgerCare Plus and/or Medicaid SSI HMO shall report the appearance, suspicion or diagnosis of a communicable disease or death resulting from a communicable disease to the local health department for any enrollee treated or visited by the provider. Reports of human immunodeficiency virus (HIV) infection shall

be made directly to the State Epidemiologist. Such reports shall include the name, sex, age, residence, communicable disease, and any other facts required by the local health department and Wisconsin Division of Public Health. Such reporting shall be made within 24 hours of learning about the communicable disease or death or as specified in Wis. Adm. Code HFS 145. Charts and reporting forms on communicable diseases are available from the local health department. Each laboratory subcontracted or otherwise affiliated with the HMO shall report to the local health department the identification or suspected identification of any communicable disease listed in Wis. Adm. Code HFS 145. Reports of HIV infections shall be made directly to the State Epidemiologist.

2. Fraud and Abuse Investigations

The HMO agrees to cooperate with the Department on fraud and abuse investigations. In addition, the HMO agrees to report allegations of fraud and abuse (both provider and enrollee) to the Department within 15 days of the suspected fraud or abuse coming to the attention of the HMO. Failure on the part of the HMO to cooperate or report fraud and/or abuse may result in any applicable sanctions under Article XI, F.

3. Physician Incentive Plans

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

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

Q. Abortions, Hysterectomies and Sterilization Requirements

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

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

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

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

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

IV. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT (QAPI)

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

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

A. QAPI Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Monitoring and Evaluation

1. The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Important aspects of care (i.e., acute, chronic conditions, high volume, high-risk preventive care and services) are studied and prioritized for performance improvement and/or development of practice guidelines. Standardized quality indicators must be used to assess improvement, ensure achievement of minimum performance levels, monitor adherence to guidelines, and identify patterns of over and under utilization. The Department will begin HEDIS reporting in CY 2009, using CY 2008 clinical services data. The HMO agrees to begin reporting HEDIS measures in CY 2009 according to a timetable developed by the Department in consultation with the HMO. The Department will provide technical assistance to the HMO for HEDIS implementation.

For clinical services where no HEDIS measure exists or until HEDIS is fully implemented, the Department will use the existing MEDDIC-MS and/or MEDDIC-MS SSI performance measures for the remaining areas of measurement.

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

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

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

5. The HMO must develop or adopt practice guidelines that are disseminated to providers and to enrollees as appropriate or upon request. The guidelines are based on valid and reliable medical evidence or consensus of health professionals; consider the needs of the enrollees; developed or adopted in consultation with the contracting health professionals, and reviewed and updated periodically.

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

C. Health Promotion and Disease Prevention Services

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

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

3. The Department encourages the HMO to develop and implement disease management programs and systems to enhance quality of care for individuals identified as having chronic or special health care needs known to be responsive to application of clinical practice guidelines and other techniques.

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

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

1. The HMO must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides services to the HMO's enrollees, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under BadgerCare Plus and/or Medicaid SSI. The HMO's written policies

and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.

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

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

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

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

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

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

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

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

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

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

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

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

10. These standards do not apply to:

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

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

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

E. Enrollee Feedback on Quality Improvement

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

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

F. Medical Records

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

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

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

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

3. Because the HMO is considered a contractor of the state and therefore (only for the limited purpose of obtaining medical records of its enrollees) entitled to obtain medical records according to Wis. Adm. Code, HFS 104.01(3), the Department requires BadgerCare Plus and/or Medicaid SSI certified providers to release relevant records to the HMO to assist in compliance with this section. The HMO that have not specifically addressed photocopying expenses in their provider contracts or other arrangements, are liable for charges for copying records only to the extent that the Department would reimburse on a FFS basis.

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

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

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

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

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

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

G. Utilization Management (UM)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Dental Services Quality Improvement (Applies only to an HMO Covering Dental Services)

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

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

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

3. HMO-affiliated dentists must provide a routine dental appointment to an assigned enrollee within 90 days after the request. Enrollee requests for

emergency treatment must be addressed within 24 hours after the request is received.

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

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

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

I. Accreditation

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

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

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

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

J. Performance Improvement Priority Areas and Projects

The HMO must develop and ensure implementation of program initiatives to address the specific clinical needs of the HMO's enrolled population served under

this Contract. These priority areas may include clinical and non-clinical Performance Improvement Projects.

The Department strongly advocates 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. Linkages between health maintenance organizations and public health agencies is an essential element for the achievement of the public health objectives, potentially reducing the quantity and intensity of services the HMO needs to provide. The Department and the HMO are jointly committed to an on going collaboration 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 (MEDDIC-MS).

The HMO must annually monitor and evaluate the quality of care and services through performance improvement projects for at least two of the priority areas specified by the Department and listed in Subsection 3, or the HMO may propose to address alternative performance improvement topics by making a request in writing to the Department.

The performance improvement topic must take into account the prevalence of a condition among, or needed for a specific service by, the HMO enrollees served under this Contract; enrollee demographic characteristics and health risks; and the interest of consumers or purchasers in the aspect of care or services to be addressed.

The report for each Performance Improvement Project must address each of the following points in order for the Department to evaluate the reliability and validity of the data and the conclusions described in the study. The BCAP method for reporting outlined below is not mandated, but is an acceptable format for Performance Improvement Projects. Other formats may be used as long as the Performance Improvement Project criteria outlined is addressed.

1. **10 Steps for Completing a Performance Improvement Project:**

    a. Select a Study Topic

        1) Was the process of the topic selection described?

        2) Is the topic important to the enrolled population?

        3) Does it affect a significant portion of the enrollees (or specified sub-portion) and reflect a high volume or high-risk condition of the population served?

        4) Can it be affected by the actions of the HMO?

b. Define a Study Question

1) Was the method and procedure used to study the topic clear?

2) Was the study question clearly stated and consistent throughout the study?

3) Is the study question specific and answerable?

c. Select Study Indicators

1) Were the indicators objective, and unambiguously defined?

2) Are the indicators based on current clinical knowledge or health services research (healthcare guidelines)?

3) Do the indicators objectively measure either enrollee outcomes such as health or functional status, enrollee satisfaction, or valid proxies of these outcomes?

d. Identify the Study

1) Is there a clear definition of who to include in the study?

2) Did the study define an "at risk" population?

3) Was the entire population included or was sample used?

4) Was the assignment to groups random?

5) If the entire population was included, were all enrollees captured by the data collection process used?

e. Utilize Sampling Methods (if applicable)

1) Was a valid sample size calculated?

2) Were valid sampling techniques used?

f. Data Collection

1) Were the data fully described in detail?

2) Were the data appropriate to answer the study question?

3) Was the data collection process fully described?

4) Was the data collection process appropriate for the data to be collected?

5) Did the data collectors have the appropriate qualifications/experience to collect the data?

6) Was interrater reliability adequate?

7) Did the loss of data or subjects affect validity?

8) Was the study time frame clear?

g. Improvement Strategies/Interventions (not applicable if the project is to establish a baseline only)

1) Were interventions related to causes/barriers identified through data analysis?

2) Were the interventions fully described?

3) Was the intervention practical in that it can be widely implemented?

4) Was the implementation of the intervention monitored for effectiveness and reported to ensure that it was done properly?

h. Results and Interpretation of Findings

1) Was the data collected fully reported?

2) Did the study include comparisons to give meaning to the results?

3) Is the norm or standard expressed in a specific numerical manner?

4) Is the goal, norm or standard appropriate to this population and study?

5) Was the comparison group (if applicable) as close as possible to the population under study and were any differences acknowledged?

6) If pre-and-post measures were used, was an explanation for the differences between the measures considered?

7) Did the study appropriately use statistical testing? (x2 t-test, regression analysis, etc.)?

8) Were the conclusions consistent with the results?

9) Were data tables, figures and graphs consistent with the text?

10) Did table, figures and graphs convey their information clearly without reference to the report text?

11) Did the study consider its limitations?

12) Did the study conclude or imply causality when the supporting data is only correlational?

14) Did the study present appropriate recommendations based on the results?

15) Did the report clearly state whether performance improvement goals were met (if an intervention was carried out), and if the goals were not met, was there an analysis of why they were not met?

16) Did the report include any additional questions raised by performing the study?

17) What are the next steps, if any, to study these additional questions/topics?

18) Did the report include what the HMO plans to do differently as a result of their study?

19) Were next steps described in detail (dates and timelines)?

i. Real Improvement Achieved

1) Was statistically significant improvement achieved?

2) Does the improvement in performance appear to be due to the planned intervention?

j. Sustained Improvement

1) Was sustained improvement demonstrated through repeated measurements over comparable time periods?

k. Miscellaneous

1) Was enrollee confidentiality protected?

2) Did consumers participate in the study (other than as the subjects)?

3) Did the study include cost/benefit analysis or some other consideration of financial impact?

4) Were the results and conclusions distributed throughout the HMO?

5) Did the study report include an accurate summary?

6) Was the study clearly written?

2. The Department will accept for fulfillment of the above requirement Performance Improvement Project Reports arising out of voluntary HMO participation in collaborative quality improvement projects including, but not limited to, the Improving Birth Outcomes Project (IBOP), First Breath smoking cessation project, Care Analysis Projects (CAP) or other collaborative efforts designed by the Department. In order to be accepted the project report by the HMO must meet all the content criteria described in the Performance Improvement Project Outline.3.

3. Priority Areas

- BadgerCare and Medicaid SSI Expansion
- HMO Accreditation
- SSI Care Management Incentive
- HealthCheck
- Smoking Cessation
- Blood Lead
- Dental Incentive
- Healthy Birth Outcomes

- Diabetic Management
- Asthma Management
- Childhood Obesity

Non-Clinical Priority Areas:

- Grievances, appeals and complaints;
- Access to and availability of services;
- Enrollee satisfaction with the HMO customer service;
- Satisfaction with services for enrollees with special health care needs or cultural competency of the HMO and its providers.

In addition, the HMO may be required to conduct performance improvement projects specific to the HMO and to participate in one annual statewide project that may be specified by the Department.

4. Pay for Performance

The Department will implement pay for performance incentives, in addition to those specifically listed below, for the HMO for selected health status or outcome improvements to be mutually agreed upon. The incentive payment will be based on criteria to be developed and agreed upon through a contract amendment.

- Dental Care Access (See Addendum VI)
- Tobacco Cessation (See Addendum VI)

ARTICLE V

V. FUNCTIONS AND DUTIES OF THE DEPARTMENT

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

A. Enrollment Determination

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

BadgerCare Plus		
Med Stat	**Cap Rate***	**Description**
BA	A	BC+ Standard Plan - Income equal or greater than 0% FPL and less than or equal to 200% of FPL for pregnant women
BE	A	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	A	BC+ Standard Plan – Income greater than 100% of FPL and less than or equal to 150% of FPL for child, under age 6
BF	A	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	A	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for child, under age 6
BG	A	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	A	BC+ Standard Plan – Income equal or greater than 0% FPL and less than or equal to 100% of FPL for parents/caretakers
BM	A	BC+ Standard Plan – Income greater than 100% of FPL and less than or equal to 150% of FPL for caretakers
BN	A	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for caretakers
B8	A	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for parents/caretakers, waiver eligible
BY	A	BC+ Standard Plan – Youths exiting out of home care
BP	A	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	A	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	A	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	A	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

BadgerCare Plus		
Med Stat	**Cap Rate***	**Description**
N1	A	BC+ Standard Plan – Income equal or greater than 0% of FPL and less than or equal to 200% of FPL for CEN – mom in SP or MA on DOB
1B	A	BC+ Standard Plan – Income greater than 100% of FPL and less than or equal to 130% of FPL for parents
2B	A	BC+ Standard Plan – Income greater than 130% of FPL and less than or equal to 150% of FPL for parents
3B	A	BC+ Standard Plan – Income greater than 150% of FPL and less than or equal to 200% of FPL for parents
X6	A	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
X7	A	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
BO	A	BC+ Benchmark Plan – Income greater than 200% of FPL for caretakers (self-employed and farmers) – No dental benefit
4B	A	BC+ Benchmark Plan – Income or greater than 200% of FPL for parents (self-employed & farmers) – No dental benefit
BB	A	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL and less than or equal to 300% of FPL for pregnant women
PM	A	BC+ Benchmark Plan + Dental – Income greater than 300% of FPL for pregnant minor, under age 19
TP	A	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL and less than or equal to 300% of FPL for pregnant minor, under age 19 – tribal member
BH	A	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL and less than or equal to 250% of FPL for child, under age 19
TC	A	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
BI	A	BC+ Benchmark Plan + Dental – Income greater than 250% of FPL for child, under age 19
N3	A	BC+ Benchmark Plan + Dental – Income greater than 200% of FPL for CEN – mom in BMP on DOB

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

A = BadgerCare Plus capitation rate.
B = Medicaid SSI and SSI-related capitation rate.

*See Actuarial Basis, for overview of capitation rate determination. For the HMO specific capitation rate, see Exhibit Sections.

B. Enrollment

Promptly notify the HMO of all BadgerCare Plus and/or Medicaid SSI members enrolled in the HMO under this Contract. Notification will be effected through the HMO Enrollment Reports. All members listed as an ADD or CONTINUE on either the Initial or Final HMO Enrollment Report are members of the HMO during the enrollment month. The reports will be generated in the sequence specified under HMO enrollment reports. These reports shall be in both tape and hard copy formats or available through electronic file transfer capability and will include medical status codes. The Department will make all reasonable efforts to enroll pregnancy cases as soon as possible for BadgerCare Plus.

C. Disenrollment

Promptly notify the HMO of all BadgerCare Plus and/or Medicaid SSI members no longer eligible to receive services through the HMO under this Contract. Notification will be effected through the HMO Enrollment Reports which the Department will transmit to the HMO for each month of coverage throughout the term of the Contract. The reports will be generated in the sequence under the HMO Enrollment Report below. Any member who was enrolled in the HMO in the previous enrollment month, but does not appear as an ADD or CONTINUE on either the Initial or Final HMO Enrollment Report for the current enrollment month is disenrolled from the HMO effective the last day of the previous enrollment month.

D. Enrollment Errors

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

E. HMO Enrollment Reports

For each month of coverage throughout the term of the Contract, the Department will transmit "HMO Enrollment Reports" to the HMO. These reports will provide the HMO with ongoing information about its BadgerCare Plus and/or Medicaid SSI enrollees and disenrollees and will be used as the basis for the monthly capitation claim payments to the HMO. The HMO Enrollment Reports will be generated in the following sequence:

1. The Initial HMO Enrollment Report will list all of the HMO's enrollees and disenrollees for the enrollment month that are known on the date of report generation. The Initial HMO Enrollment Report will be available to the HMO on or about the twenty-first of each month. A capitation claim shall be generated for each enrollee listed as an ADD or CONTINUE on this report. Enrollees who appear as PENDING on the

Initial Report and are reinstated into the HMO prior to the end of the month will appear as a CONTINUE on the Final Report and a capitation claim will be generated at that time.

2. The final HMO Enrollment Report will list all of the HMO's enrollees for the enrollment month, who were not included in the Initial HMO Enrollment Report. The Final HMO Enrollment Report will be available to the HMO by the first day of the capitation month. A capitation claim will be generated for every enrollee listed as an ADD or CONTINUE on this report. Enrollees in PENDING status will not be included on the final report.

3. The Department will provide the HMO with effective dates for medical status code changes, county changes and other address changes in each enrollment report to the extent that the county reports these to the Department.

F. Utilization Review and Control

Waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other BadgerCare Plus and/or Medicaid SSI restrictions for the provision of contract services provided by the HMO to enrollees, except as may be required by the terms of this contract.

G. HMO Review

Submit to the HMO for prior approval materials that describe the specific HMO. Approved materials will be distributed by the Department or County to members.

H. Department Audit Schedule

The HMO will be notified approximately 30 days prior to regularly scheduled, routine audits being conducted via a letter from the Division of Health Care Access and Accountability. The Department will develop an annual schedule of known audits for the next Contract period.

I. HMO Review of Study or Audit Results

Submit to the HMO for a 30 business day review/comment period, any BadgerCare Plus and/or Medicaid SSI and HMO audits, HMO report card, HMO Consumer Satisfaction Reports, or any other BadgerCare Plus and/or Medicaid SSI HMO studies the Department releases to the public that identifies the HMO by name. The review/comment period will commence on the fifth business day after the audit report is mailed. The HMO may request an extension and the Department will exercise reasonable discretion in making the determination to waive the 30 business day review/comment requirement.

J. Vaccines for Family (BadgerCare Plus Only)

Provide certain vaccines to HMO providers for administration to BadgerCare Plus HMO enrollees according to the policies and procedures in the Wisconsin Health Care Programs Online Handbook. The Department will reimburse the HMO for the cost of vaccines that are newly approved during the contract year and not yet part of the Vaccine for Children program. The reimbursement of the vaccine shall be the same as the Department reimburses FFS providers during the period of VFC availability. The HMO retains liability for the cost of administering the vaccines.

K. Coordination of Benefits

Maintain a report of recovered money reported by the HMO and its subcontractor.

L. BadgerCare Plus and Medicaid SSI Provider Reports

Provide a monthly electronic listing of all BadgerCare Plus and/or Medicaid SSI certified providers to include, at a minimum, the name, address, BadgerCare Plus and/or Medicaid SSI provider ID number and/or National Provider Identifier, if applicable, and dates of certification for BadgerCare Plus and/or Medicaid SSI.

M. Enrollee Health Status and Primary Language Report

The Department will provide the HMO with an enrollee health status and primary language report of all enrollees who have agreed to participate with the gathering of this data. The reports will be provided to the HMO on a monthly basis. The purpose of this report is to assist the HMO with continuity of care issues and with the identification of non-English speaking enrollees and to facilitate appointments for enrollees who have urgent health care needs.

N. Fraud and Abuse Training

The Department will provide fraud and abuse detection training to the HMO annually.

O. Provision of Data to the HMO

Provide to the HMO immunization information from the Wisconsin Immunization Registry, to the extent available.

ARTICLE VI

VI. PAYMENT TO THE HMO

A. Capitation Rates

In consideration of full compliance by the HMO with contract requirements, the Department agrees to pay the HMO monthly payments based on the capitation rates. The capitation rates shall be prospective and based on an actuarially sound methodology as required by federal regulations. The capitation rate shall not include any amount for recoupment of losses incurred by the HMO under previous contracts nor does it include services that are not covered under the State Plan. Specifics are:

- The Department's enhanced funding policies include NICU risk sharing, ventilator dependent and AIDS/HIV enrollees. The HMO cannot submit a request for enhanced funding under more than one of the three funding policies for the same enrollee for the same date(s) of service.
- The Department will conduct an analysis comparing actual HMO enrollee's diagnosis and service usage intensity (utilization and costs) with the comparable FFS equivalent population using the Chronic Illness and Disability Payment System (CDPS).

B. Actuarial Basis

The capitation rate is calculated on an actuarial basis recognizing the payment limits set forth in 42 CFR 438.6.

C. Annual Negotiation of Capitation Rates

The monthly capitation rates are recalculated on an annual basis. The HMO will have 30 days from the date of the written notification to accept the new capitation rates in writing or to initiate termination or non-renewal of the Contract. The capitation rates are not subject to renegotiation once they have been accepted, unless such renegotiation is required by changes in federal or state laws, rules or regulations.

D. Reinsurance

The HMO may obtain a risk-sharing arrangement from an insurer other than the Department for coverage of enrollees under this Contract, provided that the HMO remains substantially at risk for providing services under this Contract.

E. Payment Schedule

Payment to the HMO is based on the HMO Enrollment Reports that the Department transmits to the HMO. Payment for each person listed as an ADD or CONTINUE on the HMO Enrollment Reports shall be made by the Department within 60 days of the date the report is generated. Any claim that is not paid within these time limits will be denied by the Department and the member will be disenrolled from the HMO for the capitation month specified on the claim. Notification of all paid and denied claims will be given through the weekly Remittance Status Report, which is available on both tape and hard copy. Specifics for:

- **Capitation Payments for Newborns**

  The HMO will authorize provision of contract services to the newborn child of an enrolled mother for the first 10 days of life. The child's date of birth should be counted as day one. In addition, if the child is reported within 100 days of the date of birth, the HMO will provide contract services to the child from its date of birth until the child is disenrolled from the HMO. The HMO will receive a separate capitation payment for the month of birth and for all other months the HMO is responsible for providing contract services to the child. If the child is not reported within 100 days of the date of birth, the child will not be retroactively enrolled into the HMO. In this case, the HMO is not responsible for payment of services provided prior to the child's enrollment and will receive no capitation payments for that time period and may recoup payments from providers for any services that were authorized in that 100 day time period. The providers who gave services in this 100 day time period may then bill the Department on a FFS basis. Examples of these situations can be found in the Claims Submission section of the Wisconsin Health Care Programs Online Handbook.

  The HMO and their providers must complete an HMO Newborn Report. The HMO will report all births to the Department's fiscal agent as soon as possible after the date of birth, but at least monthly. Prompt HMO reporting of newborns will facilitate retroactive, enrollment and capitation payments for newborns, since this newborn reporting will ensure the newborn's BadgerCare Plus eligibility for the first 12 months of life contingent upon the newborn continuously residing with the mother.

  Infants weighing less than 1200 grams will be exempt from enrollment if the data submitted by the HMO or the provider supports the infant's low birth eight. If an infant weighs less than 1200 grams, the HMO or provider should check the box on the BadgerCare Plus Newborn Report.

F. Coordination of Benefits (COB)

The HMO must actively pursue, collect and retain all monies from all available resources for services to 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 AIDS and ventilator dependent patients). COB recoveries will be done by post-payment billing (pay and chase) for certain prenatal care and preventive pediatric services. Post-payment billing will also be done in situations where the third party liability (TPL) is derived from a parent whose obligation to pay is being enforced by the State Child Support Enforcement Agency and the provider has not received payment within 30 days after the date of service.

1. Cost effectiveness of recovery is determined by, but not limited to time, effort, and capital outlay required to perform the activity. The HMO upon request of the Department must be able to specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which the HMO determines seeking reimbursement would not be cost effective.

2. To ensure compliance, the HMO must maintain records of all COB collections and report them to the Department on a quarterly basis. The COB report must be submitted in the format specified in this Contract. The HMO must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for enrollees. The HMO must seek from all enrollees' information on other available resources. The HMO must also seek to coordinate benefits before claiming reimbursement from the Department for the AIDS and ventilator dependent enrollees:

    a. Other available resources may include, but are not limited to, all other state or federal medical care programs that are primary to BadgerCare Plus and/or Medicaid SSI, group or individual health insurance, ERISAs, service benefit plans, the insurance of absent parents who may have insurance to pay medical care for spouses or minor enrollees, and subrogation/worker's compensation collections.

    b. Subrogation collections are any recoverable amounts arising out of the settlement of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the HMO under Act 31, Laws of 1989, s. 49.89(9). After attorneys' fees and expenses have been paid, the HMO will collect the full amount paid on behalf of the enrollee.

