CONTRACT FOR SERVICES

Between

Department of Health and Family Services

and

Milwaukee County

October 1, 2007 – June 30, 2009

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CONTRACT FOR SERVICES

Between

Department of Health and Family Services

and

Milwaukee County

ARTICLE I

THIS CONTRACT is made and entered into this first day of October 2007 for the period of October 1, 2007, through June 30, 2009, by and between the Department of Health and Family Services (hereinafter Department) and the County Board Supervisors of the County of Milwaukee (hereinafter County) for the purpose of providing and/or purchasing mental health services for severely emotionally disturbed children who are Medicaid/BadgerCare recipients enrolled in the County's managed care program known as Wraparound Milwaukee (WM).

WHEREAS THE DEPARTMENT wishes to purchase with periodic fixed payments on a risk basis, as defined in 42 CFR 438.2, the "Contract services" and "administrative services" specifically described below; and

WHEREAS the County is able and willing to provide and/or purchase such services,

NOW THEREFORE, in consideration of the mutual covenants hereinafter set forth, the Department of Health and Family Services and the County agree as follows:

I. DEFINITIONS

"**Abuse**" – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid/BadgerCare, in reimbursement for services that fail to meet professionally recognized standards for health. Abuse also includes client or member practices that result in unnecessary costs to Medicaid.

"**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 of service.

"**Administrative Services**" – An obligation of the County under this Contract other than Contract services.

"**Appeal**" – A request for review of an action.

"**BadgerCare**" – A part of the Wisconsin Medicaid Program operated by the Wisconsin Department of Health and Family Services under Title XIX and Title XXI of the Federal Social Security Act, Chapter 49 Wis. Stats., and related state and federal rules and regulations. This term is used throughout this Contract.

"CFR" – Code of Federal Regulations.

"Clean Claims" – A truthful, complete and accurate claim. A claim that does not have to be returned for additional information.

"**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. The Contract includes the base agreement and documents specified in Article XII, Sections A and B.

"**Contract Services**" – Those Medicaid/BadgerCare covered services found in this Contract and non-Medicaid services recommended by the child and family treatment team including, but not limited to, those services found in the Utilization Report which the County is required to provide under this Contract.

"**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, Wraparound Milwaukee (WM) and adapting to and encouraging organizational diversity.

"**Department**" – The Wisconsin Department of Health and Family Services (DHFS).

"**Emergency Medical Condition**" –

A. A psychiatric emergency involving a significant risk of serious harm to an enrollee or others.

B. 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.

"Encounter Record" – An electronically formatted list of encounter data elements per encounter as specified in the Wisconsin Medicaid MCO Encounter Data User Manual. An encounter record may be prepared from a single detail line from a claim such as the CMS 1500, UB-92, or ASCX12N 837.

"**Enrollee**" and "**Participant**" – A Medicaid or BadgerCare recipient who has been certified by the state as eligible to enroll under this Contract, and whose name appears on the County Enrollment Reports which the Department will transmit to the County every month in accordance with an established notification schedule.

"**Enrollment Area**" – Refers to Milwaukee County and is the geographic area within which a recipient's parent, guardian or primary caregiver must reside in order to enroll in the County's Managed Care Program under this Contract. A recipient may enroll

regardless of where the recipient's parent, guardian, or primary caregiver lives when the recipient is legally the responsibility of the County.

"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 to some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

"**Grievance**" – An expression of dissatisfaction 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 County. 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.

"HHS" – Refers to the federal Department of Health and Human Services.

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

"**Medicaid**" – The Wisconsin Medical Assistance program is operated by the Wisconsin Department of Health and Family Services under Title XIX of the Federal Social Security Act, Ch. 49, Wis. Stats., and related state and federal rules and regulations. This is the term used consistently in this Contract. Other expressions or words equivalent to Medicaid are "MA," and "Medical Assistance."

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

"**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 recipients and to be reimbursed by Medicaid 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.

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

"**Risk**" – The possibility of monetary loss or gain by the County resulting from service costs exceeding or being less than payments made to it by the Department.

"**Serious Emotional Disturbance**," – "Severe Emotional Disturbance," "Severely Emotionally Disturbed," and "SED": A mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

"State" – State of Wisconsin.

"**Subcontract**" – Any written agreement between the County and another party to fulfill the requirements of this Contract.

"Wraparound System of Care" – A process within a system of care that individualizes services for children with complicated, multi-dimensional problems; often such as those with emotional/behavioral disturbances having multi-system needs.

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

ARTICLE II

II. DELEGATIONS OF AUTHORITY

The County 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 County shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

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

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

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

ARTICLE III

III. COVERED POPULATION

The eligible population will be those Medicaid/BadgerCare eligible children and adolescents who meet the following criteria:

A. RESIDENCY----The parents, guardian or primary caregiver of eligible children and adolescents will live in Milwaukee County unless the eligible child is legally the responsibility of the county.

B. AGE----Eligible children and adolescents will be from birth through 18 years of age.

C. SEVERE EMOTIONAL DISTURBANCE----Eligible children and youth will be determined to have severe emotional disturbance as defined in this Contract.

D. IMMINENT RISK OF PLACEMENT----Eligible children and youth will be in an out-of-home placement or at imminent risk of admission to a psychiatric hospital or placement in a residential care center or juvenile correction facility.

E. NON-NURSING HOME----Eligible children and youth will not be residents of a nursing facility at the time of enrollment.

F. NON-PSYCHIATRIC HOSPITAL----Eligible children and youth will not be residing in a psychiatric hospital or a psychiatric unit of a general hospital at the time of enrollment.

ARTICLE IV

IV. FUNCTIONS AND DUTIES OF THE COUNTY

In consideration of promises of the Department contained in this Contract, the County shall:

A. PROVISION OF CONTRACT SERVICES----

1. Promptly provide or arrange for the provision of all services as described in this Contract attached hereto and included herein by reference.

2. Be liable, where emergencies and County referrals to out-of-area or non-affiliated providers occur, for payment only to the extent that Medicaid pays, including Medicare deductibles, or would pay its fee-for-service providers for services to Medicaid/BadgerCare recipients. For outpatient hospital services the Department will provide each managed care program per diem outpatient rates based on the Medicaid fee-for-service equivalent. This condition does not apply to: (1) Cases where prior payment arrangements were established; and (2) Specific subcontract agreements. The County is not required to make retroactive payment adjustments consistent with the Wisconsin Medicaid Maximum Allowable Fee Schedule and Hospital reimbursement made by the State of Wisconsin for fee-for-service providers including, but not limited to, payments for inpatient and outpatient hospital services.

3. Changes to Medicaid 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 into the Contract effective the date the law goes into effect, if it adjusts the capitation rate accordingly. The Department will give the County at least 30 days notice before the intended effective date of any such change that reflects service increases and the County may elect to accept or reject the service increases for the remainder of that Contract year.

   The Department will give the County 60 days notice of any such change that reflects service decreases, with a right of the County to dispute the amount of the decrease within those 60 days. The County 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 State Appropriations.

This Contract is contingent upon authorization of federal and state law and any material amendment or repeal of same affecting relevant funding to, or authority of, the Department shall serve to terminate this agreement except as further agreed by the parties hereto. Nothing contained in this Contract shall be construed to supersede the lawful power or duties of either party.

4. Be responsible for the provision and payment of all Contract services provided to all Medicaid/BadgerCare recipients listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage. Additionally, the County agrees to provide, or authorize provision of, services to all Medicaid/BadgerCare enrollees with valid Forward cards indicating County enrollment without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the reports will be reported to the Department for resolution. The County shall continue to provide and authorize provision of all Contract services until the discrepancy is resolved. This includes enrollees who were PEND/CLOSE on the Initial Report and held a valid Forward card indicating County enrollment, but did not appear as a CONTINUE on the Final Report.

5. Assist enrollees in scheduling and obtaining HealthCheck services from their regular provider of primary health care, or other certified HealthCheck service provider.

6. The actual provision of any service is subject to the judgment of the members of the child and family treatment team as to the medical necessity and appropriateness of the service, except that the County must provide assessment and evaluation services ordered by a court. The County shall not establish any monetary limit or time limit on mental health and substance abuse treatment where it has been determined that this treatment is medically necessary. 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) and the recommendations of the child and family treatment team. Disputes between the County and enrollees about medical necessity and appropriateness can be appealed through a County grievance system and ultimately to the Department for a binding determination. Parents must be informed of the grievance procedure in writing.

7. The County and its providers and subcontractors will not bill a Medicaid/ BadgerCare enrollee for Medicaid services covered under the County Contract and provided during the enrollee's period of County enrollment.

This provision shall continue to be in effect even if the County becomes insolvent.

B. TIME LIMIT FOR DECISION ON CERTAIN REFERRALS----Pay for covered services pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-County provider, and extending until the County issues a written denial of referral. This requirement does not apply if the County issues a written denial of referral within seven (7) days of receiving the request for referral.

C. EMERGENCY CARE----Promptly provide or pay for needed Contract services for emergency mental health conditions, regardless of whether the provider that furnishes the services has a Contract with the entity, and post-stabilization services. Payments for qualifying emergencies are to be based on the mental health 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.