3. Section 1912(b) of the Social Security Act must be construed in a beneficiary-specific manner. The purpose of the distribution provision is

to permit the beneficiary to retain TPL benefits to which he or she is entitled except to the extent that BadgerCare Plus and/or Medicaid SSI (or the HMO on behalf of BadgerCare Plus and/or Medicaid SSI) is reimbursed for its costs. The HMO is free, within the constraints of state law and this Contract, to make whatever case it can to recover the costs it incurred on behalf of its enrollee. It can use the max fee schedule, an estimate of what a capitated physician would charge on a FFS basis, the value of the care provided in the market place, or some other acceptable proxy as the basis of recovery. However, any excess recovery, over and above the cost of care (however the HMO chooses to define that cost), must be returned to the beneficiary. The HMO may not collect from amounts allotted to the beneficiary in a judgment or court-approved settlement. The HMO must follow the practices outlined in the Department's Casualty Recovery Manual.

4. COB collections are the responsibility of the HMO or its subcontractors. Subcontractors must report COB information to the HMO. The HMO and its subcontractors must not pursue collection from the enrollee, but directly from the third party payer. Access to medical services must not be restricted due to COB collection.

5. The following requirement applies if the Contractor (or the Contractor's parent firm and/or any subdivision or subsidiary of either the Contractor's parent firm or of the Contractor) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organization(s), and/or employer self-insurer health plan(s):

    a. Throughout the Contract term, these insurers and third-party administrators must comply in full with the provision of Wis. Stats., Subsection 49.475. Such compliance must include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided must be consistent with the Department's written specifications.

    b. Throughout the Contract term, these insurers and third-party administrators must also accept and properly process post payment billings from the Department's fiscal agent for health care services and items received by BadgerCare Plus and Medicaid SSI enrollees.

6. If at any time during the Contract term any of the insurers or third party administrators fail, in whole or in part, the Department may take the remedial measures specified in this Contract.

G. Recoupments

The Department will not normally recoup HMO per capita payments when the HMO actually provided services. However, if the BadgerCare Plus and/or Medicaid SSI enrollee cannot use HMO facilities, the Department will recoup the HMO capitation payments. Such situations are described more fully below:

1. The Department will recoup the HMO capitation payments for the following situations where an enrollee's HMO status has changed before the first day of a month for which a capitation payment has been made:

    a. Enrollee moves out of the HMO's service area.

    b. Enrollee enters a public institution.

    c. Enrollee dies.

2. The Department will recoup the HMO capitation payments for the following situations where the Department initiates a change in an enrollee's HMO status on a retroactive basis, reflecting the fact that the HMO was not able to provide services. In these situations, recoupments for multiple months' capitation payments are more likely:

    a. Correction of a computer or human error, where the person was never really enrolled in the HMO.

    b. Disenrollments of enrollees for reasons of pregnancy and continuity of care, or for the reasons specified in this Contract.

3. If membership is disputed between two HMOs, the Department will be the final arbitrator of HMO membership and reserve the right to recoup an inappropriate capitation payment.

4. If the HMO enrollee moves out of the HMO's service area, the enrollee will be disenrolled from the HMO on the date the enrollee moved as verified by the eligibility worker. If the eligibility worker is unable to verify the enrollee's move, the HMO may mail a "certified return receipt requested" letter to the enrollee to verify the move. The enrollee must sign for the letter. A copy of the letter and the signed return receipt must be sent to the Department or its designee within 20 days of the enrollee's signature date. If this criteria is met the effective date of the disenrollment is the first of the month in which the certified returned receipt requested letter was sent. Documentation that fails to meet the 20 day criteria will result in disenrollment the first day of the month that the HMO supplied information to the Department or its designee. This policy does not apply to extended service area requests that have been approved by the HMO unless the enrollee moves out of the extended service area or the HMO's

service area. Any capitation payment made for periods of time after disenrollment will be recouped.

5. If the HMO is unable to meet the HealthCheck requirements.

H. Neonatal Intensive Care Unit (NICU) Risk-Sharing Payment(s) (BadgerCare Plus Only)

The HMO may seek reimbursement as specified. The Department will reimburse each HMO for a portion of the NICU costs incurred by the HMO per county for those enrollees who meet the criteria defined in Subsection 1 below and if the HMO's average number of NICU days per thousand member years per county exceeds 75 days per thousand member years per county during the Contract period.

1. *Coverage Criteria*

a. NICU days cover any newborn transferred or directly admitted after birth to a Level II, Level III, or Level IV SCN/NICD for treatment and/or observation under the care of a neonatologist or pediatrician. NICU coverage continues until the infant is deemed medically stable to be discharged to a newborn nursery, medical floor or home. Level II, III, and IV facilities provide the following services:

1) Level II facilities provide a full range of services for low birth weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates.

2) Level III facilities provide a full range of newborn intensive care services for neonatal patients who do not require intensive care but require 6-12 hours of nursing each day.

3) Level IV facilities provide a full range of services for severely ill neonates who require constant nursing and continuous cardiopulmonary and other support.

b. NICU days also cover any newborn infant transferred or directly admitted after birth to a Level II, Level III, or Level IV SCN/NICD who requires transfer to another institution for a severe compromised physical status, diagnostic testing or surgical intervention that cannot be provided at the hospital or initial admission. NICU coverage continues until the infant is transferred back to the initial hospital and deemed medically stable to be discharged to a newborn nursery, medical floor or home.

2. *Reimbursement Criteria*

a. The HMO's NICU reimbursement amount is calculated by contract period and by county. For NICU risk sharing, a "contract period" is defined as one year.

b. The Department will reimburse the HMO for 90% of the HMO's NICU cost per day, not to exceed a reimbursement of $1,443 per day, for each day that the HMO's average number of NICU days per thousand member years exceeds 75 NICU days per thousand member years per county during the Contract period.

c. The HMO's NICU cost per day includes the HMO's NICU inpatient payment per day and the HMO's associated physician payments. Associated physician payments refer to the total HMO payments made by the HMO to the physician(s) for services provided to the infant during the NICU stay. Associated physician payments are divided by the number of days reported for the NICU stay to determine the HMO's payment per day of associated physician payments.

Amounts paid must include payments for all physician and hospital services that were proved during the report period regardless of the HMO's actual payment date.

d. The Department makes the NICU reimbursement to the HMO after the end of the Contract year, after the HMO has submitted all needed NICU data. The Department will reimburse the HMO within 60 days of receipt of all necessary data from the HMO. The Department may make a final adjustment to the NICU reimbursement amount one year after the initial payment. This adjustment will be based on adjustments to eligible months and, updated information from the HMO such as the number of NICU days, inpatient payments, associated physician payments and amounts recovered from third parties.

e. The number of eligible months for the NICU calculation must include the HMO's entire BadgerCare Plus population. If an enrollee's medical status code is retroactively backdated to an SSI medical status code and the HMO receives a capitation payment for those months, those months must also be included in the NICU calculation. The Department will make the final determination regarding the number of eligible months for the NICU calculation by HMO, by county and by year, using Wisconsin Health InterChange.

f. Costs for care provided to NICU enrollees who are retroactively disenrolled are not payable. The HMO must back out the costs of care provided during the backdated period from their NICU reports.

3. *Reporting Requirements*

The HMO that chooses to submit their report(s) under the NICU enhanced funding policy must follow the reporting requirements below:

a. The HMO may submit an interim and final report for each contract period if the NICU criteria is met. The HMO does not have to file a report if the NICU criteria are not met:

1) Interim reports must be submitted to the Department on or before May 1 of the following year (i.e., an interim report for the period January 1, 2008, through December 31, 2009, must be submitted on or before May 1, 2008 and on or before May 1, 2009).

2) Final reports must be submitted on or before May 1, one year after the submission of an interim report (i.e., a final report for the period January 1, 2008, through December 31, 2009, must be submitted on or before May 1, 2008 and on or before May 1, 2009).

b. The HMO must submit all data by county and in the format requested by the Department for calculating the NICU reimbursement on or before May 1 of the following calendar year. The data and data format requirements are defined Article VII.

c. The HMO must submit their NICU report(s) to the Department's Bureau of Fiscal Management.

I. Payment(s) for AIDS/HIV and Ventilator Dependent Enrollees

1. General Criteria

To qualify enrollees for reimbursement the HMO must submit the documentation that is required for each policy at the same time as the quarterly reports in Article VI. The HMO may use the Department's designated form or develop their own as long as it contains the required information as specified for each policy.

a. AIDS

1) Criteria Requirement

a) AIDS Enrollees (except newborns)

For those enrollees with a confirmed diagnosis of AIDS, as indicated by and 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.

b) Newborns

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

2) Enhanced Funding

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 as specified in this contract.

3) Documentation Requirement

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) Criteria Requirement

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.

2) Enhanced Funding

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 as specified in this contract.

3) 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. If the name of the anti-retroviral medication and the date it was started is unclear, the Department will use the HMO's pharmacy detail records(s) to determine the effective date of enhanced funding. In cases where pharmacy detail records are used, the effective date will be the first day of the month that the first anti-retroviral medical was dispensed.

c. Ventilator Dependent Enrollees

1) General Information

For the purposes of this reimbursement, a ventilator-assisted patient must require equipment that provides total respiratory support or the patient must have died while on respiratory support. This equipment may be a volume ventilator, a negative pressure ventilator, a continuous positive airway pressure (CPAP) system, or a Bi (inspiratory and expiratory) PAP. The patient may need a combination of these systems. The patient may need a combination of these systems. Any equipment used only

for the treatment of sleep apnea does not qualify as total respiratory support.

2) Criteria Requirement

a) BadgerCare Plus

Total respiratory support must be required for a total of six or more hours per 24 hours. The patient must have total respiratory support for at least 30 days that need not be continuous. Day one is the day that the patient is placed on the ventilator. If the patient is on the ventilator for less than six hours on the first day, the use must continue into the next day and be more than six total hours. Each day that the patient is on the ventilator for part of any day, as long as it is part of the six total hours per 24 hours, it counts as a day for enhanced funding. The absolute need for respiratory support must be supported by appropriate medical documentation.

b) Medicaid SSI

The enrollee had an inpatient stay for a minimum of four days or lesser length if the enrollee died while on total respiratory support with one of the following qualifying LTC-DRG codes and the qualifying ICD-9-CM procedure code where applicable:

- 504-Extensive third degree burn with skin graft and with ICD-9-CM procedure code 96.72 (continuous mechanical ventilation for 96 consecutive hours or more), or
- 505-Extensive third degree burn without skin graft and with ICD-9-CM procedure code 96.72 (continuous mechanical ventilation for 96 consecutive hours or more), or
- 541-Tracheostomy with mechanical ventilation 96+ hours or principle diagnosis except face, neck and mouth diagnosis with major OR procedure, or
- 542 – Tracheostomy with mechanical ventilation 96+ hours or principle diagnosis

except face, neck and mouth diagnosis without major OR procedure, or

- 565-Respiratory system diagnosis with ventilator support 96+ hours, or

- 566-Respiratory system diagnosis with ventilator support 96+ hours.

3) Enhanced Funding

a) Newborns (BadgerCare Plus Only)

Newborns who are total respiratory support at birth, the date of enhanced funding will begin with the newborn's date of birth.

b) All Other Enrollees

The period of enhanced funding will end on the enrollees's date of death if the enrollee dies while on total respiratory support, the last day of the month of the qualifying hospital stay, the date the enrollee loses BadgerCare Plus or Medicaid SSI eligibility, 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.

4) Documentation Requirements

a) BadgerCare Plus

- A signed statement from the physician attesting to the need of the patient.

- Copies of the vent flow chart or progress notes that show the need for continuation of total ventilator support, and any change in the type of ventilator support and the removal of the ventilator support.

b) Medicaid SSI

Submission of a copy of the UB92 or a copy equivalent UB 92 data with at least one of

the following LTC-DRG codes with a designated ICD-9-CM procedure code where applicable:

- 504 with ICD-9-CM procedure code 96.72
- 505 with ICD-9-CM procedure code 96.72
- 541
- 542
- 565
- 566

2. Payment Requirements for All Policies

The Department will pay 100% of the HMO's costs of providing BadgerCare Plus and/or Medicaid SSI covered services to BadgerCare Plus and Medicaid SSI HMO enrollees who meet the AIDS, HIV-positive, or ventilator dependent criteria. HMO's may seek reimbursement as specified.

a) Reporting

The HMO must submit detail reports on disk in an Excel file and hard copy. The reports must be submitted to the Department's Bureau of Fiscal Management on a quarterly basis as specified in Article VII and include all the data elements specified in Addendum V. If an HMO is contracted to serve both BadgerCare Plus and Medicaid SSI enrollees the reports must be submitted separately.

As required by the Wis. Adm. Code HFS 106.03 payment data or adjustment data must be received within 365 days after the date of the service. Since the HMO is required to submit their AIDS, HIV, and ventilator claim(s) to the Department on a quarterly basis, the HMO will be given an additional three months plus 10 days to file their claim(s) or payment data adjustment(s). In addition, if the last date of service for an inpatient hospital facility stay occurs within the same timeline specified (365 days plus three months plus 10 days) the Department will reimburse the HMO for the facility charges that entire stay. If the HMO cannot meet these requirements, the HMO must provide documentation that substantiates the delay. The Department will make the final determination to pay or deny the services. The Department will exercise reasonable discretion in making the determination to waive the 365 day filing requirements.

b) Payment Adjustments

Adjustment that will be made to the HMO's final payment include, but are not limited to:

- Reimbursement(s) already paid to the HMO in the form of capitation payments for enrollees who qualify as being AIDS, HIV-positive, or ventilator dependent will be deducted from the HMO's 100% reimbursement.

- Costs for care provided to AIDS, HIV-positive, or ventilator dependent enrollees are retroactively disenrolled are not payable. The HMO must back out the cost of the care provided during the backdated period from their reports.

c) Payment Dispute Resolution

Disputes regarding the Department's payment or nonpayment of HIV-positive, or ventilator dependent BadgerCare Plus and/or Medicaid SSI services as well as any adjustments made by the HMO (e.g., adjustments to provider payments or adjustments due to amounts recovered from third parties) must be submitted in the next report period.

J. Expansion Incentive

1. BadgerCare Plus

A special incentive payment will be made for the HMO that increases its net enrollment in those areas significantly below enrollment capacity, or those areas currently designated as voluntary or FFS only. Incentive payments will be awarded based on enrollment increases in the selected areas compared to enrollment numbers shown on the January 2007 WI Health InterChange enrollment report. The incentive payment award will be made at the sole discretion of the Department and will be based on criteria to be developed and communicated to the HMO through a contract amendment.

2. Medicaid SSI

A special incentive payment will be made for the HMO that increases its net SSI enrollment in those areas below enrollment capacity or where there currently is no HMO. Incentive payments will be awarded based the following:

- 4% incentive payment for areas not currently under consideration for expansion where there is no HMO or plans to expand into other counties.

- 2% incentive, depending on area where the HMO has planned expansions effective June 1, 2007.

The incentive payment award will be made at the sole discretion of the Department and will be based on the above criteria communicated to the HMO through a contract amendment.

ARTICLE VII

VII. COMPUTER/DATA REPORTING SYSTEM, DATA, RECORDS AND REPORTS

A. Access to and/or Disclosure of Financial Records

The HMO and any subcontractors must make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the HMO or subcontractors that relate to the HMO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this Contract. The HMO must comply with applicable record keeping requirements specified in Wis. Adm. Code HFS 105.02(1)-(7) as amended.

B. Access to and Audit of Contract Records

Throughout the duration of this Contract, and for a period of five years after termination of this Contract, the HMO must provide duly authorized representatives of the state or federal government access to all records and material relating to the HMO's provision of and reimbursement for activities contemplated under the Contract. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of this Contract. All information so obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

C. Computer Data Reporting System

The HMO must maintain a computer/data reporting system that meets the following Department requirements. The HMO is responsible for complying with all the Department's reporting requirements and with ensuring the accuracy and completeness of the data as well as the timely submission of data. The data submitted must be supported by records available to the Department or its designee. The Department reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract. The HMO must have a contact person responsible for the computer/data reporting system and who can answer questions from the Department and resolve problems identified by the Department regarding the requirements listed below:

1. The HMO must have a claims processing system that is adequate to meet all claims processing and retrieval requirements specified.

2. The HMO must have a computer/data collection, processing, and reporting system sufficient to monitor HMO enrollment/disenrollment (in order to determine on any specific day which members are enrolled or disenrolled from the HMO) and to monitor service utilization for the Utilization Management requirements of Quality Assessment/Performance Improvement (QAPI).

3. The HMO must have a computer/data collection, processing, and reporting system sufficient to support the QAPI requirements. The system must be able to support the variety of QAPI monitoring and evaluation activities, including the monitoring/evaluation of quality of clinical care and service; periodic evaluation of HMO providers; member feedback on QAPI; maintenance of and use of medical records in QAPI; and monitoring and evaluation for annual QAPI study topics.

4. The HMO must have a computer and data processing system sufficient to accurately produce the data, reports, and encounter data set, in the formats and time lines prescribed by the Department in this Contract to the HMO is required to submit electronic test encounter data files as required by the Department in the format specified by the Department. The electronic test encounter data files are subject to Department review and approval before production data is accepted by the Department. Production claims or other documented encounter data must be used for the test data files.

5. The HMO must capture and maintain a claim record of each service or item provided to enrollees, using CMS 1500, UB-04, NCPDP, HIPAA transaction code sets, or other claim, or claim formats that are adequate to meet all reporting requirements of this Contact. The computerized database must be a complete and accurate representation of all services the HMO covers for the Contract period. The HMO is responsible for monitoring the integrity of the database, and facilitating its appropriate use for such required reports as encounter data and targeted performance improvement studies.

6. The HMO must have a computer processing and reporting system that is capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

7. The HMO reporting system must have the ability to identify all denied claims/encounters using national HIPAA Claim Adjustment Reason Codes.

8. The HMO system must be capable of reporting original and reversed claim detail records or encounters.

9. The HMO system must be capable of correcting an error to the encounter record within 90 days of notification by the Department.

The HMO must notify the Department of all significant personnel changes and system changes that may impact the integrity of the data, including new claims processing vendors and significant changes in personnel.

D. Coordination of Benefits (COB), Encounter Record, Formal Grievances and Birth Cost Reporting Requirements

The HMO agrees to furnish to the Department and to its authorized agents, within the Department's time frame and format, information that the Department requires to administer this Contract, including but not limited to the following:

1. *Coordination of Benefits (COB)*

   Summaries of amounts recovered from third parties for services rendered to enrollees under this Contract.

2. *Encounter Record for Each Enrollee Service*

   An encounter record for each service provided to enrollees covered under this Contract. The encounter data set must include at least those data elements specified.

3. *Formal Grievances*

   Copies of all formal grievances and documentation of actions taken on each grievance.

4. *Birth Cost (BadgerCare Plus Only)*

   As specified in Addendum IV, E.

E. Encounter Data Reporting Requirements

The HMO that contracts with the Department to provide BadgerCare Plus and/or Medicaid SSI services must submit monthly encounter data files according to the specifications and submission protocols published in the HMO Encounter Data User Manual.

1. Reporting Requirement

   The rules governing the level of detail when reporting encounters should be those rules established by the following classification schemes: ICD-9-CM (or ICD-10-CM) diagnosis codes and CPT and HCPCS procedure codes National Drug Codes (NDC), CDT codes, hospital revenue codes for inpatient and outpatient hospital services, and hospital inpatient Diagnostic Related Group (DRG) codes, if DRG codes are used.

   Multiple encounters can occur between a single provider and a single member on a day. For example, if a physician provides a limited office visit, administers an immunization, and takes a chest x-ray, and the provider submits a claim or report specifically identifying all three services, then there are three encounters, and the HMO will report three encounters to the BadgerCare Plus and Medicaid SSI Programs.

2. Testing Encounter Data

A new HMO must test the encounter data set until the Department is satisfied that the HMO is capable of submitting valid, accurate, and timely encounter data according to the schedule and timetable.

3. Primary HMO Contact Person

The HMO must specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting HMO encounter and utilization data, and a secondary contact person in the event the primary contact person is not available.

4. HMO Encounter Technical Workgroup Requirement

The HMO must assign staff to participate in HMO encounter technical workgroup meetings periodically scheduled by the Department. This workgroup's purpose is to enhance the HMO and BadgerCare Plus and/or Medicaid SSI data submission protocols and improve the accuracy and completeness of the data.

5. Encounter Data Completeness and Accuracy

The Department will conduct data validity and completeness audits during the Contract period. At least one of these audits will include a review of the HMO's encounter data system and system logic.

6. Analysis of Encounter Data

The Department retains the right to analyze encounter data and use it for any purpose it deems necessary. However, the Department will make every effort to ensure that the analysis does not violate the integrity of the reported data submitted by the HMO.

The HMO that subcontracts with providers must have the provisions for assuring that the data required on the HMO Utilization Report is reported to the HMO by the subcontractor. For example, subcontracts with providers of mental health or dental services must have a provision ensuring that survey and encounter data is reported to the HMO in an accurate and timely fashion.

The Department agrees to involve the HMO in the planning process prior to implementing any changes in questions or measures, format and definitions, and will request the HMO to review and comment on those changes before they go into effect.

F. Records Retention

The HMO must retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including paper

and electronic claim forms, for a period of not less than five years from the date of termination of this Contract. Records involving matters that are the subject of litigation shall be retained for a period of not less than five years following the termination of litigation. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, if the Department approves the microfilming procedures as reliable and supported by an effective retrieval system.

Upon expiration of the five year retention period and upon request, the subject records must be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

G. Reporting of Corporate and Other Changes

The HMO must report to the Department any change in corporate structure or any other change in information previously reported. The HMO must report the change as soon as possible, but no later than 30 days after the effective date of the change. Changes in information covered under this section include all of the following:

1. Any change to the information the HMO previously provided in response to the Department's questions in the current HMO certification application or any previous RFB for BadgerCare Plus and/or Medicaid SSI HMO Contracts. This includes any change in information provided by the HMO as a "new HMO," within the meaning of the HMO certification application or RFB.

2. Any change in information relevant to ineligible organizations.

3. Any change in information relevant to ownership and business transactions of the HMO.

H. Provider List Requirement

The HMO that contracts with the Department to provide BadgerCare Plus and/or Medicaid SSI services must submit provider data once per contract period, based on the HMO files as of December 31, 2009.

The data must be provided in a Microsoft Access database by January 31, 2009. A CD containing the database with instructions for the required fields will be provided by the Department by November 1, 2008.