D. 24-HOUR COVERAGE----Provide all emergency Contract and post-stabilization services as defined in this Contract 24-hours each day, seven (7) days a week, either by the County's own facilities or through arrangements approved by the Department with other providers. County shall have one (1) telephone number that enrollees or individuals acting on behalf of an enrollee can call at any time to obtain authorization for emergency care. Through this number enrollees must have access to individuals authorizing treatment as appropriate. A response to such a call must be provided within 30 minutes or the County will be liable for the cost of medically necessary services covered under this Contract that are related to that illness or injury incident whether treatment is in-or out-of-plan and whether the condition is emergency, urgent, or routine.

The County must be able to communicate with a caller in the language spoken by the caller or the County will be liable for the cost of subsequent care related to that illness or injury incident whether treatment is in-or out-of-plan and whether the condition is emergency, urgent, or routine.

These calls must be logged with time, date and any pertinent information related to persons involved, resolution and follow-up instructions.

County shall notify the Department of any changes of this one telephone number for emergency calls within seven (7) working days of change.

E. THIRTY-DAY PAYMENT REQUIREMENT----The County must pay at least 90% of adjudicated clean claims from subcontractors for covered medically necessary services within 30 days of receipt of bill, 99% within 90 days, and 100% of the claims within 180 days of receipt, except to the extent subcontractors have agreed to later payment. The County agrees not to delay payment to

subcontractors pending subcontractor collection of third party liability unless the County has an agreement with their subcontractor to collect third party liability.

F. COUNTY CLAIM RETRIEVAL SYSTEM----The County must maintain a claim retrieval system that can on request identify date of receipt, action taken on all provider claims (i.e., paid, denied, other), and when action was taken. County shall date stamp all provider claims upon receipt. In addition, the County must maintain a claim retrieval system that can identify, within the individual claim, services provided and diagnoses of enrollees with nationally accepted coding systems: HCPCS including Level I CPT codes, 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 Wisconsin Medicaid provider ID number assigned to all in-plan providers.

G. PROVIDER APPEALS TO THE DEPARTMENT

1. Providers must appeal first to the County and then to the Department if they disagree with the County's payment or nonpayment of a claim.

   The County must notify providers in writing of the County's decision to pay or deny the original claim. This notification should include:

   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 County.

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

   d. An explanation of the process the provider should follow when appealing the County'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, recipient's name and Medicaid or BadgerCare 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 County 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 County fails to respond to the appeal within 45 days or if the provider is not satisfied with the County's response to the request for reconsideration. Appeals to the Department must be submitted in writing within 60 days of the County's final decision or, in the case of no response, within 60 days from the 45 day timeline allotted the County to respond. Appeals should be sent to:

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

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

3. After a provider has appealed to the County 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 County's final decision resulting from a request for reconsideration or, if the County fails to respond, within 60 days from the 45 day timeline allotted the County to respond. In exceptional cases, the Department may override the County'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 County of the final decision. If the Department's decision is in favor of the provider, the County will pay provider(s) within 45 days of receipt of the Department's final determination. The County must accept the Department's determinations regarding appeals of disputed claims.

H. ENROLLEE APPEALS ----County must provide written notification to providers on enrollee grievance procedures as outlined in this Contract.

I. PAYMENTS FOR DIAGNOSIS OF WHETHER AN EMERGENCY CONDITION EXISTS----Pay for appropriate diagnostic tests or evaluations

utilized to determine if an emergency exists. Payment for emergency services continue until the patient is stabilized and can be safely discharged or transferred.

J. MEMORANDA OF UNDERSTANDING (MOU) FOR EMERGENCY SERVICES AND POST-STABILIZATION SERVICES----Negotiate in good faith MOUs with emergency care providers to ensure prompt and appropriate delivery of and payment for emergency services.

Such MOUs shall provide for:

1. The process for determining whether an emergency exists.

2. The requirements and procedures for contacting the County before the provision of urgent or routine care.

3. Agreements, if any, between the County and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the County or provider in the absence of such an agreement.

4. Payments for appropriate diagnostic tests or evaluations to determine if an emergency exists.

5. Assurance of timely and appropriate provision of and payment for emergency services.

Unless a Contract or MOU specifies otherwise, the County is liable to the extent that fee-for-service would have been liable for the emergency situation. The Department reserves the right to resolve disputes between the County, hospitals and urgent care centers regarding emergency situations based on fee-for-service criteria.