I. Contract Specified Reports and Due Dates

REPORTS AND DUE DATES

Due Date	Type of Report	Reporting Period	Reporting Unit	Reporting Format
Within 15 days of contract signing	Civil Rights Compliance Plan: Affirmative Action Plan and Civil Rights Plan components	Contract period	DHFS	
Within 30 days of contract signing	Disclosure Statements	As of present time	BBM	
YEAR 2008				
Jan 10	Encounter Data File	Dec. 2007	Fiscal Agent	Electronic Media
Jan 10	Electronic list of HMO providers	Oct- Dec. 2007	Enrollment Specialist	As Agreed Upon
Jan 15	**Dental Progress Report	Oct.-Dec. 2007	BBM	Hardcopy
Jan 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Jan 31	Formal/Informal Grievance Experience Summary report	Oct.-Dec. 2007	BBM	Hardcopy
Feb 10	Encounter Data File	Jan. 2008	Fiscal Agent	Electronic Media
Feb 1	AIDS/Ventilator Dependent	Oct.-Dec. 2007	BFM	CD & Disc
Feb 15	Federally Qualified Health Centers & Rural Health Centers	Oct.-Dec. 2007	BBM	Hardcopy – no form
Feb 15	Coordination of Benefits Report	Oct.-Dec. 2007	BBM	Hardcopy
Feb 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Mar 10	Encounter Data File	Feb. 2008	Fiscal Agent	Electronic Media
March 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Apr 10	Encounter Data File	March 2008	Fiscal Agent	Electronic Media
Apr 10	Electronic list of HMO providers	Jan.-March 2008	Enrollment Specialist	As Agreed Upon
Apr 15	**Dental Progress Report	Jan.-March 2008	BBM	Hardcopy
April 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Apr 30	Formal/Informal Grievance Experience Summary report	Jan.-March 2008	BBM	Hardcopy
May 1	Common Carrier Data	Jan.-March 2008	BFM-Rate Section	Disc

Due Date	Type of Report	Reporting Period	Reporting Unit	Reporting Format
May 1	Neonatal ICU Patient Care Data	Jan. -Dec. 2007	BFM	Hardcopy
May 1	AIDS/Ventilator Dependent	Jan.- March 2008	BFM	CD & Disc
May 10	Encounter Data File	Apr. 2008	Fiscal Agent-	Electronic Media
May 15	Federally Qualified Health Centers & Rural Health Centers	Jan.-March 2008	BBM	Hardcopy - no form
May 15	Coordination of Benefits Report	Jan.-March 2008	BBM	Hardcopy
May 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Jun 10	Encounter File	May 2008	Fiscal Agent	Electronic Media
June 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Jul 1	Encounter File	June 2008	Fiscal Agent	Electronic Media
Jul 10	Electronic list of HMO providers	Apr.-June 2008	Enrollment Specialist	As Agreed Upon
Jul 15	**Dental Progress Report	Mar.- June 2008	BBM	Hardcopy
July 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Jul 31	Formal/Informal Grievance Experience Summary report	Apr.-June 2008	BBM	Hardcopy
Aug 1	AIDS/Ventilator Dependent	Apr.-June 2008	BFM	CD & Disc
Aug 1	Common Carrier Data	Apr.-June 2008	BFM-Rate Section	Disc
Aug 10	Encounter File	July 2008	Fiscal Agent	Electronic Media
Aug 15	Federally Qualified Health Centers & Rural Health Centers	Apr.-June 2008	BBM	Hardcopy - no form
Aug 15	Coordination of Benefits Report	Apr- June 2008	BBM	Hardcopy
Aug 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Sept 10	Encounter File	Aug. 2008	Fiscal Agent	Electronic Media
Sept 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Oct 1	Performance Improvement Projects	Jan.- Dec. 2007	BBM	Hardcopy

Due Date	Type of Report	Reporting Period	Reporting Unit	Reporting Format
Oct 10	Encounter File	Sept. 2008	Fiscal Agent	Electronic Media
Oct 10	Electronic list of HMO providers	July-Sept. 2008	Enrollment Specialist	As Agreed Upon
Oct 15	**Dental Progress Report	July-Sept. 2008	BBM	Hardcopy
Oct 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Oct 31	Formal/Informal Grievance Experience Summary report	July-Sept. 2008	BBM	Hardcopy
Nov 1	Common Carrier Data	July-Sept. 2008	BFM-Rate Section	Disc
Nov 1	AIDS/Ventilator Dependent	July-Sept. 2008	BFM	CD & Disc
Nov 10	Encounter File	Oct. 2008	Fiscal Agent	Electronic Media
Nov 15	Federally Qualified Health Centers & Rural Health Centers	July-Sept. 2008	BBM	Hardcopy - no form
Nov 15	Coordination of Benefits Report	July-Sept. 2008	BBM	Hardcopy
Nov 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Dec 10	Encounter File	Nov. 2008	Fiscal Agent	Electronic Media
Dec 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
YEAR 2009				
Jan 10	Encounter Data File	Dec. 2008	Fiscal Agent	Electronic Media
Jan 10	Electronic list of HMO providers	Oct.-Dec. 2008	Enrollment Specialist	As Agreed Upon
Jan 15	**Dental Progress Report	Oct.-Dec. 2008	BBM	Hardcopy
Jan 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Jan 31	Formal/Informal Grievance Experience Summary report	Oct.-Dec. 2008	BBM	Hardcopy
Feb 1	Common Carrier Data	Oct.-Dec 2008	BFM-Rate Section	Disc
Feb 1	AIDS/Ventilator Dependent	Oct.-Dec. 2008	BFM	CD & Disc
Feb 10	Encounter Data File	Jan. 2009	Fiscal Agent	Electronic Media
Feb 15	Federally Qualified Health Centers & Rural Health Centers	Oct.-Dec. 2008	BBM	Hardcopy – no form

Due Date	Type of Report	Reporting Period	Reporting Unit	Reporting Format
Feb 15	Coordination of Benefits Report	Oct.-Dec. 2008	BBM	Hardcopy
Feb 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Mar 10	Encounter Data File	Feb. 2009	Fiscal Agent	Electronic Media
March 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Apr 10	Encounter Data File	March 2009	Fiscal Agent	Electronic Media
Apr 10	Electronic list of HMO providers	Jan.-March 2009	Enrollment Specialist	As Agreed Upon
Apr 15	**Dental Progress Report	Jan.-March 2009	BBM	Hardcopy
April 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Apr 30	Formal/Informal Grievance Experience Summary report	Jan.-March 2009	BBM	Hardcopy
May 1	Common Carrier Data	Jan.-March 2009	BFM-Rate Section	Disc
May 1	Neonatal ICU Patient Care Data	Jan.-Dec. 2008	BFM	Hardcopy
May 1	AIDS/Ventilator Dependent	Jan.-March 2009	BFM	CD & Disc
May 10	Encounter Data File	Apr. 2009	Fiscal Agent	Electronic Media
May 15	Federally Qualified Health Centers & Rural Health Centers	Jan.-March 2009	BBM	Hardcopy - no form
May 15	Coordination of Benefits Report	Jan.-March 2009	BBM	Hardcopy
May 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Jun 10	Encounter File	May 2009	Fiscal Agent	Electronic Media
June 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Jul 10	Encounter File	June 2009	Fiscal Agent	Electronic Media
Jul 10	Electronic list of HMO providers	Apr.-June 2009	Enrollment Specialist	As Agreed Upon
Jul 15	**Dental Progress Report	Mar-June 2009	BBM	Hardcopy
July 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media

Due Date	Type of Report	Reporting Period	Reporting Unit	Reporting Format
Jul 31	Formal/Informal Grievance Experience Summary report	Apr.-June 2009	BBM	Hardcopy
Aug 1	Common Carrier Data	Apr.-June 2009	BFM – Rate Section	Disc
Aug 1	AIDS/Ventilator Dependent	Apr.-June 2009	BFM	CD & Disc
Aug 10	Encounter File	July 2009	Fiscal Agent	Electronic Media
Aug 15	Federally Qualified Health Centers & Rural Health Centers	Apr.-June 2009	BBM	Hardcopy - no form
Aug 15	Coordination of Benefits Report	Apr.-June 2009	BBM	Hardcopy
Aug 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Sept 10	Encounter File	Aug. 2009	Fiscal Agent	Electronic Media
Sept 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Oct 1	Performance Improvement Projects	Jan.-Dec. 2008	BBM	Hardcopy
Oct 10	Encounter File	Sept. 2009	Fiscal Agent	Electronic Media
Oct 10	Electronic list of HMO providers	July-Sept. 2009	Enrollment Specialist	As Agreed Upon
Oct 15	**Dental Progress Report	July-Sept. 2009	BBM	Hardcopy
Oct 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Oct 31	Formal/Informal Grievance Experience Summary report	July-Sept. 2009	BBM	Hardcopy
Nov 1	Common Carrier Data	July-Sept. 2009	BFM	Disc
Nov 1	AIDS/Ventilator Dependent	July-Sep. 2009	BFM	CD & Disc
Nov 10	Encounter File	Oct. 2009	Fiscal Agent	Electronic Media
Nov 15	Federally Qualified Health Centers & Rural Health Centers	July-Sept. 2009	BBM	Hardcopy - no form
Nov 15	Coordination of Benefits Report	July-Sept. 2009	BBM	Hardcopy
Nov 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media
Dec 10	Encounter File	Nov. 2009	Fiscal Agent	Electronic Media

Due Date	Type of Report	Reporting Period	Reporting Unit	Reporting Format
Dec 20	Assessment Report	Monthly	Enrollment Specialist	Electronic Media

Any reports that are due on a weekend or holiday are due the following business day.

** Only the HMO that is certified to provide dental services is required to submit dental progress reports for the service area in which the HMO is certified to provide dental.

BBM = Bureau of Benefits Management

BFM = Bureau of Fiscal Management

Report Mailing Addresses:

Department of Health and Family Services
Bureau of Benefits Management
P.O. Box 309
Madison, WI 53701-0309

Fiscal Agent
Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470

Department of Health and Family Services
Affirmative Action/Civil Rights Compliance Office
P.O. Box 7850
Madison, WI 53707-7850

ARTICLE VIII

VIII. ENROLLMENT AND DISENROLLMENTS

A. Enrollment

The HMO must accept as enrolled all persons who appear as enrollees on the HMO Enrollment Reports. The Department reserves the right to assign a BadgerCare Plus and/or Medicaid SSI member into a specific HMO when the member fails to choose an HMO during a required enrollment period.

Persons otherwise eligible for enrollment into the HMO cannot enroll if they are already participating in:

(1) A Community Integration Program (CIP); or
(2) A Community Options Program (COP); or
(3) Family Care (FC); or
(4) PACE or Partnership Program

BadgerCare Plus 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.

For 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.

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

B. Enrollment Levels

The HMO, for BadgerCare Plus or Medicaid SSI, must designate a maximum enrollment level for each service area. The Department may take up to 60 days from the date of written notification to implement maximum enrollment level changes. The HMO must accept as enrolled all persons who appear as enrollees on the HMO Enrollment Reports up to the HMO specified enrollment level for its service area. The number of enrollees may exceed the maximum enrollment level by 5% on a temporary basis. The Department does not guarantee any minimum enrollment level. The maximum enrollment level for a service

area may be increased or decreased during the course of the Contract period based on mutual acceptance of a different maximum enrollment level.

The HMO must not obtain enrollment through the offer of any compensation, reward, or benefit to the enrollee except for additional health-related services that have been approved by the Department.

C. Enrollment and Disenrollment Practices

The HMO must permit the Department to monitor its enrollment and disenrollment practices. The HMO will not discriminate in enrollment or disenrollment activities between individuals on the basis of health status or requirement for health care services, including those who have AIDS or are HIV-positive. This includes an enrollee with a diminished mental capacity, who is uncooperative and displays disruptive behavior due to the enrollee's special needs.

The Department must ensure that members with medical status codes that are not eligible for HMO enrollment are appropriately disenrolled according to Department policy.

This section does not prevent the HMO from assisting in the disenrollment process for individuals who the Department determines should be assigned a different medical status code.

D. Disenrollment Requests

1. Voluntary Disenrollment

All BadgerCare Plus enrollees shall have the right to disenroll from the HMO pursuant to 42 CFR 43427(b)(1) unless otherwise limited by a State Plan Amendment or a Section 1115(a) waiver of federal laws. A voluntary disenrollment shall be effective no later than the first day of the second month following the month in which the enrollee requests termination. Wisconsin currently has a State Plan Amendment and an 1115(a) waiver which allows the Department to "lock-in" enrollees to the HMO for a period of 12 months in mandatory HMO service areas, except that disenrollment is allowed for just cause. Voluntary exemptions and disenrollments from the HMO are allowed for a variety of reasons.

All mandatory Medicaid SSI or SSI-related Medicaid enrollees have the right to disenroll from the HMO after completing a 60 day trial period. A voluntary disenrollment for the mandatory Medicaid SSI population shall be effective no earlier than the first day of the third month following enrollment. If the enrollee, legal guardian or authorized representative does not elect disenrollment during the first four months of enrollment, the enrollee will be locked-in to the HMO for the remainder of the 12 month

enrollment period. The enrollee is required to complete only one 60 day trial period. If there is a disenrollment and subsequent re-enrollment, the enrollee is not required to complete another trial period.

All voluntary Medicaid SSI enrollees shall have the right to disenroll from the HMO within the first 90 days of enrollment. Such voluntary Medicaid SSI disenrollment shall be effective no earlier than the first day of the month following the request to disenroll. If the enrollee, legal guardian or authorized representative does not elect disenrollment during the first three months of enrollment, the enrollee will be locked-in to the HMO for the remainder of the 12-month enrollment period.

Members may also request disenrollment upon automatic reenrollment under 42 CFR 438.56(g) if the temporary loss of BadgerCare Plus and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period.

2. Involuntary Disenrollment

The Department may approve an involuntary disenrollment with an effective date that will be the next available benefit month based on enrollment system logic, except for specific cases or persons where there is a situation where enrollment would be harmful to the interests of the enrollee or in which the HMO cannot provide the enrollee with appropriate medically necessary contract services for reasons beyond its control. For any request for involuntary disenrollment, the HMO must submit a disenrollment request to the Department and include evidence attesting to cause which might include, but is not limited to:

(a) Just Cause

The HMO may request and the Department will approve disenrollment requests for specific cases or persons where there is just cause. Just cause is defined as a situation where enrollment would be harmful to the interests of the member or in which the HMO cannot provide the member with appropriate medically necessary contract services for reasons beyond its control. The HMO may not request just cause disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative disruptive behavior resulting from his or her special needs (42 CFR 438.56).

Examples of some just cause disenrollment requests are:

(i) The enrollee does not comply with critical aspects of the individual care plan or is unable to maintain a reasonable

working relationship with the team or physician, despite repeated good faith efforts by the HMO to communicate the seriousness of the problem and attempt alternate methods of providing care in a manner more consistent with enrollee preferences.

(ii) The enrollee refuses critical services and/or is unwilling to meet significant conditions of participation, despite repeated good faith efforts by the HMO to communicate the seriousness of the problem and attempt alternate methods of providing care in a manner more consistent with enrollee preferences.

(iii) A Medicaid SSI enrollee is unreachable for assessment and care planning during the first 60 days of enrollment. The HMO must provide the Department with convincing evidence that proves that they have made extensive good faith efforts to reach the enrollee, including by mail (with a certified letter), telephone and in person.

b. Nursing Home (Medicaid SSI Only)

If an enrollee is in a nursing home 90 days or longer, the enrollee shall be disenrolled. In the event the enrollee transfers from the nursing home to a hospital and back to the nursing home, the applicable 90 day period shall run continuously from the first admission to the nursing home and shall include any days in the hospital.

E. Out of Service Area, County Waiver Programs, and Loss of BadgerCare Plus or Medicaid SSI Disenrollments

The enrollee will be disenrolled if any of the following occur:

1. Out-of-Service Area

The enrollee moved to a location that is outside of the HMO's service area(s). The date of the disenrollment shall be the date the move occurred, even if this requires retroactive disenrollment. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

2. County Case Management Waiver Programs or Other Managed Care Programs

The enrollee is or will be participating in CIP, COP, or PACE/Partnership, other home and community waivers, or other managed care programs (such as Family Care). The HMO must inform the Enrollment Specialist of the effective dates that the enrollee is/was participating in the county waiver program or other managed care program to accommodate a timely disenrollment. Disenrollment shall be effective the first of the month in which the enrollee entered the other program. Exemptions are not backdated more than four months from the date the request is received. Any capitation payments made for months subsequent to disenrollment will be recouped.

3. Loss of BadgerCare Plus and/or Medicaid SSI Eligibility

If an enrollee looses BadgerCare Plus or Medicaid SSI eligibility or dies, the enrollee shall be disenrolled. The date of disenrollment shall be the date of BadgerCare Plus or Medicaid SSI eligibility termination or the date after the date of death. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

F. Other Disenrollment and Exemption Requests

Other disenrollment and exemption requests will be processed as soon as possible and will generally be effective the first day of the next month of the request, unless otherwise specified. All disenrollment and exemption requests must be directed to the Department's Enrollment Specialist.

Disenrollment and exemptions, requests will not normally be backdated. The Department will not use its authority regarding backdating unreasonably. If the disenrollment or exemption is approved, the HMO will not be liable for services, as of the effective date of the disenrollment or exemption. If the Department fails to make a disenrollment or exemption determination within 30 days of receipt of all necessary information the disenrollment or exemption is considered approved.

1. Other Disenrollment Criteria:

(a) Inmates of a Public Institution

The HMO is not liable for providing care to enrollees who are inmates in a public institution for more than a full calendar month as defined in HFS 101.03(85). The HMO must provide documentation that shows the enrollee is incarcerated. The disenrollment will be effective the first of the month

following the first full month of incarceration or the date of BadgerCare Plus and/or Medicaid SSI ineligibility, wherever comes first.

(b) Medicare Beneficiaries (BadgerCare Plus Only)

Enrollees who become eligible for Medicare will be disenrolled effective the first of the month of notification to the BadgerCare Plus program from the Social Security Administration (SSA). Even if SSA awards Medicare eligibility retroactively, the effective date of HMO disenrollment will be the first of the month of notification.

(c) Native American

Enrollees who are Native American and members of a federally recognized tribe are eligible for disenrollment.

2. Exemptions

Exemption requests must come from the enrollee, the enrollee's family, or legal guardian. Below are listed the exemption criteria that the Department uses to grant exemptions. The exemption chart (Subsection G of this article) indicates which medical status for each eligibility category that is eligible for each exemption.

(a) AIDS or HIV-Positive

Enrollees with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code, or who are HIV-positive and on anti-retroviral drug treatment approved by the federal Food and Drug Administration, are eligible for an exemption. The HMO must not counsel or otherwise influence an enrollee or potential enrollee in such a way as to encourage exemption from enrollment or continued enrollment. The exemption is processed as soon as possible and is effective on the first day of the month that the anti-retroviral treatment began or the date that the enrollee is diagnosed with AIDS. Exemptions are not backdated more than nine months from the date the request is received.

(b) Certified Nurse Midwives or Nurse Practitioners

Enrollees may be eligible for an exemption from enrollment if all the following criteria are met:

- The enrollee resides in a service area of a certified nurse midwife or nurse practitioner.

- The enrollee chooses to receive her pregnancy care from a certified nurse midwife or a nurse practitioner.

- The certified nurse midwife or nurse practitioner is not affiliated with any HMO in the service area either as an independently certified provider or as a non-billing provider.

(c) Commercial HMO Insurance

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

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

When the Department's member eligibility file indicates commercial HMO coverage limiting an enrollee to providers outside the BadgerCare Plus and/or Medicaid SSI HMO network and the enrollee seeks services from the BadgerCare Plus and/or Medicaid SSI HMO network providers, the BadgerCare Plus and/or Medicaid SSI HMO network providers may refuse to provide services to that enrollee and refer him/her to their commercial network, except in the case of an emergency.

(d) Federally Qualified Health Centers

Enrollees may be eligible for an exemption from enrollment if the following criteria are met:

- The enrollee resides in the service area of an FQHC.
- The enrollee chooses to receive their primary care from the FQHC.
- The FQHC is not affiliated with any HMO within the service area.

(e) Mental Health and Substance Abuse Exemption (BadgerCare Plus Only)

Requests for exemption from HMO enrollment must be initiated by the case head or the enrollee who meets one or more of the following:

- A child meeting criteria for severe emotional disturbance (SED) who is enrolled or has been accepted in a SED program, such as intensive in-home psychotherapy or child/adolescent day treatment, during the term of the SED treatment.

- A person participating in a methadone treatment program, or who has been determined to need methadone treatment unless the person declines to receive such treatment. Enrollees who request exemption prior to participation in a methadone treatment program may be exempted for a maximum of two months, and the exemption may be extended if they continue to participate in the program.

- A person with a complex physical or psychiatric condition who has extensive non-medical programming needs best provided or coordinated by the 51.42, 51.437, and/or social or human services systems (such as Community Support Programs, Comprehensive Community Services, etc.).

When the HMO confirms that at least one of these conditions exists, the HMO must inform the BadgerCare Plus case head of their options to enroll the affected enrollee in the HMO or to request that the person remain in the FFS system. The HMO shall not encourage an enrollee to request an exemption from enrollment or to continue enrollment. The Department, the local boards, and the county social service departments may notify enrollees or potential enrollees of their options independently where such notification is deemed appropriate.

(f) Ninth Month Pregnancy

Enrollees who deliver or are expected to deliver the first month they are assigned to the HMO may be eligible for exemption. In order for an exemption to occur the enrollee:

- Must have been automatically assigned or reassigned and must not have been in the HMO to which they were assigned or reassigned within the last seven months; and

- Must be seeking care from a provider (physician and/or hospital) not affiliated with the HMO to which they were assigned.

Exemptions requests can be made by the HMO, a provider, or the enrollee.

(g) Medicaid SSI Families

Families may be eligible for an exemption from enrollment if:

- There are one or more members in the family who are receiving SSI benefits, and
- The SSI member receives primary care from a provider who does not accept any HMO, and
- Other family members receive their primary care from the same provider as the SSI member.

The exemption request may be made by the SSI member, parent,
or guardian.

(h) Third Trimester Pregnancy

Enrollees who are in their third trimester of pregnancy when they are expected to enter the HMO may be eligible for an exemption. In order for an exemption to occur the enrollee:

- Must have been automatically assigned or reassigned to their current HMO; and
- The enrollee must be seeking care from a provider (physician or hospital) who is either not affiliated with the HMO to which they were assigned or is affiliated but the HMO is closed to new enrollment.

Only the enrollee, legal guardian, or authorized representative can make exemption requests. The exemption request must be made before the end of the second month in the HMO or before the birth, whichever occurs first.

(i) Transplant

Transplant coverage is as follows:

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

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

As a general principle, Wisconsin BadgerCare Plus and Medicaid SSI does not pay for transplants that it determines to be experimental in nature.

Enrollees who have had one or more of the transplant surgeries referenced above will be permanently exempted from HMO enrollment.

(j) Admission to a Birth-to-3 Exemption (BadgerCare Plus Only)

A child from birth through two years of age (including two year olds), who is severely developmentally disabled or suspected of a severe developmental delay, or who is admitted to a Birth-to-3 program is eligible for an exemption. Exemption request must be made by the case head of the enrollee or the County Birth-to-3 programs, on behalf of an enrollee. Exemption requests should be directed to the Department's Enrollment Specialist. Exemptions are backdated no more than two months from the date the request is received.

G. System Based Disenrollments

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

Exemption Type	BadgerCare Plus	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	Medicaid SSI/SSI Related
Ninth Month Pregnancy	Yes	Yes
Third Trimester Pregnancy	Yes	Yes
SSI Family Member	Yes	No
Nurse Midwife/Certified Nurse Practitioner	Yes	Yes
FQHC	Yes	Yes
Mental Health and/or Substance Abuse	Yes	No
HIV/AIDS	Yes	Yes
Commercial HMO	Yes	Yes
Native American	Yes	Yes
Birth-to-3	Yes	No

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

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

H. Enrollee Lock-In Period

1. *BadgerCare Plus*

Under the Department's State Plan Amendment, mandatory enrollees will be locked into the HMO for 12 months. The first 90 days of the 12-month lock-in period is an open enrollment period during which the enrollee may change HMOs without cause.

2. *Mandatory SSI and SSI-Related Medicaid*

For mandatory Medicaid SSI and SSI-related Medicaid the first 120 days of the 12 month lock-in period are an open enrollment period during which the enrollee may change HMOs without cause. The enrollee may disenroll from the HMO without cause and return to FFS after the initial 60 day trial period. The enrollee, legal guardian, or authorized representative may request disenrollment without cause at any time during the first 120 days of enrollment. If the HMO fails to complete the assessment and care plan during the 120 day period, the disenrollment period will be extended for 30 days following completion of the assessment and care plan.

3. *Voluntary Medicaid SSI and SSI-Related Medicaid*

Voluntary Medicaid SSI and SSI-related Medicaid has 90 days for an open enrollment period during which the enrollee may request disenrollment without cause at any time. After the 90 day opt-out period, if the enrollee does not choose to go back to FFS, they will be locked-in for nine additional months. If the HMO fails to

complete the assessment and care plan during the first 90 days of enrollment, the disenrollment period will be extended for 30 days following completion of the assessment and care plan.

I. Reenrollment

A member may be automatically reenrolled into the HMO if they were solely disenrolled because she/he loses BadgerCare Plus or Medicaid SSI eligibility for a period of six months or less. If a member wants to choose another HMO, they may do so at any time within 90 days after re-enrollment.

ARTICLE IX

IX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The grievance process refers to the overall system that includes complaints, grievances and appeals or expedited appeals as defined in Article I. BadgerCare Plus and/or Medicaid SSI enrollees and/or their authorized representative may grieve any aspect of service delivery provided or arranged by the HMO, to the HMO and to the Department. The enrollee may appeal an action to the HMO, the Department and/or to the Division of Hearings and Appeals.

A. Procedures

The HMO must:

1. Have written policies and procedures that detail what the grievance and appeal system is and how it operates.

2. Identify a contact person in the HMO to receive grievances and appeals and be responsible for routing and processing.

3. Operate a complaint process that enrollees can use to get problems resolved without going through the formal, written grievance process.

4. Operate a grievance process that enrollees can use to grieve in writing.

5. Inform enrollees about the existence of the complaint and grievance processes and how to use them.

6. Attempt to resolve complaints, grievances and appeals informally.

7. Respond to grievances and appeals in writing within 10 business days of receipt, except in cases of emergency or urgent (expedited grievance) situations. This represents the first response. The HMO must resolve the grievance or appeal within two business days of receipt of an expedited grievance, or sooner if possible.

8. Operate a grievance process within the HMO that enrollees can use to grieve or appeal any negative response to the Board of Directors of the HMO. The HMO Board of Directors may delegate the authority to review grievances and appeals to the HMO grievance appeal committee, but the delegation must be in writing. If a grievance appeal committee is established, the BadgerCare Plus and/or Medicaid SSI HMO Advocate must be a member of the committee.

9. Provide the enrollee and his or her representative an opportunity, before and during the appeals process, to examine enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

10. Grant the enrollee the right to appear in person before the grievance appeal committee to present written and oral information. The enrollee may bring a representative to the meeting. The HMO must inform the enrollee in writing of the time and place of the meeting at least seven days before the meeting.

11. Maintain a record keeping "log" of complaints and grievances that includes a short, dated summary of each problem, the response, and the resolution. The log must distinguish BadgerCare Plus or Medicaid SSI from commercial enrollees, if the HMO does not have a separate log for BadgerCare Plus or Medicaid SSI. The HMO must submit quarterly reports to the Department of all complaints, grievances and appeals. The analysis of the log will include the number of complaints, grievances and appeals divided into two categories, program administration and benefit denials.

12. Maintain a record keeping system for grievances and appeals that includes a copy of the original grievance or appeal, the response, and the resolution. The system must distinguish BadgerCare Plus or Medicaid SSI from commercial enrollees.

13. At the time of the HMO's initial grievance denial of an action decision the HMO must notify the enrollee that the grievance denial decision may be appealed to the Department and/or to the Division of Hearings and Appeals. The enrollee or his/her authorized representative may appeal orally, but must follow up with a signed written appeal.

14. Ensure that individuals with the authority to require corrective actions are involved in the grievance process.

15. Distribute to its gatekeepers[1] and IPAs the informational flyer on enrollee grievance and appeal rights (the Ombuds Brochure). When a new brochure is available, the HMO must distribute copies to its gatekeepers and IPAs within three weeks of receipt of the new brochure.

16. Ensure that its gatekeepers and IPAs have written procedures for describing how enrollees are informed of denied services. The HMO will make copies of the gatekeepers' and IPAs' grievance procedures available for review upon request by the Department.

[1] The word "gatekeeper" in this context refers to any entity that performs a management services contract, a behavioral health science IPA, or a dental IPA, and not to individual physicians acting as a gatekeeper to primary care services.

17. Inform enrollees about the availability of interpreter services and provide interpreter services for non-English speaking and hearing impaired enrollees throughout the HMO's grievance process.

B. Grievance and Appeal Process

The enrollee may choose to use the HMO's grievance and appeal process or may appeal to the Department instead of using the HMO's grievance and appeal process. If the enrollee chooses to use the HMO's process, the HMO must provide an initial response within 10 business days and a final response within 30 days of receiving the grievance or appeal. If the HMO is unable to resolve the grievance or appeal within 30 days, the time period may be extended another 14 days from receipt if the HMO notifies the enrollee in writing that the HMO has not resolved the grievance or appeal, when the resolution may be expected, and why the additional time is needed. The total timeline for the HMO to finalize a formal grievance or appeal may not exceed 45 days from the date of the receipt.

Any grievance or appeal decision by the HMO may be appealed by the enrollee and/or their authorized representative to the Department. The Department shall review such appeals and may affirm, modify, or reject any formal decision of the HMO at any time after the enrollee files the formal appeal. The Department will request the name and credentials of the person making the denial decision as part of the grievance process. The Department will give a final response within 30 days from the date the Department has all information needed for a decision. Also, an enrollee can submit a grievance or appeal directly to the Department at any time during the grievance process. Any decision made by the Department under this section is subject to enrollee appeal rights to the extent provided by state and federal laws and rules. The Department will receive input from the member and the HMO in considering grievances and appeals.

For an expedited grievance or appeal, the HMO must resolve all issues within two business days of receiving the written request for an expedited grievance. The HMO must make reasonable effort to provide oral notice, in addition to written notice for the resolution.

The HMO must ensure that punitive action is not taken against anyone who either requests an expedited resolution or supports an enrollee's grievance.

C. Notifications to Enrollees

When the HMO, its gatekeepers, or its IPAs discontinues, terminates, suspends, limits, or reduces a service (including services authorized by the HMO the enrollee was previously enrolled in or services received by the enrollee on a FFS basis), the HMO must notify the affected enrollee(s), and his/her provider when appropriate, in writing at least 10 days before the date of action. When the HMO, its gatekeepers, or its IPAs deny coverage of a new service, the HMO must notify the enrollee of the denial in writing.

Notices for both ongoing services and new benefits must include all of the following:

1. The nature of the intended action.

2. The reasons for the intended action. The reason must be clearly stated in sufficient detail to ensure that the enrollee understands the action being taken by the HMO.

3. The fact that the enrollee and/or his/her authorized representative has the right to appeal within 45 days of the date of the notice.

4. The enrollee has the right to examine the documentation the HMO used to make its determination prior to the HMO grievance committee hearing or the DHA.

5. The fact that interpreter services are available free of charge during the grievance and appeal process and how the enrollee can access those services.

6. A sentence in various languages that explains who to call for interpreter services or a copy of the letter in the appropriate language.

7. The right of the enrollee to have a representative assist him/her at any point in the appeal process including reviews or hearings.

8. The right of the enrollee to present "new" information before or during the grievance and appeal process including reviews or hearings.

9. The fact that punitive action will not be taken against an enrollee who appeals an HMO decision.

10. That the process for requesting an oral or written expedited grievance or appeal requires a medical provider to verify that delay can be a health risk.

11. An explanation of the enrollee's right to appeal the HMO's decision to the Department at any point in the process.

12. The fact that the enrollee, if appealing the HMO action, may file a request for a hearing with the Division of Hearings and Appeals (DHA) at any point in the process and the address of the DHA.

13. The fact that the enrollee can receive help in filing a grievance or appeal by calling the HMO Advocate, the Ombuds, or the SSI External Advocate (SSI managed care enrollees in counties served by the External Advocate).

14. The address and telephone number of the HMO Advocate, the Ombuds and the External Advocate. (The External Advocate is for Medicaid SSI only.)

Notifications to enrollees of termination, suspension, or reduction of an ongoing benefit (including services authorized by the HMO the enrollee was previously enrolled in or services received by the enrollee on a FFS basis), must in addition to items 1 through 14 above, also include the following:

a) The fact that a benefit will continue during the appeal or DHA fair hearing process if the enrollee requests that it continue within 10 days of notification or before the effective date of the action, whichever is later.

b) The circumstances under which a benefit will continue during the grievance and appeal process.

c) The fact that if the enrollee continues to receive the disputed service, the enrollee may be liable for the cost of care if the decision is adverse to the enrollee.

This notice requirement does not apply when the HMO, its gatekeeper or its IPA triages an enrollee to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary.

The Department must review and approve all notice language prior to its use by the HMO. Department review and approval will occur during the BadgerCare Plus and/or Medicaid SSI certification process of the HMO and prior to any change of the notice language by the HMO.

D. Continuation of Benefits Requirements

If the enrollee files a request for a hearing with the DHA on or before the later of the effective date or within 10 days of the HMO mailing the notice of action to reduce, limit, terminate or suspend benefits, upon notification by the DHA the HMO will notify the enrollee they are eligible to continue receiving care but may be liable for care if DHA upholds the HMO's decision. If the enrollee requests that the services in question be continued pending the outcome of the fair hearing, the following conditions apply:

1. If the DHA reverses the HMO's decision the HMO is responsible to cover services provided to the enrollee during the administrative hearing process.

2. If the DHA upholds the HMO's decision, the HMO may pursue reimbursement from the enrollee for all services provided to the enrollee, to the extent that the services were covered solely because of this requirement.

   Benefits must be continued until one of the following occurs:

   - The enrollee withdraws the appeal.
   - A state fair hearing decision adverse to the enrollee is made.
   - The authorization expires or the authorization service is met.

E. Reporting of Grievances to the Department

The HMO must forward both the complaint and grievance reports to the Department within 30 days of the end of a quarter in the format specified. Failure on the part of the HMO to submit the quarterly complaint and grievance reports in the required format within five days of the due date may result in any or all sanctions available under this Contract.

ARTICLE X

X. SUBCONTRACTS

This Article does not apply to subcontracts between the Department and the HMO. The Department shall have sole authority to determine the conditions and terms of such subcontracts. Subcontractor (hereinafter identified as subcontractor) agrees to abide by all applicable provisions of (HMO NAME)'s contract with the Department of Health and Family Services, hereinafter referred to as the BadgerCare Plus and Medicaid SSI HMO Contract. Subcontractor compliance with the BadgerCare Plus and Medicaid SSI HMO Contract specifically includes but is not limited to the requirements specified below.

A. Subcontract Standard Language

The HMO must ensure that all subcontracts are in writing and include the following standard language when applicable.

1. Subcontractor uses only BadgerCare Plus and/or Medicaid SSI-certified providers in accordance with this Contract.

2. No terms of this subcontract are valid which terminate legal liability of the HMO.

3. Subcontractor agrees to participate in and contribute required data to HMO Quality Assessment/Performance Improvement programs.

4. Subcontractor agrees to abide by the terms of this Contract for the timely provision of emergency and urgent care. Where applicable, subcontractor agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by the HMO in accordance with this Contract.

5. Subcontractor agrees to submit HMO encounter data in the format specified by the HMO, so that the HMO can meet the Department specifications required by this Contract. The HMO will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.

6. Subcontractor agrees to comply with all non-discrimination requirements.

7. Subcontractor agrees to comply with all record retention requirements and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements.

8. Subcontractor agrees to provide representatives of the HMO, as well as duly authorized agents or representatives of the Department and the

federal Department of Health and Human Services, access to its premises and its contracts and/or medical records. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

9. Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in this Contract.

10. Subcontractor agrees to ensure confidentiality of family planning services.

11. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus and/or Medicaid SSI benefits (e.g., COB recovery procedures that delay or prevent care).

12. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

13. Subcontractor agrees not to bill BadgerCare Plus and/or Medicaid SSI enrollees for medically necessary services covered under this Contract and provided during the enrollees' period of HMO enrollment. Subcontractor also agrees not to bill enrollees for any missed appointments while the enrollees are eligible under the BadgerCare Plus – Standard Plan and/or Medicaid SSI Programs. This provision will remain in effect even if the HMO becomes insolvent. However, BadgerCare Plus – Benchmark 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.

    The standard release form signed by the enrollee at the time of services does not relieve the HMO and its providers and subcontractors from the prohibition against billing a BadgerCare Plus – Standard Plan or Medicaid SSI enrollee in the absence of a knowing assumption of liability for a non-covered service. The form or other type of acknowledgment relevant to BadgerCare Plus or Medicaid SSI enrollee liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus or Medicaid SSI.

14. Within 15 business days of the HMO's request subcontractors must forward medical records pursuant to grievances to the HMO. If the subcontractor does not meet the 15 business day requirement, the subcontractor must explain why and indicate when the medical records will be provided.

15 Subcontractor agrees to abide by the terms regarding appeals to the HMO and to the Department regarding the HMO's nonpayment for services providers render to enrollees.

16. Subcontractor agrees to abide by the HMO marketing/informing requirements. Subcontractor will forward to the HMO for prior approval all flyers, brochures, letters and pamphlets the subcontractor intends to distribute to its enrollees concerning its HMO affiliation(s), or changes in affiliation, or relating directly to the BadgerCare Plus and/or Medicaid SSI population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the HMO and the Department.

B. Subcontract Submission Requirements

1. Changes in Established Subcontracts

   a. The HMO must submit changes in previously approved subcontracts to the Department for review and approval before they take effect. This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services.

      1) Technical changes do not have to be approved.

      2) Changes in rates paid do not have to be approved, with the exception of changes in the amounts paid to HMO management services subcontractors.

   b. The Department will review the subcontract changes and respond to the HMO within 15 business days. If the Department does not respond to the request for review within 15 business days of submission, the HMO must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within five business days of this contact.

2. New Subcontracts

   The HMO must submit new subcontracts to the Department for review and approval before they take effect. If the Department does not respond to the request for review within 15 business days of submission, the HMO must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within five business days of this contact.

C. Review and Approval of Subcontracts

The Department may approve, approve with modification, or deny subcontracts under this Contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the state and BadgerCare Plus and/or Medicaid SSI members, including but not limited to the proposed subcontractor's past performance. The Department will:

1. Give the HMO:

    - 120 days to implement a change that requires the HMO to find a new subcontractor, and

    - 60 days to implement any other change required by the Department.

2. Acknowledge the approval or disapproval of a subcontract within 15 business days after its receipt from the HMO.

3. Review and approve or disapprove each new subcontract before the Contract takes effect. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to of this Contract.

4. Ensure that the HMO has included the standard subcontract language as specified in Section A of this Article (except for specific provisions that are inapplicable in a specific HMO management subcontract).

D. Transition Plan

The HMO may be required to submit transition plans when a primary care provider(s), mental health provider(s), gatekeeper or dental clinic terminates their contractual relationship with the HMO. The transition plan will address continuity of care issues, enrollee notification and any other information required by the Department to ensure adequate enrollee access. The Department will either
approve, deny, or modify the transition plan within 15 business days of receipt or prior to the effective date of the subcontract change.

E. Notification Requirements Regarding Subcontract Additions or Terminations

The HMO must:

1. Notify the Department of Additions or Terminations

The HMO must notify the Department within 10 days of subcontract additions or terminations involving:

- A clinic or group of physicians, mental health providers, or dentists,
- An individual physician,
- An individual mental health provider and/or clinic,
- An individual dental provider and/or clinic.

2. Notify the Department of a Termination or Modification that Involves Reducing Access to Care

The HMO must notify the Department within seven days of any notice by the HMO to a subcontractor, or any notice to the HMO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce enrollee access to care.

If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize enrollee access to care, then the Department may invoke the remedies pursuant to this Contract. These remedies include contract termination (notice to the HMO and opportunity to correct are provided for), suspension of new enrollment, and giving enrollees an opportunity to enroll in a different HMO.

3. Notify the Enrollment Broker of an Addition or Termination

The HMO must notify the Department's enrollment broker within 10 days of additions to, and deletions from, the provider network. The HMO must also submit to the enrollment broker an electronic listing of all network providers, and facilities within the first 10 days of each calendar quarter in a mutually agreed upon format approved by the Department. This listing will include, but is not limited to, provider name, provider number, address, telephone number, and specialty as well as indicators designating whether a provider can be selected as a PCP, and whether the PCP is accepting new patients. The listing shall include only certified providers who are contracted with the HMO to provide contract services to enrollees.

4. Notify Enrollees of Provider Terminations

Not less than 30 days prior to the effective date of the termination, the HMO must also send written notification to enrollees whose PCP, mental health provider, gatekeeper or dental clinic terminates a contract with the HMO. The Department must approve all notifications before they are sent to enrollees.

F. Management Subcontracts

The Department will review HMO management subcontracts to ensure that:

1. Rates are reasonable.

2. They clearly describe the services to be provided and the compensation to be paid.

3. Any potential bonus, profit-sharing, or other compensation, not directly related to the cost of providing goods and services to the HMO, is identified and clearly defined in terms of potential magnitude and expected magnitude during this Contract period. Any such bonus or profit-sharing must be reasonable compared to the services performed. The HMO must document reasonableness. A maximum dollar amount for such bonus or profit-sharing shall be specified for the Contract period.

   The requirements addressed in 1. through 3. do not have to relate to non-BadgerCare Plus and/or Medicaid SSI enrollees if the HMO wishes to have separate arrangements for non-BadgerCare Plus and/or Medicaid SSI enrollees.

ARTICLE XI

XI. REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

A. Suspension of New Enrollment

Whenever the Department determines that the HMO is out of compliance with this Contract, the Department may suspend the HMO's right to receive new enrollment under this Contract. When exercising this option, the Department, must notify the HMO in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that enrollee health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the Contract.

The Department may also notify enrollees of HMO non-compliance and provide an opportunity to enroll in another HMO.

B. Department-Initiated Enrollment Reductions

The Department may reduce the maximum enrollment level and/or number of current enrollees whenever it determines that the HMO has failed to provide one or more of the Contract services required under that the Contract or the HMO has failed to maintain or make available any records or reports required under this Contract that the Department needs to determine whether the HMO is providing contract services as required. The HMO will have at least 30 days to correct the non-compliance prior to the Department taking any action set forth in this paragraph. The Department may reduce enrollment sooner than the time period specified in this paragraph if the Department finds that enrollee health or welfare is jeopardized.

C. Other Enrollment Reductions

The Department may also suspend new enrollment or disenroll enrollees in anticipation of the HMO not being able to comply with federal or state law at its current enrollment level. Such suspension shall not be subject to the 30 day notification requirement.

D. Withholding of Capitation Payments and Orders to Provide Services

Not withstanding the provisions of this Contract, the Department may withhold portions of capitation payments as liquidated damages or otherwise recover damages from the HMO on the following grounds:

1. Whenever the Department determines that the HMO has failed to provide one or more of the medically necessary covered services required under the Contract, the Department may either order the HMO to provide such service, or withhold a portion of the HMO's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

   If the Department orders the HMO to provide services under this section and the HMO fails to provide the services within the timeline specified by the Department, the Department may withhold from the HMO's capitation payments an amount up to 150% of the FFS amount for such services.

   When it withholds payments under this section, the Department must submit to the HMO a list of the participants for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

   If the Department acts under this section and subsequently determines that the services in question were not covered services:

   a. If the Department withheld payments, it will restore to the HMO the full capitation payment; or

   b. If the Department ordered the HMO to provide services under this section, it will pay the HMO the actual documented cost of providing the services.

2. If the HMO fails to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such data or information in the required form or format, by the deadline specified by the Department, the Department may immediately impose liquidated damages in the amount of $1,500 per day for each day beyond the deadline that the HMO fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the HMO's capitation payments.

3. If the HMO fails to comply with state and federal compliance requirements for abortions, hysterectomies and sterilizations, the Department may impose liquidated damages in the amount of $10,000.

4. The term "erred encounter record" means an encounter record that has failed an edit when a correction is expected by the Department. If the HMO fails to correct an error to the encounter record within the timeframe specified, the Department may assess liquidated damages of $5 per erred encounter record per month until the error has been corrected. The liquidated damage amount will be deducted from the HMO's capitation payment. When applied, these liquidated damages will be calculated and assessed on a monthly basis.

   If upon audit or review, the Department finds that the HMO has removed an erred encounter record without the Department's approval, the Department may assess liquidated damages for each day from the date of original error notification until the date of correction.

   The following criteria will be used prior to assessing liquidated damages:

   - The Department will calculate a percentage rate by dividing the number of erred records not corrected within 90 days (numerator), by the total number of records in error (denominator) and multiply the result by 100.
   - Records failing non-critical edits, as defined in the HMO Encounter Data User Manual, will not be included in the numerator.
   - If this rate is 2% or less, liquidated damages will not be assessed.
   - The Department will calculate this rate each month.

5. Whenever the Department determines that the HMO has failed to perform an administrative function required under this Contract, the Department may withhold a portion of future capitation payments. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services. The amount withheld by the Department under this section will be an amount that the Department determines in the reasonable exercise of its discretion to approximate the cost to the Department to perform the function. The Department may increase these amounts by 50% for each subsequent non-compliance.

   Whenever the Department determines that the HMO has failed to perform the administrative functions, the Department may withhold a portion of future capitation payments sufficient to directly compensate the Department for the program's costs of providing health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.

6. In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages.

7. Notwithstanding the provisions of this subsection, in any case where the Department deducts a portion of capitation payments under the Contract, the following procedures will be used:

   a. The Department will notify the HMO's contract administrator no later than the second business day after the Department's deadline that the HMO has failed to submit the required data or the required data cannot be processed.

   b. Beginning on the second business day after the Department's deadline, the HMO will be subject without further notification to liquidated damages per data file or report.

   c. If the HMO submits encounter data late but submits it within five business days from the deadline, the Department will rescind liquidated damages if the data can be processed according to the criteria published in the HMO Encounter Data User Manual. The Department will not edit the data until the process period in the subsequent month.

   d. If the HMO submits any other required data or report but in the required format within five business days from the deadline, the Department will rescind liquidated damages and immediately process the data or report.

   e. If the HMO repeatedly fails to submit required data or reports, or submits data that cannot be processed, the Department will require the HMO to develop an action plan to comply with the Contract requirements that must meet Department approval.

   f. After the corrective action plan has been implemented, if the HMO continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under Section A (Suspension of New Enrollment), or under Section B (Department-Initiated Enrollment Reductions) of this Article, or both, in addition to liquidated damages that may have been imposed for a current violation.

   g. If the HMO notifies the Department that it will discontinue contracting with the Department at the end of a contract period, but reports or data are due for a contract period, the Department retains the right to withhold up to two months of capitation payments otherwise due the HMO that will not be released to the HMO until all required reports or data are submitted and accepted after

expiration of the Contract. Upon determination by the Department that the reports and data are accepted, the Department will release the monies withheld.

E. Inappropriate Payment Denials

The HMO that inappropriately fails to provide or deny payments for services may be subject to suspension of new enrollments, withholding, in full or in part, of capitation payments, contract termination, or refusal to contract in a future time period, as determined by the Department. The Department will select among these sanctions based upon the nature of the services in question, whether the failure or denial was an isolated instance or a repeated pattern or practice, and whether the health of an enrollee was injured, threatened or jeopardized by the failure or denial. These sanctions apply not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal was made (i.e., the Department knows about the documented abuse from other sources).

F. Sanctions

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny BadgerCare Plus and/or Medicaid SSI payments to the HMO for enrollees who enroll after the date on which the HMO has been found to have committed one of the violations identified in the federal law. State payment for enrollees of the contracting organization is automatically denied whenever, and for as long as, federal payment for such enrollees has been denied as a result of the commission of such violations.

G. Sanctions and Remedial Actions

The Department may pursue all sanctions and remedial actions with the HMO that is taken with FFS providers, including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [42 U.S.C. 1396v(d)(2)].

ARTICLE XII

XII. TERMINATION AND MODIFICATION OF CONTRACT

A. Termination by Mutual Consent

This Contract may be terminated at any time by mutual written agreement of both the HMO and the Department.

B. Unilateral Termination

This Contract between the parties may be terminated by either party as follows:

1. Either party may terminate this Contract at any time, due to modifications mandated by changes in federal or state laws, rules or regulations that materially affect either party's rights or responsibilities under this Contract. At least 90 days prior to the proposed date of termination, the party initiating the termination must notify the other party of its intent to terminate this Contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the Contractor's reasonable and necessarily incurred termination expenses.

2. Either party may terminate this Contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this Contract. The party exercising this option must notify the other party in writing of this intent to terminate this Contract and give the other party 30 days to correct the identified violation, breach or non-performance of Contract. If such violation, breach or non-performance of Contract is not satisfactorily addressed within this time period, the exercising party may terminate this Contract. The termination date shall always be the last day of a month. The Contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that enrollee health or welfare is jeopardized by continued enrollment in the HMO. A "substantial failure to perform" for purposes of this paragraph includes any violation of any requirement of this Contract that is repeated or ongoing, that goes to the essentials or purpose of the Contract, or that injures, jeopardizes or threatens the health, safety, welfare, rights or other interests of enrollees.

3. Either party may terminate this Contract if federal or state funding of contractual services rendered by the Contractor become or will become permanently unavailable. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the Contractor will be temporarily suspended or unavailable, the Department shall immediately notify the Contractor, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, the Department or the Contractor may suspend performance of any or all of the Contractor's obligations under this Contract if the suspension

or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or Contractor shall attempt to give notice of suspension of performance of any or all of the Contractor's obligations by 60 days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the Contractor may remove suspension hereunder by written notice to the Department, to be made within 30 days from the date the funds are reinstated. In the event the Contractor elects not to reinstate services, the Contractor shall give the Department written notice of its reasons for such decision, to be made within 30 days from the date the funds are reinstated. The Contractor shall make such decision in good faith and will provide to the Department documentation supporting its decision. In the event of termination under this Section, this Contract shall terminate without termination costs to either party.

C. Obligations of Contracting Parties Upon Termination

When termination of the Contract occurs, the following obligations must be met by the parties:

1. Where this Contract is terminated unilaterally by the Department due to non-performance by the HMO or by mutual consent with termination initiated by the HMO:

    a. The Department will be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive contract services.

    b. The HMO will be responsible for all expenses related to said notification.

    c. The Department will grant the HMO a hearing before termination by the Department occurs. The Department will notify the enrollees of the hearing and allow them to disenroll from the HMO without cause.

2. Where this Contract is terminated on any basis not given in 1 above including non-renewal of the Contract for a given contract period:

    a. The Department will be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive contract services.

    b. The Department will be responsible for all expenses relating to said notification.

3. Where this Contract is terminated for any reason the following payment criteria will apply:

   a. Any payments advanced to the HMO for coverage of enrollees for periods after the date of termination will be returned to the Department within the period of time specified by the Department.

   b. The HMO will supply all information necessary for the reimbursement of any outstanding BadgerCare Plus and/or Medicaid SSI claims within the period of time specified by the Department.

   c. If a contract is terminated, recoupments will be handled through a payment by the HMO within 90 days of contract termination.

D. Modification

This Contract may be modified at any time by written mutual consent of the HMO and the Department or when modifications are mandated by changes in federal or state laws, rules or regulations. If changes in state or federal laws, rules or regulations require the Department to modify its contract with the HMO, the HMO will receive written notice.

If the Department exercises its right to renew this Contract, as allowed, the Department will recalculate the capitation rate for succeeding calendar years. The HMO will have 30 days to accept the new capitation rate in writing or to initiate termination of the Contract. If the Department changes the reporting requirements during the Contract period, the HMO shall have 180 days to comply with such changes or to initiate termination of the Contract.

ARTICLE XIII

XIII. INTERPRETATION OF CONTRACT LANGUAGE

When disputes arise, the Department has the right to final interpretation and/or application of the Contract language. The HMO will abide by the interpretation and/or application.

ARTICLE XIV

XIV. CONFIDENTIALITY OF RECORDS AND HIPAA REQUIREMENTS

The parties agree that all information, records, and data collected in connection with this Contract will be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, Wis. Stats., 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. The HMO agrees to forward to the Department all media contacts regarding BadgerCare Plus and/or Medicaid SSI program or enrollees.

B. Regarding the services provided under this Contract, the HMO will comply with all applicable health data and information privacy and security policies, standards and regulations as may be adopted or promulgated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 in final form, and as amended or revised from time to time. This includes cooperating with the Department in amending this Contract, or developing a new agreement, if the Department deems it necessary to meet the Department's obligations under HIPAA.

C. 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.

ARTICLE XV

XV. DOCUMENTS CONSTITUTING CONTRACT

A. Current Documents

In addition to this base agreement, the Contract between the Department and the HMO includes, existing BadgerCare Plus and/or Medicaid SSI provider publications addressed to the HMO, the terms of the most recent HMO certification application issued by this Department for HMO contracts, any questions and answers released pursuant to said HMO certification application by the Department, and the HMO's signed application. The terms of the HMO certification application are also part of this Contract even if the HMO had a contract in the prior contract period and consequently did not have to answer all the questions in the HMO certification application. In the event of any conflict in provisions among these documents, the terms of this base agreement will prevail. The provisions in any question and answer document will prevail over the HMO certification application. The HMO certification application terms shall prevail over any conflict with the HMO's actual signed application.

B. Future Documents

The HMO is required by this Contract to comply with all future Wisconsin Health Care Programs Online Handbooks and Contract Interpretation Bulletins issued pursuant to this Contract. The documents listed in this section constitute the entire Contract between the parties. No other oral or written expression constitutes any part of this Contract.

ARTICLE XVI

XVI. DISCLOSURE STATEMENT(S) OF OWNERSHIP OR CONTROLLING INTEREST IN AN HMO AND BUSINESS TRANSACTIONS

A. Ownership or Controlling Interest Disclosure Statement(s)

The HMO agrees to submit to the Department full and complete information as to the identity of each person or corporation with an ownership or controlling interest in the HMO, or any subcontractor in which the HMO has a 5% or more ownership interest. A "person with an ownership or controlling interest" means a person or corporation that:

1. Owns, directly or indirectly, 5% or more of the HMO's capital or stock or receives 5% or more of its profits:

   a. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the HMO or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the HMO; or

   b. Is an officer or director of the HMO (if it is organized as a corporation or is a partner in the HMO (if it is organized as a partnership).

2. Calculation of 5% Ownership or Control is as follows:

   The percentage of direct ownership or control is the percentage interest in the capital, stock or profits.

   The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation that owns 80% of the stock of the HMO, the person owns 8% of the HMO.

   The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest that a person owns in that obligation by the percent of the HMO's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the HMO's assets, the person owns 6% of the HMO.

3. Information to be Disclosed

   The following information must be disclosed:

   a. The name and address of each person with an ownership or controlling interest of 5% or more in the HMO or in any

subcontractor in which the HMO has direct or indirect ownership of 5% or more;

b. A statement as to whether any of the persons with ownership or controlling interest is related as spouse, parent, child, or sibling to any other of the persons with ownership or controlling interest; and

c. The name of any other organization in which the person also has ownership or controlling interest. This is required to the extent that the HMO can obtain this information by requesting it in writing. The HMO must keep copies of all of these requests and the responses to them, make them available upon request, and advise the Department when there is no response to a request.

4. Potential Sources of Disclosure Information:

This information may already have been reported on form HCFA-1513, "Disclosure of Ownership and Controlling Interest Statement." Form HCFA-1513 is likely to have been completed in two different cases. First, if the HMO is federally qualified and has a Medicare contract, it is required to file form HCFA-1513 with CMS within 120 days of the HMO's fiscal year end. Secondly, if the HMO is owned by or has subcontracts with BadgerCare Plus and/or Medicaid SSI providers that are reviewed by the state survey agency, these providers may have completed form HCFA-1513 as part of the survey process. If form HCFA-1513 has not been completed, the HMO may supply the ownership and controlling information on a separate report or submit reports filed with the state's insurance or health regulators as long as these reports provide the necessary information for the prior 12 month period.

As directed by the CMS Regional Office (RO), the Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If the HMO has not supplied the information that must be disclosed, a contract with the HMO is not considered approved for this period of time and no FFP is available for the period of time preceding the disclosure.

A managed care entity may not knowingly have as a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's a person who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under the Federal Acquisition Regulation or who has an employment, consulting, or other agreement for the provision of items and services that are significant and material to the entity's obligations under its contract with the state.

B. Business Transaction Disclosures

The HMO that is not federally qualified must disclose to the Department information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.)

1. Party In Interest as defined in Section 1318(b) of the Public Health Service Act, is:

    a. Any director, officer, partner, or employee responsible for management or administration of the HMO and HIO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the HMO; any person who is the beneficial owner of more than 5% of the HMO; or, in the case of the HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

    b. Any organization in which a person described in Subsection A, 1 above is director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the HMO;

    c. Any person directly or indirectly controlling, controlled by, or under common control with the HMO; or

    d. Any spouse, child, or parent of an individual described in Subsections 1, 2, or 3 above.

2. Business Transactions That Must Be Disclosed Include:

    a. Any sale, exchange or lease of any property between the HMO and a party in interest.

    b. Any lending of money or other extension of credit between the HMO and a party in interest.

    c. Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

3. Information That Must Be Disclosed In The Transactions Between the HMO and a Party In Interest Includes:

    a. The name of the party in interest for each transaction.

    b. A description of each transaction and the quantity or units involved.

c. The accrued dollar value of each transaction during the fiscal year.

d. Justification of the reasonableness of each transaction.

If the BadgerCare Plus and Medicaid SSI HMO Contract is being renewed or extended, the HMO must disclose information on those business transactions that occurred during the prior contract period. If the Contract is an initial contract with BadgerCare Plus and/or Medicaid SSI, but the HMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving BadgerCare Plus and/or Medicaid SSI enrollment. All of these HMO business transactions must be reported.

ARTICLE XVII

XVII. MISCELLANEOUS

A. Indemnification

The HMO agrees to defend, indemnify and hold the Department harmless with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees that are related to or arise out of:

1. Any failure, inability, or refusal of the HMO or any of its subcontractors to provide contract services.

2. The negligent provision of contract services by the HMO or any of its subcontractors.

3. Any failure, inability or refusal of the HMO to pay any of its subcontractors for contract services.

B. Independent Capacity of Contractor

The Department and the HMO agree that the HMO and any agents or employees of the HMO, in the performance of this Contract, will act in an independent capacity, and not as officers or employees of Department.

C. Omissions

In the event either party hereto discovers any material omission in the provisions of this Contract that is essential to the successful performance of this Contract, said party may so inform the other party in writing. The parties hereto will thereafter promptly negotiate the issues in good faith in order to make all reasonable adjustments necessary to perform the objectives of this Contract.

D. Choice of Law

This Contract is governed by and construed in accordance with the laws of the State of Wisconsin. The HMO shall be required to bring all legal proceedings against the Department in Wisconsin state courts.

E. Waiver

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract will impair that right or power or be construed as a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other will not be construed as a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement contained herein.

F. Severability

If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties will be relieved of all obligations arising under such provision. If such provision does not relate to payments or services to enrollees and if the remainder of this Contract is not affected then each provision not so affected will be enforced to the fullest extent permitted by law.

G. Survival

The terms and conditions contained in this Contract that by their sense and context are intended to survive the completion of performance shall so survive the completion, expiration or termination of the Contract. This specifically includes, but is not limited to recoupments and confidentiality provisions.

H. Force Majeure

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

I. Headings

The article and section headings used herein are for reference and convenience only and do not affect its interpretation.

J. Assignability

Except as allowed under subcontracting, the Contract is not assignable by the HMO either in whole or in part, without the prior written consent of the Department.

K. Right to Publish

The HMO must obtain prior written approval from the Department before publishing any material on subjects addressed by this Contract.

ARTICLE XVIII

XVIII. HMO SPECIFIC CONTRACT TERMS

A. Initial Contract Period

The respective rights and obligations of the parties as set forth in this Contract shall commence on February 1, 2008, and unless earlier terminated, shall remain in full force effective through December 31, 2009. The specific terms for enrollment, rates, risk-sharing, dental coverage, and chiropractic coverage are as specified in the Contract.

B. Renewals

By mutual written agreement of the parties, there may be one one-year renewal of the term of the Contract. An agreement to renew must be effected at least 30 days prior to the expiration date of any contract term. The terms and conditions of the Contract shall remain in full force and effect throughout any renewal period, unless modified under the provision of the Contract.

C. Specific Terms of the Contract

The specific terms are agreed to as set forth in this Contract. The Contract rates to which the HMO agrees are indicated by the Department. Except as stated:

1. The specific terms in the HMO's completed application for certification are incorporated into this Contract, including whether dental services and chiropractic services will be provided by the HMO.

2. For each rate period in this Contract, the HMO agrees not to reduce its service area that was in effect at the time of acceptance of the rates.

3. The HMO's service area and maximum enrollment are specified in its certification application.

4. Rates for county(ies) in which enrollment is accepted.

5. The capitation rates to which the HMO agrees are indicated by the Department in the Exhibits section.

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

7. The Department will make case mix adjusted payments to the HMO for BadgerCare Plus – Standard Plan enrollees if the prospective Chronic Illness and Disability Payment System (CDPS) based adjustment method is approved by CMS. The payment rates for enrollees will be adjusted

based upon the prospective CDPS scores applied prospectively to the rate schedule in the attached Exhibits, subject to CMS approval. If the prospective CDPS case mix adjustment method is not approved by CMS, the Department will revert to a retrospective CDPS case mix adjustment method.

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

1. Case Mix Adjustment:

   Milwaukee Region: The Department will make case mix adjusted payment to the HMO if the prospective Chronic Illness and Disability Payment System (CDPS)-based adjustment method is approved by CMS. The payment rates for the Medicaid SSI only enrollees will be adjusted based upon the prospective CDPS scores applied to the rate schedule in the Exhibits 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.

   All Remaining Regions: The Department will conduct an analysis comparing actual Medicaid SSI HMO enrollee'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 the HMO operating in the Southeast region if the CDPS-based adjustment method is approved by CMS. The payment rates for enrollees will be adjusted based upon the final outcome of the CDPS analysis as applied to the rate schedule in the Exhibits 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. The Department may make case mix adjustments to payments to the HMO operating in other regions depending on the results of the analysis.

2. Expedited Case Mix Adjustment:

   The Department may adjust the HMO prospective risk score whenever a significant variance occurs from the index used to calculate the rate schedule in the Exhibit. Significant variance is defined as a case mix variance greater than 5.0% from the average index. Any such adjustment will take effect no sooner than 45 days following the calculation of the variance.

3. Payment to the Medicaid SSI Managed Care External Advocate:

A Milwaukee County Medicaid SSI HMO is responsible for paying Disability Rights Wisconsin on a quarterly basis (calendar year) for providing external advocacy services for the Medicaid SSI Program in all counties included in the External Advocate's contract with the Department. Payments are to be made to:

Disability Rights Wisconsin
131 W. Wilson Street, Suite 700
Madison, WI 53703

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 $1.82. The source for member month data will be the Department's monthly Enrollment Report.

Total combined payment to the Milwaukee County HMO in the Medicaid SSI Managed Care Program for external advocate services will not exceed $310,049 for services provided in the period October 1, 2007, through September 30, 2008, and paid in calendar year 2008. If total payments to the External Advocate are projected to exceed $310,049, the final quarterly payment to the External Advocate will be adjusted so that no more than $310,049 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 $310,049 will be subject to reconciliation with a final adjusting reconciliation no later than March 31, 2009.

4. Determination of the HMO's Quarterly Payment to the Medicaid SSI External Advocate:

The Department will provide the Medicaid SSI HMO with a report calculating the amount due to Disability Rights Wisconsin within seven business days of the Remittance and Status date for the final enrollment cycle following the last month of each calendar year quarter. The Medicaid SSI HMO is responsible for paying Disability Rights Wisconsin services within 10 business days of receiving each report from the Department.

5. Dispute(s) of Payment Amount:

The Medicaid SSI HMO and the External Advocate have 30 days from the date of payment to dispute the payment amount. Disputes should be sent to the Department.

Upon receiving a written notice of dispute, the Department has 30 days to review the data and determine the accuracy of the enrollment numbers and the corresponding payment amount. The Department's decision will be

communicated to both parties in writing. The Department's decision is final.

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.

We agree to provide services for the following Medicaid populations (check appropriate line(s)):

____ BadgerCare Plus Only

____ Medicaid SSI Only

____ BadgerCare Plus and Medicaid SSI

In WITNESS WHEREOF, the State of Wisconsin has executed this agreement:

HMO Name	State of Wisconsin
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

Note: The HMO that elects to enter into a subcontract with the state, for the provision of Chiropractic Services, must sign and date the Subcontract for Chiropractic Services (following page). This subcontract will not become effective without a signature.

SUBCONTRACT FOR CHIROPRACTIC SERVICES

A. THIS AGREEMENT is made and entered into by and between the HMO and the Department of Health and Family Services.

The parties agree as follows:

1. The Department agrees to be at risk for and pay claims for chiropractic services covered under this Contract.

2. The HMO agrees to a deduction from the capitation rate of an amount of money based on the cost of chiropractic services. This deduction is reflected in the Contract that is being signed on the same date.

B. This is the only subcontract for services that the Department is entering into with the HMO.

C. The provisions of the Contract regarding subcontracts, do not apply to this subcontract.

The term of this subcontract is for the same period as the Contract between the HMO and the Department for medical services.

HMO Name	**State of Wisconsin**
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM I

MEMORANDA OF UNDERSTANDING

I. MOU Submission Requirements

The HMO must submit to the Department copies of new MOUs, or changes in existing MOUs for review and approval before they take effect. This requirement will be considered met if the Department has not responded within 15 business days after receipt of the MOU.

The HMO shall submit MOUs referred to in this Contract and this Addendum to the Department upon the Department's request and during the certification process if required by the Department.

II. Emergency Services MOU or Contract

The HMO may have a contract or an MOU with hospitals or urgent care centers within the HMO's service area(s) to ensure prompt and appropriate payment for emergency services.

A. The MOU Shall Provide For:

1. The process for determining whether an emergency exists.

2. The requirements and procedures for contacting the HMO before the provision of urgent or routine care.

3. Agreements, if any, between the HMO and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the HMO or provider in the absence of such an agreement.

4. Payments for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.

5. Assurance of timely and appropriate provision of and payment for emergency services.

B. The HMO's Liability for Emergency Situations

Unless a contract or MOU specifies otherwise, the HMO is liable to the extent that FFS would have been liable for the emergency situation. The Department reserves the right to resolve disputes between the HMO, hospitals and urgent care centers regarding emergency situations based on FFS criteria.

III. County and Other Human Service Agencies MOU or Contract Requirements for Services Ordered by the Courts

The HMO must make a good faith attempt to negotiate either an MOU or a contract with the county(ies) in their service area. The MOU, contract, or written documentation of a good faith attempt must be available when requested by the Department. Failure of the HMO to have an MOU, contract or a demonstrated good faith effort, as specified, by the Department, may result in the application by the Department of remedies, specified under this Contract.

A. MOU Requirement with Boards Created Under Wis. Stats., §. 51.42, 51.437 or 46.23.

At a minimum the MOU must specify the conditions under which the HMO will either reimburse the Board(s) or another contract provider, or directly cover medical services, including, but not limited to, examinations ordered by a court, specified by the Board's designated assessment agency in an enrollee's driver safety plan as provided under HFS 62. It is the responsibility of both the HMO and the Board to ensure that court orders the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full BadgerCare Plus and/or Medicaid SSI rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own provider arrangements, the HMO is not liable. Reasonable arrangements, in this situation, are certified providers with facilities and services to safely meet the medical and psychiatric needs of the member within a prompt and reasonable time frame. The MOU shall further specify reimbursement arrangements between the HMO and the Board's provider for assessments performed by the Board's designated assessment agency under HFS 62, Intoxicated Driver Program rules. The MOU shall also specify other reporting and referral relationships if required by the Board or the HMO.

B. MOU Requirement with the Department of Social Services (DSS) Created Under Wis. Stats., s. 46.21 or 46.22, or the Human Service Department Created Under Wis. Stats., s. 46.23.

At a minimum the MOU must specify that the HMO will reimburse the DSS or its provider if the HMO cannot provide the treatment, or will directly cover medical services including examinations and treatment which are ordered by a court. It is the responsibility of both the HMO and the DSS to ensure that courts order the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full BadgerCare Plus and/or Medicaid SSI rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own provider arrangements, the HMO is not liable. The MOU will also specify the reporting and referral relationships for suspected cases of child abuse or neglect pursuant to Wis. Stats., s. 48.981. The MOU shall also specify a referral agreement for HMO enrollees who are physically disabled and who may be in need of supportive home care or other programming provided or purchased by the county agency.

The MOU may specify that evaluations for substitute care will be provided by a provider acceptable to both parties; the DSS may require in the MOU that the HMO specify expert providers acceptable to the DSS and the HMO in dealing with court-related children's services, victims of child abuse and neglect, and domestic abuse.

The HMO and the counties may develop alternative MOU language, if both parties agree. However, all elements defined above must be addressed in the MOU. As an alternative to an MOU, the HMO may enter into contracts with the counties. Any contracts the HMO enters into with the counties must be in compliance with Part A of this Addendum and would supersede any MOU requirements.

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ADDENDUM II

STANDARD ENROLLEE HANDBOOK LANGUAGE FOR BADGERCARE PLUS AND MEDICAID SSI

INTERPRETER SERVICES

English – For help to translate or understand this, please call 1-800-xxx-xxxx (TTY).

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-xxx-xxxx (TTY).

Russian – Если вам не всё понятно в этом документе, позвоните по телефону 1-800-xxx-xxxx (TTY).

Hmong – Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-xxx-xxxx (TTY).

Interpreter services are provided free of charge to you.

IMPORTANT [HMO NAME] TELEPHONE NUMBERS

Customer Service	1-800-xxx-xxxx	[Hours/Days Available]
Emergency Number	1-800-xxx-xxxx	Call 24 hours a day, seven (7) days a week
TDD/TTY	1-800-xxx-xxxx	

WELCOME

Welcome to [HMO NAME]. As a member of [HMO NAME], you will receive all your health care from [HMO NAME] doctors, hospitals, and pharmacies. See [HMO NAME] Provider Directory for a list of these providers. You may also call our Customer Service Department at 1-800-xxx-xxxx. Providers not accepting new patients are marked in the Provider Directory.

YOUR FORWARD HEALTH OR FORWARD ID CARD

Always carry your Forward Health or Forward ID card with you, and show it every time you get care. You may have problems getting care or prescriptions if you do not have your card with you. Also bring any other health insurance cards you may have.

PRIMARY CARE PHYSICIAN (PCP)

It is important to call your primary care physician (PCP) first when you need care. This doctor will manage all your health care. If you think you need to see another doctor, or a specialist, ask your PCP. Your PCP will help you decide if you need to see another doctor, and give you a referral. Remember, you must get approval from your PCP before you see another doctor.

You can choose your primary care physician (PCP) from those available (NOTE: For women you may also see a women's health specialist (for example an OB/GYN doctor or a nurse midwife) without a referral, in addition to choosing your PCP). There are HMO doctors who are sensitive to the needs of many cultures. To choose a PCP, or to change to a different PCP, call our Customer Service Department at 1-800-xxx-xxxx.

EMERGENCY CARE

Emergency care is care needed right away. This may be caused by an injury or a sudden illness. Some examples are:

Choking	Severe or unusual bleeding
Trouble breathing	Suspected poisoning
Serious broken bones	Suspected heart attack
Unconsciousness	Suspected stroke
Severe burns	Convulsions
Severe pain	Prolonged or repeated seizures

If you need emergency care, go to a [HMO NAME] provider for help if you can. BUT, if the emergency is severe, go to the nearest provider (hospital, doctor or clinic). You may want to call 911 or your local police or fire department emergency services if the emergency is severe.

If you must go to a [non-HMO NAME] hospital or provider, call [HMO NAME] at 1-800-xxx-xxxx as soon as you can and tell us what happened. This is important so we can help you get follow up care.

Remember, hospital emergency rooms are for true emergencies only. Call your doctor or our 24-hour emergency number at [1-800-xxx-xxxx] before you go to the emergency room, unless your emergency is severe

URGENT CARE

Urgent Care is care you need sooner than a routine doctor's visit. Urgent care is not emergency care. Do not go to a hospital emergency room for urgent care unless your doctor tells you to go there.

Some examples of urgent care are:

Most broken bones	Minor cuts
Sprains	Bruises
Non-severe bleeding	Most drug reactions
Minor burns	

If you need urgent care call [insert instructions here—call clinic, doctor, 24-hour number, nurse line, etc.] We will tell you where you can get care. You must get urgent care from [HMO NAME] doctors unless you get our approval to see a [non-HMO NAME] doctor.

Remember do not go to a hospital emergency room for urgent care unless you get approval from [HMO NAME] first.

HOW TO GET MEDICAL CARE WHEN YOU ARE AWAY FROM HOME

Follow these rules if you need medical care but are too far away from home to go to your assigned primary care physician (PCP) or clinic.

For severe emergencies, go to the nearest hospital, clinic, or doctor.

For urgent or routine care away from home, you must get approval from us to go to a different doctor, clinic or hospital. This includes children who are spending time away from home with a parent or relative. Call us at 1-800-xxx-xxxx for approval to go to a different doctor, clinic, or hospital.

PREGNANT WOMEN AND DELIVERIES

You must go to a [HMO NAME] hospital to have your baby. Talk to your [HMO NAME] doctor to make sure you understand which hospital you are to go to when it's time to have your baby.

Also, talk to your doctor if you plan to travel in your last month of pregnancy. Because we want you to have a healthy birth and a good birthing experience, it may not be a good time for you and your unborn child to be traveling. We want you to have a healthy birth and your [HMO Name] doctor knows your history and is the best doctor to help you have a healthy birth. Do not go out of area to have your baby unless you have [HMO NAME] approval.

WHEN YOU MAY BE BILLED FOR SERVICES

It is very important to follow the rules when you get medical care so you are not billed for services. You must receive your care from [HMO NAME] providers, hospitals, and pharmacies unless you have our approval. The only exception is for severe emergencies.

If you travel outside of Wisconsin and need emergency services, health care providers can treat you and send claims to [HMO NAME]. You will have to pay for any service you get outside Wisconsin if the health care provider refuses to submit claims or refuses to accept [HMO NAME] payment as payment in full.

[HMO NAME] does not cover any service, including emergency services, provided outside of the United States, Canada and Mexico.

BILLING ENROLLEES

Covered and Non-Covered Services

Under BadgerCare Plus – Standard Plan and Medicaid SSI if you receive a bill for services, call our Customer Service Department at 1-800-xxx-xxxx. You do not have to pay for covered services (other than a required copayment) that are provided by a BadgerCare Plus and Medicaid SSI certified provider and that [HMO NAME] is required to provide you unless prior authorization is denied and you are told there will be a charge for the service before it is provided.

Generally, charging a member for a non-covered service is allowed, except for certain non-covered services or activities related to covered services, like missed appointments, telephone calls and translation services.

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

You may request non-covered services from providers, and providers may collect payment for non-covered services from you if you accept responsibility for payment and make payment arrangements with the provider. Providers may bill you up to their usual and customary charges for non-covered services.

Copayments

Under the BadgerCare Plus - Standard Plan the HMO and its providers and subcontractors may bill you for nominal copayments. The following members are exempt from copayments:

- Medicaid SSI members,
- Nursing home residents,
- Pregnant women,
- Members under 18 years of age who are members of a federally recognized tribe, and
- Members under 18 years of age with incomes at or below 100 percent of the Federal Poverty Level (FPL).

Under BadgerCare Plus – Benchmark Plan the HMO and its providers and subcontractors may bill you for copayments for covered services or for other medical services that are provided by a BadgerCare Plus certified provider. The following members are exempt from copayments:

- Pregnant women,
- Members under 18 years of age who are members of a federally recognized tribe.

OTHER INSURANCE

If you have other insurance in addition to [HMO NAME], you must tell your doctor or other provider. Your health care provider must bill your other insurance before billing [HMO NAME]. If your [HMO NAME] doctor does not accept your other insurance, call the HMO Enrollment Specialist at 1-800-291-2002. The Enrollment Specialist can tell you how to match your HMO enrollment with your other insurance so you can use both insurance plans.

SERVICES COVERED BY [HMO NAME]

The HMO is responsible to provide all medically necessary covered services under BadgerCare Plus Standard and Benchmark Plans (specific covered services and copayments amounts for the Benchmark Plan are listed in Addendum V) and/or Medicaid SSI. (**The HMO must provide information for this section that is approved by the Department.)**

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

[HMO NAME] provides mental health and substance abuse (drug and alcohol) services to all enrollees. If you need these services, call [PCP, gatekeeper, customer service, as appropriate].

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

We provide confidential family planning services to all enrollees. This includes minors. If you do not want to talk to your primary care doctor about family planning, call our Customer Service Department at 1–800-xxx-xxxx. We will help you choose a [HMO NAME] family planning doctor who is different from your primary care doctor.

We encourage you to receive family planning services from a (HMO Name) doctor. That way we can better coordinate all your health care. Federal law allows members to choose their provider, including physicians and family planning clinics, for reproductive care and supplies. Therefore, you can also go to any family planning clinic that will accept your Forward Health or Forward ID card even if the clinic is not part of (HMO NAME).

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. See covered services and copayments in Addendum V.)

Note to HMO: Use Statement 1 if you provide dental services. Use Statement 2 if you do not provide dental services. If you provide dental services in only part of your service area, use both statements and list the appropriate counties with each statement.

1. [HMO NAME] provides all covered dental services. But you must go to a [HMO NAME] dentist. See the Provider Directory or call the Customer Service Department at 1-800-xxx-xxxx for the names of our dentists.

2. You may get dental services from any dentist who will accept your Forward Health or Forward ID card. Your dental services are provided by the State, not [HMO NAME].

Dental Emergency: A dental emergency is an immediate dental service needed to treat dental pain, swelling, fever, infection, or injury to the teeth.

1. If you already have a dentist who is with (HMO Name):

    - Call the dentist's office.
    - Identify yourself or your child as having a dental emergency.
    - Tell the dentist's office what the exact dental problem is. This may be something like a toothache or swollen face. Make sure the office understands that you or your child is having a "dental emergency."
    - Call us if you need help with transportation to your dental appointment.

2. If you do not currently have a dentist who is with (HMO Name):

    - Call (HMO specific dental gatekeeper or HMO). Tell us that you/your child is having a dental emergency. We can help you get dental services.
    - Tell us if you need a ride to the dentist's office.
    - Alternative language for HMO's whose dental gatekeeper handles appointment for emergencies. Call (HMO Name) if you need help with transportation to the dentist's office. We can help with transportation.

For help with a dental emergency call (xxx-xxx-xxxx).

CHIROPRACTIC SERVICES (Covered services are the same for BadgerCare Plus – Standard and Benchmark Plans. Copayments differ between the Standard and Benchmark Plans. See Addendum V.)

Note to HMO: Use Statement 1 if you provide chiropractic services. Use Statement 2 if you do not provide chiropractic services.

1. [HMO NAME] provides covered chiropractic services. But you must go to a [HMO NAME] chiropractor. See the Provider Directory or call the Customer Service Department at 1-800-xxx-xxxx for the names of our chiropractors.

2. You may get chiropractic services from any chiropractor who will accept your Forward Health or Forward ID card. Your chiropractic services are provided by the State, not [HMO NAME].

HEALTHCHECK

HealthCheck is a preventive health checkup program for enrollees under the age of 21. The HealthCheck program covers complete health checkups. These checkups are very important for those under 21. The doctor wants to see those under 21 for regular checkups, not just when they are sick.

The HealthCheck health program has three purposes:

1. To find and treat health problems for those under 21.

2. To let you know about the special health services for those under 21.

3. To make those under 21 eligible for some health care not otherwise covered.

The HealthCheck program covers the medical care for health problems found during the checkup including medical care, eye care and dental care.

The HealthCheck checkup includes:

- Health and developmental history (including anticipatory guidance).
- Unclothed physical examination.
- Vision screening.
- Hearing screening.
- Dental screening and a referral to a dentist beginning at age three.
- Immunizations appropriate for age (shots).
- Blood and urine lab tests (including blood lead level testing when appropriate for age).

[HMO NAME] will help arrange for transportation for HealthCheck visits. Call our Customer Service Department a 1-800-xxx-xxxx.

To schedule a HealthCheck exam or for more information call our Customer Service Department at 1-800-xxx-xxxx.

TRANSPORTATION

BadgerCare Plus – Standard Plan and Medicaid SSI Members

Note to HMO: Use Statement 1 if you arrange transportation for your enrollees. Use Statement 2 if you do not arrange transportation for your enrollees. Use Statement 3 if you arrange transportation in only part of your service area.

1. Bus or taxi rides to receive care are arranged by [HMO NAME]. Call our Customer Service Department at 1-800-xxx-xxxx if you need a ride.

2. Bus or taxi rides to receive care are arranged by your county Department of Social or Human Services. Call them for information. (For the HMO whose service area is outside of Milwaukee County.)

3. Bus or taxi rides to receive care are arranged by [HMO NAME] if you live in [INSERT COUNTIES]. Call our Customer Service Department at 1-800-xxx-xxxx if you need a ride. If you live in a county that is not listed, please call your county Department of Social or Human Services for information about arranging a ride.

BadgerCare Plus – Benchmark Plan Members

Non-emergency transportation is not a covered benefit.

SPECIAL MEDICAL VEHICLE (SMV)

BadgerCare Plus – Standard Plan and Medicaid SSI Members

[HMO NAME] covers transportation by special vehicle for those in wheelchairs. We may also cover this service for others if your doctor asks for it. Call our Customer Service Department at 1-800-xxx-xxxx if you need this service.

BadgerCare Plus – Benchmark Members

Non-emergency transportation is not a covered benefit.

AMBULANCE

[HMO NAME] covers ambulance service for emergency care. We may also cover this service at other times, but you must have approval for all non-emergency ambulance trips. Call our Customer Service Department at 1-800-xxx-xxxx for approval.

IF YOU MOVE

If you are planning to move, contact your county Department of Social or Human Services. If you move to a different county, you must also contact the Department of Social or Human Services in your new county to update your eligibility.

If you move out of [HMO NAME'S] service area, call the HMO Enrollment Specialist at 1-800 291-2002. [HMO NAME] will only provide emergency care if you move out of our service area. The Enrollment Specialist will help you choose an HMO that serves your area.

HEALTH INSURANCE AFTER YOUR ELIGIBILITY ENDS

You have the right to purchase a private health insurance policy from [HMO NAME] when your eligibility ends. Call our Customer Service Department at [1-800-xxx-xxxx]. If you decide to purchase a policy from us, you have 30 days after the date your eligibility ends to apply.

SECOND MEDICAL OPINION

A second medical opinion on recommended surgeries may be appropriate in some cases. Contact your doctor or our Customer Service Department for information.

HMO EXEMPTIONS

An HMO exemption means you are not required to join an HMO to receive your health care benefits. Most exemptions are granted for only a short period of time so you can complete a course of treatment before you are enrolled in an HMO. If you think you need an exemption from HMO enrollment, call the HMO Enrollment Specialist at 1-800-291-2002 for more information.

LIVING WILL OR POWER OF ATTORNEY FOR HEALTH CARE

You have a right to make decisions about your medical care. You have a right to accept or refuse medical or surgical treatment. You also have the right to plan and direct the types of health care you may receive in the future if you become unable to express your wishes. You can let your doctor know about your feelings by completing a living will or power of attorney for health care form. Contact your doctor for more information.

RIGHT TO MEDICAL RECORDS

You have the right to ask for copies of your medical record from your provider(s). We can help you get copies of these records. Please call [1-800-xxx-xxxx] for help. Please note: You may have to pay to copy your medical record. You also may correct wrong information in your medical records if your doctor agrees to the correction.

[HMO NAME'S] MEMBER ADVOCATE

[HMO NAME] has a Member Advocate to help you get the care you need. The Advocate can answer your questions about getting health care from [HMO NAME]. The Advocate can also help you solve any problems you may have getting health care from [HMO NAME]. You can reach the Advocate at 1-800-xxx-xxxx.

EXTERNAL ADVOCATE (for Medicaid SSI Only)

If you have problems getting services while you are enrolled with (HMO Name) for Medicaid SSI services call the SSI HMO Advocate at 1-800-xxx-xxxx.

STATE OF WISCONSIN HMO OMBUDS PROGRAM

The State has Ombuds who can help you with any questions or problems you have as an HMO member. The Ombuds can tell you how to get the care you need from your HMO. The Ombuds can also help you solve problems or complaints you may have about the HMO Program or your HMO. Call 1-800-760-0001 and ask to speak to an Ombuds.

COMPLAINTS, GRIEVANCES AND APPEALS

We would like to know if you have a complaint about your care at [HMO NAME]. Please call [HMO NAME'S] Member Advocate at 1-800-xxx-xxxx if you have a complaint. Or you can write to us at:

[HMO name and mailing address]

If you want to talk to someone outside of [HMO NAME] about the problem, call the HMO Enrollment Specialist at 1-800-291-2002. The Enrollment Specialist may be able to help you solve the problem, or can help you write a formal grievance to [HMO NAME] or to the BadgerCare Plus and Medicaid SSI programs.

The address to complain to the Wisconsin BadgerCare Plus and Medicaid SSI Programs is:

BadgerCare Plus and Medicaid SSI
Managed Care Ombuds
P. O. Box 6470
Madison, WI 53716-0470
(800) 760-0001

If your complaint or grievance needs action right away because a delay in treatment would greatly increase the risk to your health, please call [HMO NAME] as soon as possible at 1-800-xxx-xxxx.

We cannot treat you differently than other members because you file a complaint or grievance. Your health care benefits will not be affected.

You have the right to appeal to the State of Wisconsin Division of Hearings and Appeals (DHA) for a fair hearing if you believe your benefits are wrongly denied, limited, reduced, delayed or stopped by [HMO NAME]. An appeal must be made no later than 45 days after the date of the action being appealed. If you appeal this action to DHA before the effective date, the service may continue. You may need to pay for the cost of services if the hearing decision is not in your favor.

If you want a fair hearing, send a written request to:

Department of Administration
Division of Hearings and Appeals
P. O. Box 7875
Madison, WI 53707-7875

The hearing will be held in the county where you live. You have the right to bring a friend or be represented at the hearing. If you need a special arrangement for a disability, or for English language translation, please call (608) 266-3096 (voice) or (608) 264-9853 (hearing impaired).

We cannot treat you differently than other members because you request a fair hearing. Your health care benefits will not be affected.

If you need help writing a request for a Fair Hearing, please call either the BadgerCare Plus and Medicaid SSI Ombudsman at 1-800-760-0001 or the HMO Enrollment Specialist at 1-800-291-2002.

PHYSICIAN INCENTIVE PLAN

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services you might need. To get this information, call our Customer Service Department at 1-800-xxx-xxxx and request information about our physician payment arrangements.

PROVIDER CREDENTIALS

You have the right to information about our providers that includes the provider's education, board certification and recertification. To get this information, call our Customer Service Department at 1-800-xxx-xxxx.

MEMBER RIGHTS

- You have the right to ask for an interpreter and have one provided to you during any BadgerCare Plus and/or Medicaid SSI covered service.

- You have the right to receive the information provided in this member handbook in another language or another format.

- You have the right to receive health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.

- You have the right to receive information about treatment options including the right to request a second opinion.

- You have the right to make decisions about your health care.

- You have the right to be treated with dignity and respect.

- You have the right to be free from any form of restraint or seclusion used as means of force, control, ease or reprisal.

YOUR CIVIL RIGHTS

[HMO NAME] provides covered services to all eligible members regardless of:

- Age
- Race
- Religion
- Color
- Disability
- Sex
- Sexual Orientation
- National Origin

- Marital Status
- Arrest or Conviction Record
- Military Participation

All medically necessary covered services are available to all members. All services are provided in the same manner to all members. All persons or organizations connected with [HMO Name] who refer or recommend members for services shall do so in the same manner for all members.

Translating or interpreting services are available for those members who need them. This service is free.

ADDENDUM III

GUIDELINES FOR THE COORDINATION OF SERVICES BETWEEN THE HMO, TARGETED CASE MANAGEMENT (TCM) AGENCIES, AND CHILD WELFARE AGENCIES

A. HMO Rights and Responsibilities

1. The HMO must designate at least one individual to serve as a contact person for case management providers. If the HMO chooses to designate more than one contact person, the HMO should identify the target populations for which each contact person is responsible.

2. The HMO may make referrals to case management agencies when they identify an enrollee from an eligible target population who could benefit from case management services.

3. If the enrollee or case manager requests the HMO to conduct an assessment, the HMO will determine whether there are signs and symptoms indicating the need for an assessment. If the HMO finds that assessment is needed, the HMO will determine the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the HMO determines that no assessment is needed, the HMO will document the rationale for this decision.

4. The HMO must determine the need for medical treatment of those services covered under the HMO Contract based on the results of the assessment and the medical necessity of the treatment recommended.

5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required.

    - The case planning may be done through telephone contact or means of communication other than attending a formal case planning meeting.

    - The HMO must informally discuss differences in opinion regarding the HMO's determination of treatment needs if requested by the member or case manager.

    - The HMO case management liaison and the case manager must discuss who will be responsible for ensuring that the enrollee receives the services authorized by and provided through the HMO.

    - The HMO's role in the case planning may be limited to a confirmation of the services the HMO will authorize if the enrollee and case manager find these acceptable.

ADDENDUM IV

REPORT FORMS AND WORKSHEETS

A. AIDS and Ventilator Dependent Quarterly Report Form and Detail Report Format

AIDS COST SUMMARY

HMO Name:_____
Report Period:_____
Number of Cases Reported:_____

Category of Service	Amount Billed	Amount Paid
Inpatient		
Outpatient		
Physician		
Pharmacy		
All Other		
Total		

VENTILATOR COST SUMMARY

HMO Name:_____
Report Period:_____
Number of Cases Reported:_____

Category of Service	Amount Billed	Amount Paid
Inpatient		
Outpatient		
Physician		
Pharmacy		
All Other		
Total		

MAIL TO: Bureau of Fiscal Management
ATTN: A/V Analyst, Room 350
P.O. Box 309
Madison, WI 53701-0309

AIDS and Ventilator Dependent Detail Report

The detail report must be provided on disk in an Excel file format as well as a paper copy. Reports must be separate if an HMO is contracted to serve both BadgerCare Plus and/or Medicaid SSI enrollees. The reports must include all of the following data elements:

	Data Elements
1.	HMO Name
2.	HMO Provider Payee Number
3.	Eligibility Code: A-AIDS, H- HIV, or V-Vent
4.	Enrollee BadgerCare Plus or Medicaid SSI Number
5.	Enrollee Last Name
6.	Enrollee First Name
7.	Enrollee's Date of Birth: mmddyyyy
8.	Enrollees Gender: F (female) or M (male)
9	BadgerCare Plus or Medicaid SSI Provider or NPI Number
10.	BadgerCare Plus or Medicaid SSI Provider Last Name
11.	BadgerCare Plus or Medicaid SSI Provider First Name
12.	Date of Service: From Date (mmddyyyy) (In ascending order not by provider.)
13.	Date of Service: To Date (mmddyyyy)
14.	Primary Diagnosis Code 1: ICD-9-CM or DRG
15.	Quantity: Do not zero fill
16.	Procedure/Drug Code: CPT4, ICD-9-CM, HCPCS, DRG
17.	Procedure/Drug Description: CPT4, ICD-9-CM, HCPCS, DRG
18.	Amount Billed: Include decimal (do not zero fill)
19.	Amount Paid: Include decimal (do not zero fill)
20.	County Code: County code where the enrollee resides at time of each service
21.	Total Amount Billed for Each Individual Enrollee: Include decimal (do not zero fill)
22.	Total Amount Paid for Each Individual Enrollee: Include decimal (do not zero fill)

B. Coordination of Benefits Quarterly Report Form and Instructions for Completing the Form

Note: In addition to the total dollar amount(s) billed and paid for all enrollees the HMO must report the total dollar amount(s) billed and paid for each individual enrollee.

In order to comply with CMS reporting requirements, the HMO must submit a Coordination of Benefits (COB) report regarding their BadgerCare Plus and/or Medicaid SSI enrollees. For the purposes of this report, the HMO enrollee is any BadgerCare Plus and Medicaid SSI member listed as an ADD or CONTINUE on the monthly HMO enrollment report(s) that are generated by the Department's Fiscal Agent.

Birth costs or delivery costs (e.g., routine delivery and associated hospital charges) are not to be included in the report.

The report is to be for the HMO's entire service area, aggregating separate service areas if the HMO has more than one service area. The report must be completed on a calendar quarterly basis and submitted to the Department's fiscal agent within 45 days of the end of the quarter being reported.

MAIL TO:

Bureau of Benefits Management
ATTN: (your specific HMO analyst)
Room 350
P.O. Box 309
Madison, WI 53701-0309

FAX TO:

Bureau of Benefits Management
ATTN: (your specific HMO analyst)
Room 350
(608) 261-7792

The COB report form follows this page.

STATE OF WISCONSIN
BADGERCARE PLUS AND MEDICAID SSI
HMO REPORT ON COORDINATION OF BENEFITS

Name of HMO _____ Mailing Address _____

Office Telephone _____ _____

Provider Number _____ _____

Please designate below the quarter period for which information is given in this report.

_____, 20____ through _____, 20_____

A. **Cost Avoidance** – Indicate the dollar amount you denied as a result of your knowledge of other insurance that is available for the enrollee.

Amount Cost Avoided:_____

B. **Recoveries (Post-Pay Billing/Pay and Chase)**– Indicate below the dollar amounts recovered as a result of:

Subrogation/Workers' Compensation:_____
(e.g., collections from auto, homeowners, or malpractice insurance, restitution payments from the Division of Corrections, collections from Worker's Compensation).

Other Recoveries:_____
(e.g., Third Party Liability (TPL), legal action, or any other recoveries that are not specifically noted above.)

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the HMO, except as noted on the report.

Signed: _____
Original Signature of Director or Administrator

Printed Name: _____

Title: _____

Date Signed: _____

C. Neonatal Intensive Care Unit (NICU) Risk-Sharing Report Format and Detail Data Requirements

HMO reporting of NICU costs must include all of the data elements specified in this section. Risk-sharing for NICU is based on the criteria defined in this Contract. NICU reports must be submitted to the Department's Bureau of Fiscal Management on or before May 1 of the following year. The HMO does not have to file a report if the NICU criteria is not met.

The NICU report form, detailed data format and worksheet follow this page.

HMO NEONATAL INTENSIVE CARE UNIT (NICU) REPORT FORM

HMO Name: _____

HMO BadgerCare Plus (Payee) Number _____

Report Period: January 1, 200___ through December 31, 200___

Questions regarding this report should be referred to:_____
(please print)

Telephone Number: _____

HMO DATA SUMMARY BY COUNTY

Hospital Inpatient Costs Associated with Level II, III, and IV NICU Services.

Number of Days	Number of Admissions	Amount Billed	Amount Paid

Physician Costs Associated with Level II, III, and IV NICU Services.

Amount Billed:	Amount Paid

HMO DETAILED NICU DATA FORMAT

The costs summarized in Section A must be reported by month, by county, and by year (i.e., if an enrollee is in an NICU for two or more months, the NICU days, physician and hospital costs must be separated by the month in which they occurred). Amounts paid must include payments for all physician and hospital services that were provided during the report period regardless of the HMO's actual payment date. (See example of data should be reported below.)

Enrollee Name	Enrollee MA ID#	Admit Date	Discharge Date	Total # of NICU Adm	Month
Name	xxxxxxxxxx	07/01/07	07/22/07	1	July

NICU Hosp Data by Month First NICU Day	NICU Hosp Data by Month Last NICU Day	Total # of NICU Days by Month	NICU Amt Billed Hosp (prorated by month)	NICU Amt Paid Hosp (prorated by month)	NICU Amt Billed Phys (by month)	NICU Amt Paid Phys (by month)
07/01/07	07/22/07	20	$00,000.00	$00,000.00	$0,000.00	$00.00

MAIL TO:

Bureau of Fiscal Management
ATTN: NICU Analyst, Room 350
P.O. Box 309
Madison, WI 53701-0309

NICU WORKSHEET

The HMO may complete the worksheet following this page to determine if their NICU days meet the criteria defined. The HMO does not have to file a report if the NICU criteria is not met.

Neonatal Intensive Care Unit Risk-Sharing Worksheet

Calculation

1.	HMO enrollee months:		_____
2.	Enrollee years:	(line 1/12)	_____
3.	Threshold (75 days per 1000 enrollee years):	(75 x line 2/1000)	_____
4.	NICU days reported by HMO:		_____
5.	NICU days over threshold to be reimbursed:	(line 4 – line 3)	_____
6.	Inpatient paid:		_____
7.	Physician paid:		_____
8.	Total cost:	(line 6 + line 7)	_____
9.	Average cost per day:	(line 8 /line 4)	_____
10.	90% of cost/day (Not to exceed $1,443):	(0.9 x line 9)	_____
11.	Reimbursement amount (Days x 90% cost):	(line 5 x line 10)	_____

E. Court Ordered Birth Cost Requests

County Child Support Agencies (CSA) obtain court orders requiring fathers to repay birth costs that have been paid by FFS as well as the HMO. In some counties, judges will not assign birth costs to the father based upon average costs. Upon request of the Fiscal Agent Contract Monitor, the HMO must provide actual charges less any payments made by a third party payer for the use by the court in setting actual birth and related costs to be paid by the father. Birth cost information must be submitted to the Bureau of Benefits Management within 14 days from the date the request was received by the HMO.

The birth cost report forms follows this page.

BADGERCARE PLUS HMO BIRTH COST REQUEST

PART I: Local Child Support Agency Portion

PART I: To be completed by the Local Child Support Agency. Please type or print, in a legible manner.

1. **HMO Name** _____

2. **Mother's Name** _____
(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Address _____
(Street Address)

_____
(City) (State) (Zip Code)

3. **Newborn's Name** _____
(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Date of Birth _____ Sex _____

Note: In cases of multiple births, a form must be completed for each newborn. In addition, the form(s) should not be submitted to the BUREAU OF BENEFITS MANAGEMENT until 60 days after the birth.

4. **I certify this information is accurate to the best of my knowledge**:

Name of Local Child Support Agency	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

5. **Mail To:**
Bureau of Fiscal Management
ATTN: Birth Costs, Room 350
P.O. BOX 309
MADISON, WI 53701-0309

FAX To:
Bureau of Fiscal Management
ATTN: Birth Costs
(608) 261-7792

PART II: HMO Portion

Part II: To be completed by the HMO. Please type or print in a legible manner.

1. **The actual payment for birthing costs for the mother and her baby.**

Mother's Name _____ID# _____

Baby's Name _____ID#_____DOB_____

Hospital/Birthing Center Payment (Mother) $ _____

Hospital/Birthing Center Payment (Newborn) $ _____

Physician Payment (Mother) $ _____

Physician Payment (Newborn) $ _____

Amount Paid by Other Insurance $ _____

2. **Comments: (i.e., retroactively disenrolled from [HMO NAME] effective [DATE], _ services denied)**

[State Denial Reason]: _____

3. **I certify this information is accurate to the best of my knowledge.**

Name of HMO	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

4. **Mail or FAX Part I and Part II within 14 days of receipt to:**

Mail To:
Bureau of Fiscal Management
ATTN: Birth Costs, Room 350
P.O. Box 309
Madison, WI 53701-0309

FAX To:
Bureau of Fiscal Management
ATTN: Birth Costs
(608) 261-7792

F. HMO Newborn Report (BadgerCare Plus Only)

This report should be completed for infants born to mothers who are BadgerCare Plus eligible and enrolled in the HMO at the time of birth of the infant.

1.	HMO Name:	In this field enter the name of the HMO reporting.
	HMO Provider or NPI Number:	In this field enter the BadgerCare Plus and/or Medicaid SSI provider or NPI number of the HMO reporting.
	Telephone Number:	In this field enter the HMO telephone number the fiscal agent can call with questions about submitted newborn reports.
2.	Newborn Name:	In this field enter the name of the newborn infant. If the mother has not given a first and middle name to the baby at the time the report is completed, enter the last name of the newborn as the mother's last name; the first name/middle initial can be entered as "baby male" or "baby female."
	Date of Birth:	In this field enter the date of birth of the newborn infant, in MM/DD/YY format.
	Sex:	In this field check the sex of the newborn infant, male or female.
	Low Birth Weight <1200 grams:	In this field check the box if the newborn infant weighs less than 1200 grams.
	Twin:	In this field check no if the newborn infant is not a twin, check yes if the newborn infant is a twin. If the newborn infant is a twin, complete one newborn report for each twin.
	Date of Death:	In this field enter the date of death, if the newborn infant died, in MM/DD/YY format.
3.	Mother's Name:	In this field enter the first name, middle initial, and last name of the mother of the newborn infant.
	Address:	In this field enter the address of the mother of the newborn infant – street address, city, state, and zip code.
	Mother's ID Number:	In this field enter the BadgerCare Plus number of the mother of the newborn infant.

The HMO staff person completing the report should sign and date the form and send it to the address listed at the bottom of the report.

The HMO does not have to use the above format. However, whatever format the HMO uses, the HMO must submit all of the information described above to the Department's fiscal agent.

HMO Newborn Report follows this page.

BADGERCARE PLUS HMO NEWBORN REPORT

Please print, type, or complete in a legible manner:

1. HMO Name _____

   HMO Provider Number _____

   Telephone Number _____

2. Newborn Name _____
   (First) (M.I.) (Last)

   Date of Birth _____ ☐ Male ☐ Female

   ☐ Low Birth Weight <1200 grams

   Twins: ☐ No ☐ Yes (If yes, complete two forms)

   Date of Death if Applicable _____

3. Mother's Name _____
   (First) (M.I.) (Last)

   Address _____
   (Street Address)

   _____
   (City) (State) (Zip Code)

4. Mother's BadgerCare Plus ID Number _____

5. I certify this information is accurate to the best of my knowledge.

   _____ _____
   Signature Date

Mail To:

Fiscal Agent
ATTN: Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470

FAX To:

Fiscal Agent
ATTN: Managed Care Unit
(608) 224-6318

G. HealthCheck Worksheet

HEALTHCHECK WORKSHEET

HMO NAME:_____

		Calculation	Age Groups				Total
			< 1	1-5	6–14	15–20	
1	Number of eligible months for enrollees under age 21.	Entered (Total is sum of age groups.)					
2	Number of unduplicated enrollees under age 21.	Entered					
3	Ratio of recommended screens per age group member.	Given	5.00	1.4	0.56	0.50	
4	Average period of eligibility (in years).	Line 1 ÷ line 2 ÷ 12 (Total is calculated by formula.)					
5	Adjusted ratio of recommended screens per age group member.	Line 3 x line 4					
6	Expected number of screens (100% of required screens for ages and months of eligibility).	Line 2 x line 5 (Total is sum of age groups.)					
7	Number of screens in goal (80%).	Line 6 x 0.80 (Total is calculated by formula.)					
8	Actual number of screens completed.	Entered (Total is sum of age groups.)					
9	Difference between goal and actual.	Line 8 – line 7 (Positive result means goal is met; negative result means goal is not met.)					
10	Percent of the FFS equivalent that your HMO is discounted for as applicable, except for Dane, Milwaukee, Eau Claire, Kenosha and Waukesha.						
11	Amount per screen to be recouped.	FFS maximum allowable fee x Line 10					
12	Total recoupment.	Line 11 x line 9					

H. Complaint and Grievance Reporting Forms

1. Grievance Experience Summary Report

Summarize each BadgerCare Plus and/or Medicaid SSI grievance reviewed in the past quarter.

a. Grievances Related to Program Administration

Member Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

b. Grievances Related to Benefit Denial/Reduction

Member Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

c. Summary

SUBTOTAL: Program Administration _____
SUBTOTAL: Benefit Denial/Reduction _____
TOTAL NUMBER OF GRIEVANCES: _____

2. HMO Reporting Form for Complaints

_____
HMO Name

- ☐ First Quarter
- ☐ Second Quarter
- ☐ Third Quarter
- ☐ Fourth Quarter
- ☐ Calendar Year 2006
- ☐ Calendar Year 2007

TYPE OF COMPLAINT	TOTAL NUMBER OF COMPLAINTS
1. ACCESS PROBLEMS	
2. BILLING ISSUES	
3. QUALITY OF CARE	
4. DENIAL OF SERVICE	
5. OTHER SPECIFY	

General Definitions

1. Access problems include any problem identified by the HMO that causes an enrollee to have difficulty getting an appointment, receiving care, or on culturally appropriate care, including the provision of interpreter services in a timely manner.

2. Billing issues include the denial of a service or a member receiving a bill for a BadgerCare Plus and/or Medicaid SSI covered service that the HMO is responsible for providing or arranging for the provision of that service.

3. Quality of care includes long waiting times in the reception area of providers' offices, rude providers or provider staff, or any other complaint related directly to patient care.

4. Denial of service includes any BadgerCare Plus and/or Medicaid SSI covered service that the HMO denied.

5. Others as identified by the HMO.

Return the completed form to:

Bureau of Benefits Management
ATTN: Grievances, Managed Care Analyst, Room 350
P.O. Box 309
Madison, WI 53701-0309

I. Attestation Form

ATTESTATION

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

☐ Encounter Data for (month)_____(year) 200__.

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

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

☐ Other _____ (Specify Report)

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____
(Signature) (Date)

_____ _____
(Print Name) (Print Date)

J. Milwaukee County Common Carrier Detail Report

The detail report must be provided on disk CD ROM in an excel file format. The reports must include all of the following data elements. If an HMO is contracted to serve both BadgerCare Plus and/or Medicaid SSI enrollees the reports must be submitted separately.

	Data Elements
1.	HMO Name
2.	HMO #
3.	Enrollee MA ID Number
4.	Enrollee Last Name
5.	Enrollee First Name
6.	Enrollee's Date of Birth: mmddyyyy
7.	Enrollees Gender: F (female) or M (male)
8.	Vendor Name
9.	Date of Service: mmddyyyy
10.	Month of Service
11.	Invoice Date
12.	Loaded Miles
13.	Invoice Amount
14.	Administration Fees
15.	Total Charge
16.	Amount Billed: Include decimal (do not zero fill)
17.	Amount Paid: Include decimal (do not zero fill)
18.	Procedure Codes-HCPCS
19.	Modifier (if applicable)
20.	Type of Vehicle
21.	Comments

ADDENDUM V

Summary of BadgerCare Plus Benchmark Plan Covered Services

Services	BadgerCare Plus Benchmark Plan Coverage
Drugs	Generic-only formulary drugs and a limited number of generic over-the counter drugs with a $5.00 copayment per item. Brand name drugs are only available through the Badger Rx Gold plan, which provides a discount on the cost. Benchmark Plan members are automatically enrolled in this plan.
Physician, Anesthesia, X-Ray, and Laboratory	Same coverage as Wisconsin Medicaid with a $15.00 copayment per visit.
Prenatal Care/Maternity	Same coverage as Wisconsin Medicaid including Prenatal Care Coordination for high-risk pregnancies. Coverage of mental health and substance abuse counseling, and substance abuse intervention services for pregnant women at risk of mental health or substance abuse problems.
Inpatient Hospital	Same coverage as Wisconsin Medicaid with a $100.00 copayment per hospital stay (medical surgery) and a $50.00 copayment per stay for psychiatric treatment.
Outpatient Hospital	Same coverage as Wisconsin Medicaid with a $15.00 copayment per visit (although multiple visits to the same provider on the same day will be treated as a single visit).
Emergency Room (ER)	Same coverage as Wisconsin Medicaid with a $60.00 copayment if the member is not admitted to the emergency room.
Nursing Home	Same coverage as Wisconsin Medicaid with a limit of 30 days per enrollment year in a nursing home.
Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP)	20 visits per therapy discipline per enrollment year. An additional 36 visits are covered for cardiac rehabilitation. There is a $15.00 copayment per visit.
Durable Medical Equipment (DME)	Same coverage as Wisconsin Medicaid with a $5.00 copayment per item. Reimbursement is capped at $2,500.00 of paid amount in an enrollment year.
Disposable Medical Supplies (DMS)	Coverage is limited to syringes, diabetic pens and DMS that is required with use of a DME item. There is a $0.50 copayment for syringes and diabetic pens.

Services	BadgerCare Plus Benchmark Plan Coverage
Mental Health and Substance Abuse Treatment	Coverage and coverage limitations for these services are based upon the Wisconsin State Employees' Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment, mental health day treatment for adults, child/adolescent mental health day treatment, and substance abuse day treatment for adults and children. Noncovered services include crisis intervention, Community Support Program (CSP), Comprehensive Community Services (CCS), outpatient mental health and substance abuse services in the home and community for adults, and substance abuse residential treatment. Substance abuse services will be subject to specified dollar limits established under the Wisconsin State Employees' health plan, which are as follows: • $4,500.00 for outpatient substance abuse services. Only $2,700.00 can be applied toward substance abuse day treatment services. • $6,300.00 for inpatient acute general care hospital stays for substance abuse treatment. • $7,000.00 OVERALL limit. The paid amount for all substance abuse and mental health services count toward the overall limit. Once the overall limit is reached, **no** substance abuse services will be covered. Coverage of mental health services are not subject to any dollar amount limits. Inpatient hospital stays for mental health or substance abuse treatment are limited to 30 days per enrollment year. This limit applies to general acute care and IMD hospital stays.
Home Health	Coverage of in-home skilled nursing services, home health aide services, and therapies (PT,OT,SLP) with a copayment of $15.00 per visit. Coverage is limited to 60 visits per enrollment year.
Ambulance	Full coverage of emergency transportation only with a $50.00 copayment per trip.
HealthCheck	Same coverage as Wisconsin Medicaid of HealthCheck for individuals under 21 years old. HealthCheck "Other Services" are not covered unless coverage is specified elsewhere.

Services	BadgerCare Plus Benchmark Plan Coverage
Dental	50 percent allowable charges as defined by the Department of Health and Family Services for preventive, diagnostic, simple restorative, periodontics, and surgical extractions for both pregnant women and children. Deductibles are not applied to preventive and diagnostic services.
Vision	Coverage of one eye exam every two years with a $15.00 copayment per visit. This limit only applies to optometrists.
Smoking Cessation	New expanded coverage of tobacco cessation for BadgerCare Plus members.
Hospice	Same coverage as Wisconsin Medicaid with a $2.00 copayment per day and limited to 360 days lifetime.
Reproductive Health	Same coverage as Wisconsin Medicaid. Family planning services are available without a copayment.
Chiropractic	Same coverage as Wisconsin Medicaid with a $15.00 copayment per visit.
Podiatric	Same coverage as Wisconsin Medicaid with a $15.00 copayment per visit.

ADDENDUM VI

INCENTIVES

1. Dental Care Utilization Incentive (BadgerCare Plus Only)

NOTE: For an HMO that is certified after December 31, 2006, but before January 1, 2008, the Department will use the Milwaukee HMO average rate for the CY 2006 dental MEDDIC-MS measures to establish the HMO's base year performance target.

CY 2006 MEDDIC-MS results will be used as the base performance level for preventive dental and general dental service categories by the HMO for BadgerCare Plus – Standard Plan enrollees. The HMO must achieve a 10% performance gap reduction to receive the full dental incentive payment authorized by the Department. The 10% performance gap reduction is the basis for establishing 2008 performance targets.

a. *Performance Measures*

Existing Managed Care dental performance measures will be used as the basis for awarding the incentive for CY 2008. The existing measures that will be used to determine the incentive are:

1) Preventive Care Measure Children – Preventive care, such as dental varnishes, cleanings and comprehensive exams for children ages 3 to 20.

2) General Dental Care Measure Children – All dental services, both preventive and restorative care for children ages 3 to 20.

3) General Dental Care Measure Adults – All dental services, both preventive and restorative care for adults 21 and over.

4) Preventive Care Measure Adults – Preventive care, such as dental cleanings and comprehensive exams for adults 21 and over.

CY 2006 MEDDIC-MS results will be used as the base performance level for preventive dental and general dental service categories by the HMO and for the BadgerCare Plus – Standard Plan.

The HMO must achieve a 10% performance gap reduction to receive the full dental incentive payment authorized by the Department. The 10% performance gap reduction is the basis for establishing 2008 performance targets.

Dental incentive payments will be based on CY 2008 MEDDIC-MS results compared to CY 2006 MEDDIC-MS results, adjusted for caseload growth. The net increase in the number of persons receiving dental care based on the 2008 MEDDIC-MS results will determine the level of incentive payments.

The Department will allocate up to $750,000 for dental incentive payments, subject to the 5% incentive restriction established by CMS.
Dental incentive payments will be in addition to the monthly capitation payment, but will not become part of the base capitation rate.

Incentive payments will be calculated in increments of meeting the 10% performance gap reduction. Fifty percent of the average incentive payment per person will be paid for each person in the first third of the 10% performance gap reduction, 90% will be paid for each person in the second third, and 160% will be paid for each person in the final period.

% of Avg Incentive Payment Per Person	% Increase Within the 10% Performance Gap Reduction
50%	Between 0% and 33% of Increase
90%	Between 34% and 66% of Increase
160%	Between 66% and 100% of Increase

The Department may make additional incentive payments to an HMO that exceeds 100% of the performance target.

Payments will be made in CY 2009 based on actual CY 2008 MEDDIC-MS results. The incentive payment will be made within 60 days after MEDDIC-MS tabulations are received by the Department.

2. Tobacco Cessation Incentive (TCI)

a. The Tobacco Cessation Incentive provides incentive payments to the HMO who improves the rate at which its enrollees with identified tobacco or nicotine addiction or current smoker status receive counseling and/or pharmacological intervention for such addiction and/or current smoking.

b. The TCI is based on the MEDDIC-MS specifications for tobacco dependence treatment for the current capitation year. The baseline for the number of enrollees with identified tobacco or nicotine addiction or current smoker status and the baseline rates of these enrollees who are receiving counseling and/or pharmacological intervention will be the second year prior to the current capitation year. For example, if the current capitation year is 2008, the base year data is 2006. For an HMO not certified by January 1, 2006, the TCI will be applied on the basis of HMO by HMO (i.e., HMO – A – BadgerCare Plus will be separate from HMO – A – Medicaid SSI).

c. In calendar year 2008 the HMO not previously participating in the TCI initiative must develop an electronic database of information about their enrollees who have identified tobacco or nicotine addiction or current smoker status. The 2006 performance level may be adjusted by using this updated information.

d. In calendar year 2008 the HMO must achieve at least a 10% performance gap reduction in the adjusted CY 2006 rates of counseling and/or pharmacological intervention to receive the full TCI payment authorized by the Department. The 10% performance gap reduction is the basis for establishing CY 2008 performance targets.

The Tobacco Cession workgroup may recommend a change in the above methodology of 10% performance gap reduction based on further discussions. If the workgroup recommends a change, any change in the contract will be based on a mutual agreement between the Department and the HMO and implemented through a contract amendment.

e. The Department will allocate expenditures for TCI payments and HMO administrative costs, subject to the 5% incentive restriction established by CMS.

f. The TCI payment will be in addition to the monthly capitation payment, but will not become part of the base capitation rate.

g. The HMO will receive $10,000 for the initial development and maintenance of an electronic database of information about their enrollees who have identified tobacco or nicotine addiction or current smoker status. The total amount allocated to HMOs for this purpose is $130,000.

EXHBIT

Wisconsin Department of Health and Family Services

2008 MCE and HMO Capitation Rate Development for BadgerCare Plus and Healthy Start Pregnant Women

CY 2008 Final BadgerCare Plus Standard Plan Capitation Rates by Age / Gender & Rate Region

All Service Capitation rate by Age/Gender and Rate Region

		Region					
Age Range	Gender	1	2	3	4	5	6
Age 0	All	$ 305.51	$ 302.36	$ 272.97	$ 290.89	$ 336.36	$ 351.88
Ages 1 - 5	All	70.44	66.55	62.90	67.91	73.55	77.12
Ages 6 - 14	All	59.34	53.39	52.95	57.89	58.57	61.56
Ages 15 - 20	Female	179.44	172.32	160.27	171.91	190.75	199.57
Ages 15 - 20	Male	74.84	69.65	66.82	72.23	76.72	80.35
Ages 21 - 34	Female	241.95	232.87	216.12	231.12	257.66	269.09
Ages 21 - 34	Male	118.30	111.18	105.64	113.16	122.37	127.48
Ages 35 -44	Female	257.69	247.74	230.18	245.72	273.87	285.62
Ages 35 -44	Male	174.40	165.88	155.76	166.25	182.88	190.38
Ages 45 & Over	Female	315.75	304.07	282.04	301.32	336.37	351.08
Ages 45 & Over	Male	271.54	261.00	242.54	259.34	288.67	301.38

Dental; No Chiropractic Service Capitation Rate by Age/Gender and Rate Region

		Region					
Age Range	Gender	1	2	3	4	5	6
Age 0	All	$ 304.46	$ 301.86	$ 272.04	$ 290.13	$ 336.04	$ 351.82
Ages 1 - 5	All	69.63	66.17	62.18	67.32	73.30	77.08
Ages 6 - 14	All	58.14	52.82	51.89	57.02	58.20	61.49
Ages 15 - 20	Female	177.03	171.17	158.12	170.15	190.01	199.44
Ages 15 - 20	Male	73.28	68.91	65.43	71.09	76.25	80.26
Ages 21 - 34	Female	237.42	230.73	212.08	227.81	256.27	268.85
Ages 21 - 34	Male	114.21	109.24	102.00	110.18	121.11	127.26
Ages 35 -44	Female	251.55	244.83	224.70	241.24	271.98	285.29
Ages 35 -44	Male	168.61	163.13	150.60	162.03	181.10	190.07
Ages 45 & Over	Female	309.26	301.00	276.26	296.59	334.38	350.74
Ages 45 & Over	Male	266.05	258.40	237.65	255.34	286.98	301.09

Chiropractic; No Dental Service Capitation rate by Age/Gender and Rate Region

		Region					
Age Range	Gender	1	2	3	4	5	6
Age 0	All	$ 305.38	$ 302.29	$ 272.86	$ 290.76	$ 336.29	$ 351.80
Ages 1 - 5	All	63.73	62.78	56.94	60.55	69.71	72.77
Ages 6 - 14	All	48.09	47.07	42.96	45.55	52.13	54.26
Ages 15 - 20	Female	169.26	166.60	151.24	160.75	184.94	192.97
Ages 15 - 20	Male	66.09	64.73	59.05	62.63	71.72	74.67
Ages 21 - 34	Female	230.99	226.71	206.38	219.09	251.39	261.97
Ages 21 - 34	Male	108.96	105.93	97.34	102.91	117.02	121.42
Ages 35 -44	Female	246.97	241.72	220.65	233.95	267.74	278.65
Ages 35 -44	Male	164.94	160.56	147.36	155.87	177.47	184.24
Ages 45 & Over	Female	302.54	296.65	270.31	286.83	328.82	342.51
Ages 45 & Over	Male	258.90	253.89	231.32	245.47	281.44	293.18

No Chiropractic & No Dental Service Capitation Rate by Age/Gender and Rate Region

		Region					
Age Range	Gender	1	2	3	4	5	6
Age 0	All	$ 304.33	$ 301.79	$ 271.93	$ 289.99	$ 335.97	$ 351.74
Ages 1 - 5	All	62.93	62.40	56.23	59.96	69.47	72.73
Ages 6 - 14	All	46.89	46.50	41.90	44.68	51.77	54.20
Ages 15 - 20	Female	166.85	165.46	149.08	158.99	184.19	192.84
Ages 15 - 20	Male	64.53	64.00	57.66	61.49	71.24	74.59
Ages 21 - 34	Female	226.46	224.56	202.34	215.78	250.00	261.73
Ages 21 - 34	Male	104.86	103.99	93.70	99.92	115.76	121.20
Ages 35 -44	Female	240.82	238.80	215.17	229.47	265.85	278.33
Ages 35 -44	Male	159.14	157.81	142.20	151.64	175.69	183.93
Ages 45 & Over	Female	296.05	293.57	264.52	282.10	326.82	342.16
Ages 45 & Over	Male	253.41	251.30	226.43	241.47	279.76	292.89

Wisconsin Department of Health and Family Services

2008 MCE and HMO Capitation Rate Development for BadgerCare Plus and Healthy Start Pregnant Women

CY 2008 Final BadgerCare Plus Benchmark Plan Capitation Rates by Age / Gender & Rate Region

All Service Capitation rate by Age/Gender and Rate Region

		Region					
Age Range	Gender	1	2	3	4	5	6
Age 0	All	$ 243.89	$ 255.38	$ 226.03	$ 241.24	$ 284.25	$ 297.53
Ages 1 - 5	All	56.09	56.15	51.95	56.28	62.16	65.32
Ages 6 - 14	All	47.10	44.98	43.59	47.93	49.49	52.23
Ages 15 - 20	Female	142.48	145.18	131.99	142.09	161.02	168.88
Ages 15 - 20	Male	59.23	58.59	54.84	59.60	64.73	68.06

Dental; No Chiropractic Service Capitation Rate by Age/Gender and Rate Region

		Region					
Age Range	Gender	1	2	3	4	5	6
Age 0	All	$ 243.67	$ 255.27	$ 225.82	$ 241.07	$ 284.18	$ 297.52
Ages 1 - 5	All	55.92	56.07	51.79	56.15	62.10	65.31
Ages 6 - 14	All	46.85	44.86	43.36	47.74	49.41	52.22
Ages 15 - 20	Female	141.97	144.92	131.52	141.70	160.86	168.85
Ages 15 - 20	Male	58.90	58.42	54.54	59.35	64.63	68.04

Chiropractic; No Dental Service Capitation rate by Age/Gender and Rate Region

		Region					
Age Range	Gender	1	2	3	4	5	6
Age 0	All	$ 243.79	$ 255.32	$ 225.93	$ 241.13	$ 284.19	$ 297.46
Ages 1 - 5	All	50.53	52.85	46.83	49.95	58.80	61.51
Ages 6 - 14	All	37.78	39.45	35.01	37.32	43.86	45.85
Ages 15 - 20	Female	134.05	140.17	124.22	132.49	155.93	163.10
Ages 15 - 20	Male	51.98	54.28	48.17	51.34	60.35	63.09
Ages 21 - 34	Female	204.93	214.15	189.92	202.49	238.16	249.04
Ages 21 - 34	Male	95.36	99.40	88.37	94.12	110.43	115.35
Ages 35 -44	Female	218.23	227.88	202.24	215.56	253.36	264.85
Ages 35 -44	Male	144.62	150.80	134.02	142.76	167.56	175.05
Ages 45 & Over	Female	268.04	280.02	248.40	264.81	311.39	325.58
Ages 45 & Over	Male	229.42	239.69	212.61	226.67	266.54	278.69

No Chiropractic & No Dental Service Capitation Rate by Age/Gender and Rate Region

		Region					
Age Range	Gender	1	2	3	4	5	6
Age 0	All	$ 243.57	$ 255.21	$ 225.73	$ 240.96	$ 284.11	$ 297.45
Ages 1 - 5	All	50.36	52.77	46.67	49.82	58.74	61.50
Ages 6 - 14	All	37.53	39.32	34.78	37.13	43.78	45.83
Ages 15 - 20	Female	133.54	139.92	123.75	132.10	155.76	163.08
Ages 15 - 20	Male	51.65	54.12	47.87	51.10	60.25	63.07
Ages 21 - 34	Female	203.88	213.62	188.94	201.69	237.82	248.98
Ages 21 - 34	Male	94.41	98.92	87.49	93.40	110.12	115.29
Ages 35 -44	Female	216.81	227.17	200.92	214.48	252.90	264.77
Ages 35 -44	Male	143.28	150.13	132.78	141.74	167.13	174.97
Ages 45 & Over	Female	266.53	279.27	247.01	263.67	310.90	325.49
Ages 45 & Over	Male	228.15	239.05	211.43	225.70	266.12	278.62

Wisconsin Department of Health and Family Services

2008 MCE and HMO Capitation Rate Development for BadgerCare Plus and Healthy Start Pregnant Women

CY 2008 Final Standard Plan Healthy Start Pregnant Woman Capitation Rates by Rate Region & Service

2008 Standard Plan Healthy Start Pregnant Women Rates						
	Region					
Service	1	2	3	4	5	6
All Services	$ 835.15	$ 760.75	$ 647.14	$ 792.54	$ 867.01	$ 1,048.27
Dental, No Chiro	$ 828.03	$ 758.63	$ 641.64	$ 786.55	$ 865.20	$ 1,047.77
Chiro, No Dental	$ 828.01	$ 758.01	$ 641.54	$ 783.95	$ 863.80	$ 1,043.34
No Dental or Chiro	$ 820.89	$ 755.89	$ 636.04	$ 777.96	$ 861.99	$ 1,042.84

Wisconsin Department of Health and Family Services

2008 MCE and HMO Capitation Rate Development for BadgerCare Plus and Healthy Start Pregnant Women

CY 2008 Final Benchamrk Plan Healthy Start Pregnant Woman Capitation Rates by Rate Region & Service

2008 Benchmark Plan Healthy Start Pregnant Women Rates						
	Region					
Service	1	2	3	4	5	6
All Services	$ 844.78	$ 764.44	$ 654.70	$ 804.13	$ 871.34	$ 1,054.93
Dental, No Chiro	$ 837.66	$ 762.32	$ 649.19	$ 798.14	$ 869.53	$ 1,054.42
Chiro, No Dental	$ 828.01	$ 758.01	$ 641.54	$ 783.95	$ 863.80	$ 1,043.34
No Dental or Chiro	$ 820.89	$ 755.89	$ 636.04	$ 777.96	$ 861.99	$ 1,042.84

EXHIBIT

Wisconsin Department of Health and Family Services
2008 HMO Capitation RateS for SSI Program
Effective February 1, 2008 - December 31, 2008

All Service Capitation 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	$ 366.42	$ 328.94	$ 309.66	$ 328.16	$ 402.55	$ 480.55	$ 131.72	$ 138.47	$ 121.09	$ 129.41	$ 171.92	$ 204.53
19-29	Female	436.20	391.59	368.63	390.66	479.21	571.72	127.43	133.96	117.14	125.19	166.31	197.62
30-39	Male	474.58	426.05	401.07	425.04	521.39	621.87	111.34	117.05	102.36	109.39	145.32	173.17
30-39	Female	469.78	421.74	397.01	420.74	516.11	615.60	113.13	118.93	104.00	111.14	147.66	175.92
40-64	Male	609.80	547.44	515.34	546.14	669.93	798.53	137.65	144.71	126.54	135.23	179.66	213.65
40-64	Female	616.54	553.49	521.03	552.18	677.34	807.34	153.01	160.85	140.66	150.32	199.70	237.28
65+	Male	475.23	426.63	401.62	425.62	522.10	622.72	203.51	213.94	187.08	199.93	265.61	315.00
65+	Female	586.12	526.18	495.32	524.93	643.92	767.59	220.90	232.22	203.07	217.01	288.31	341.76

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	$ 883.77	$ 745.90	$ 659.02	$ 725.40	$ 926.52	$ 680.48	$ 114.05	$ 111.43	$ 98.78	$ 114.16	$ 132.63	$ 164.18
19-29	Female	652.76	550.93	486.76	535.79	684.34	503.08	135.83	132.70	117.65	135.96	157.96	195.19
30-39	Male	1,160.40	979.39	865.31	952.46	1,216.54	892.91	173.18	169.19	149.99	173.34	201.39	248.36
30-39	Female	902.38	761.62	672.90	740.68	946.03	694.77	181.28	177.11	157.01	181.45	210.81	259.89
40-64	Male	1,914.01	1,615.43	1,427.27	1,571.03	2,006.60	1,471.61	180.39	176.24	156.24	180.55	209.77	258.62
40-64	Female	1,312.98	1,108.16	979.08	1,077.70	1,376.49	1,010.07	181.85	177.66	157.50	182.02	211.47	260.70
65+	Male	464.89	392.37	346.66	381.58	487.37	358.81	185.94	181.66	161.04	186.11	216.22	266.52
65+	Female	501.59	423.34	374.03	411.70	525.85	386.99	174.79	170.76	151.39	174.95	203.26	250.65

MAPP - Medicaid Only								MAPP - Dual Elig						
		Region						Region						
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
All	All	$ 898.02	$ 898.02	$ 898.02	$ 898.02	$ 898.02	$ 899.84	$ 164.87	$ 164.87	$ 164.87	$ 164.87	$ 164.87	$ 166.69

* Region 6 (Milwaukee) rates include an additional $1.82 External Advocate funding adjustment.

Dental; No Chiro Capitation 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	$ 364.02	$ 327.71	$ 307.35	$ 326.93	$ 401.68	$ 480.11	$ 131.24	$ 138.16	$ 120.61	$ 129.10	$ 171.75	$ 204.45
19-29	Female	433.35	390.12	365.89	389.19	478.18	571.20	126.96	133.65	116.68	124.89	166.15	197.84
30-39	Male	471.48	424.45	398.09	423.44	520.26	621.31	110.93	116.78	101.95	109.12	145.18	173.10
30-39	Female	466.71	420.16	394.06	419.16	515.00	615.04	112.72	118.66	103.59	110.88	147.51	175.85
40-64	Male	605.82	545.39	511.51	544.09	668.49	797.80	137.15	144.38	126.04	134.91	179.48	213.57
40-64	Female	612.51	551.41	517.16	550.10	675.88	806.60	152.44	160.48	140.10	149.96	199.50	237.19
65+	Male	472.13	425.03	398.63	424.02	520.97	622.15	202.76	213.45	186.34	199.45	265.35	314.87
65+	Female	582.29	524.21	491.64	522.96	642.53	766.89	220.09	231.69	202.26	216.49	288.02	341.62

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	$ 881.91	$ 744.60	$ 657.17	$ 724.09	$ 925.80	$ 680.22	$ 113.87	$ 111.27	$ 98.50	$ 114.00	$ 132.51	$ 164.15
19-29	Female	651.39	549.97	485.39	534.82	683.81	502.89	135.62	132.52	117.31	135.76	157.81	195.15
30-39	Male	1,157.97	977.67	862.87	950.74	1,215.59	892.57	172.91	168.96	149.57	173.09	201.20	248.30
30-39	Female	900.49	760.28	671.01	739.34	945.30	694.51	181.00	176.87	156.56	181.19	210.62	259.84
40-64	Male	1,910.00	1,612.60	1,423.25	1,568.18	2,005.03	1,471.05	180.11	175.99	155.79	180.30	209.58	258.56
40-64	Female	1,310.22	1,106.22	976.32	1,075.74	1,375.42	1,009.68	181.56	177.42	157.05	181.76	211.28	260.64
65+	Male	463.91	391.68	345.69	380.89	486.99	358.67	185.65	181.41	160.58	185.85	216.03	266.46
65+	Female	500.53	422.60	372.98	410.96	525.44	386.85	174.51	170.53	150.95	174.70	203.07	250.59

MAPP - Medicaid Only								MAPP - Dual Elig						
		Region						Region						
Age Range	Gender	1	2	3	4	5	6	1	2	3	4	5	6
All	All	$ 894.66	$ 894.66	$ 894.66	$ 894.66	$ 894.66	$ 896.48	$ 164.29	$ 164.29	$ 164.29	$ 164.29	$ 164.29	$ 166.11

* Region 6 (Milwaukee) rates include an additional $1.82 External Advocate funding adjustment.

Wisconsin Department of Health and Family Services
2008 HMO Capitation RateS for SSI Program
Effective February 1, 2008 - December 31, 2008

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

Med Stat Code 21 - Medicaid Only

Age Range	Gender	Region 1	2	3	4	5	6
19-29	Male	$ 360.05	$ 325.08	$ 303.35	$ 323.61	$ 397.44	$ 475.10
19-29	Female	428.62	386.99	361.12	385.23	473.13	565.23
30-39	Male	466.35	421.05	392.90	419.14	514.77	614.82
30-39	Female	461.63	416.79	388.92	414.90	509.56	608.62
40-64	Male	599.21	541.01	504.84	538.55	661.43	789.47
40-64	Female	605.83	546.99	510.42	544.51	668.74	798.18
65+	Male	466.08	421.63	393.43	419.71	515.47	615.66
65+	Female	575.94	520.00	485.23	517.64	635.74	758.88

Med Stat Code 21 - Dual Elig

Region 1	2	3	4	5	6
$ 124.22	$ 132.81	$ 113.87	$ 123.85	$ 165.53	$ 196.24
120.16	128.48	110.16	119.82	160.13	189.91
105.00	112.26	96.25	104.69	139.92	166.17
106.69	114.07	97.80	106.38	142.17	168.81
129.81	138.79	119.00	129.43	172.98	205.00
144.29	154.27	132.27	143.87	192.27	227.66
191.91	205.19	175.93	191.35	255.73	302.20
208.31	222.72	190.96	207.70	277.58	327.87

SSI Related Med Stat Codes - Medicaid Only

Age Range	Gender	Region 1	2	3	4	5	6
19-29	Male	$ 878.47	$ 741.67	$ 652.81	$ 720.59	$ 920.59	$ 672.22
19-29	Female	648.85	547.81	482.18	532.24	679.96	496.99
30-39	Male	1,153.44	973.82	857.15	946.15	1,208.75	882.06
30-39	Female	896.97	757.29	666.56	735.77	939.98	686.34
40-64	Male	1,902.53	1,606.26	1,413.82	1,560.62	1,993.76	1,453.73
40-64	Female	1,305.10	1,101.87	969.85	1,070.55	1,367.68	997.80
65+	Male	462.10	390.14	343.40	379.05	484.26	354.47
65+	Female	498.58	420.94	370.51	408.98	522.49	382.31

SSI Related Med Stat Codes - Dual Elig

Region 1	2	3	4	5	6
$ 110.12	$ 108.23	$ 94.73	$ 110.03	$ 128.02	$ 156.21
131.15	128.89	112.82	131.04	152.47	185.69
167.21	164.33	143.84	167.07	194.40	236.24
175.04	172.02	150.57	174.89	203.49	247.21
174.17	171.17	149.83	174.03	202.49	246.00
175.58	172.56	151.04	175.44	204.13	247.98
179.53	176.44	154.44	179.38	208.72	253.51
168.77	165.86	145.18	168.62	196.20	238.42

MAPP - Medicaid Only

Age Range	Gender	Region 1	2	3	4	5	6
All	All	$ 887.43	$ 887.43	$ 887.43	$ 887.43	$ 887.43	$ 889.25

MAPP - Dual Elig

Region 1	2	3	4	5	6
$ 154.89	$ 154.89	$ 154.89	$ 154.89	$ 154.89	$ 156.71

* Region 6 (Milwaukee) rates include an additional $1.82 External Advocate funding adjustment.

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

Med Stat Code 21 - Medicaid Only

Age Range	Gender	Region 1	2	3	4	5	6
19-29	Male	$ 357.66	$ 323.85	$ 301.04	$ 322.37	$ 396.57	$ 474.67
19-29	Female	425.77	385.52	358.37	383.77	472.10	564.72
30-39	Male	463.25	419.45	389.91	417.54	513.64	614.25
30-39	Female	458.56	415.21	385.97	413.32	508.45	608.06
40-64	Male	595.23	538.96	501.01	536.50	659.99	788.75
40-64	Female	601.81	544.92	506.54	542.43	667.28	797.44
65+	Male	463.88	420.03	390.45	418.11	514.35	615.09
65+	Female	572.11	518.03	481.55	515.67	634.35	758.18

Med Stat Code 21 - Dual Elig

Region 1	2	3	4	5	6
$ 123.73	$ 132.49	$ 113.39	$ 123.54	$ 165.35	$ 196.16
119.70	128.17	109.69	119.51	159.96	189.83
104.59	111.99	95.84	104.43	139.77	166.10
106.27	113.79	97.39	106.11	142.02	168.74
129.30	138.46	118.49	129.10	172.80	204.91
143.72	153.90	131.71	143.51	192.07	227.57
191.16	204.70	175.18	190.87	255.47	302.07
207.49	222.10	190.16	207.18	277.30	327.73

SSI Related Med Stat Codes - Medicaid Only

Age Range	Gender	Region 1	2	3	4	5	6
19-29	Male	$ 876.61	$ 740.36	$ 650.95	$ 719.28	$ 919.87	$ 671.96
19-29	Female	647.48	546.84	480.80	531.27	679.43	496.79
30-39	Male	1,151.01	972.11	854.71	944.43	1,207.81	881.72
30-39	Female	895.08	755.96	664.66	734.43	939.25	686.07
40-64	Male	1,898.51	1,603.43	1,409.79	1,557.77	1,992.20	1,453.16
40-64	Female	1,302.34	1,099.93	967.09	1,068.60	1,366.61	997.42
65+	Male	461.12	389.45	342.42	378.36	483.88	354.33
65+	Female	497.52	420.20	369.45	408.23	522.08	382.16

SSI Related Med Stat Codes - Dual Elig

Region 1	2	3	4	5	6
$ 109.94	$ 108.07	$ 94.45	$ 109.87	$ 127.90	$ 156.17
130.94	128.71	112.48	130.85	152.33	185.65
166.94	164.10	143.41	166.83	194.21	236.19
174.75	171.78	150.12	174.63	203.30	247.16
173.89	170.93	149.38	173.77	202.30	245.95
175.30	172.31	150.59	175.18	203.93	247.92
179.24	176.19	153.98	179.12	208.52	253.46
168.49	165.62	144.74	168.38	196.02	238.37

MAPP - Medicaid Only

Age Range	Gender	Region 1	2	3	4	5	6
All	All	$ 884.06	$ 884.06	$ 884.06	$ 884.06	$ 884.06	$ 885.88

MAPP - Dual Elig

Region 1	2	3	4	5	6
$ 154.31	$ 154.31	$ 154.31	$ 154.31	$ 154.31	$ 156.13

* Region 6 (Milwaukee) rates include an additional $1.82 External Advocate funding adjustment.