K. EQUALITY IN THE DELIVERY OF SERVICES----The county must provide Contract services to Medicaid/BadgerCare enrollees under this contract in the same manner as those services are provided to other children with serious emotional disturbances by Milwaukee County under Medicaid fee-for-service.

The County 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.

L. ENROLLMENT----The County shall accept as enrolled all persons who appear as enrollees on County Enrollment Reports. Enrollment in County's Managed Care Program shall be voluntary by the recipient. Signed and completed enrollment forms will be faxed to the Department's Medicaid Fiscal Agent the day the multi-agency team determines the child is at imminent risk of out-of-home placement. The Department's Medicaid Fiscal Agent will determine if recipient is

Medicaid/BadgerCare eligible, under 18 years of age, does not have a nursing home authorization and is not residing in a psychiatric hospital. The Department's Medicaid Fiscal Agent will have five (5) working days to process County enrollment to final disposition. Final disposition means that:

1. County enrollment is approved and updates are applied to the recipients eligibility segment; or

2. County enrollment is denied and the County is notified.

If determined eligible, recipients are enrolled effective on the date the enrollment form is received by the Department's Medicaid Fiscal Agent.

The County shall accept referrals of eligible children and adolescents at any time during the time this agreement is in effect. The County will accept Medicaid/ BadgerCare recipients in the order in which they apply without restriction, except as otherwise noted herein. The County will not discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

Enrollment opportunities will remain open and available without restriction within the total enrollment limits set by this Contract, except that the County may set reasonable limits on the number of eligibles to be enrolled on a monthly basis to ensure a manageable rate of growth and ability to provide medically necessary care. The County shall develop a policy with approval from the Department on how to determine which child to serve when there is a waiting list.

A referral can originate from County staff, community based providers or parents. A referral is a request to enroll in WM system of care. Once a referral is received by the County, the following steps will occur:

Step 1. Within five (5) business days of receiving a referral, the county shall accurately determine whether the child or adolescent referred meets the eligibility requirements for serious emotional disturbance (SED) and complete an intake update information sheet approved by the Department.

Step 2. If the child or adolescent meets the SED definition determined by Step 1, a screening will occur to determine if the child is at imminent risk for out-of-home placement. The screen will be conducted by either a multi-agency team consisting of one person from a mental health agency, a person from a child welfare agency, a person from the juvenile justice system, a person from the education system, a person from the crisis response unit, one non-residential community based provider and two parents of children with SED (but not a parent whose child is being assessed for admission); or by Wraparound identified clinicians with extensive training in working with SED youth and their families. A standardized risk assessment tool

will be used to screen potential enrollees and the tool used will be approved by the Department. The multi-agency team will meet weekly and review all referrals that meet the SED definition.

Step 3. If a referral is received and a child will be placed out-of-home in 10 business days or less, the process described in one (1) and two (2) above can be by-passed. In the case of a by-pass, the crisis unit will assess the child for meeting the SED definition and assess the child for out-of-home placement with the standardized risk assessment tool that the multi-agency team uses. Children that would require a by-pass would include those in a holding situation such as detention or a crisis home awaiting a court's decision on disposition. If the crisis unit determines that the child is eligible, the County will fax an enrollment form to the Department's Medicaid Fiscal Agent.

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

M. APPEAL OF DENIAL OF ENROLLMENT IN THE COUNTY WRAPAROUND MILWAUKEE MANAGED CARE PROGRAM ----The County will maintain and operate a grievance procedure that includes Departmental review or the right to a fair hearing when the County denies enrollment in the WM. The procedure includes:

1. A written notification to applicant's parent or guardian explaining the reason for denial.

2. A statement advising the applicant about his/her rights to request either a review by the Department or a fair hearing through the Division of Hearings and Appeals (DHA).

3. Submission of a copy of the written notification to the Contract monitor in the Division of Health Care Financing (DHCF). Notification includes the full name, address and social security number of the applicant appealing the denial.

4. Providing the Contract monitor in the DHCF with the name, address and telephone number of the person who is responsible for processing appeals for the denial of enrollment.

5. A statement indicating the actions that the County requires to consider the appeal and that are consistent with County's appeal procedure. The procedure provides reasonable time, not to exceed 30 days, in which to appeal the County denial as well as reasonable time, not to exceed 30 days, for the County to respond to the appeal.

6. Notification of County decision to the DHCF.

7. A statement indicating the final step that is available to the applicant after the County considers and denies the applicant's appeal. The applicant may submit to the Department's Contract monitor a written request to review the County decision. The Department shall receive the applicant's written request within 30 days of the date of County written notification of its decisions.

At the request of the applicant, the Department shall review County decisions. After accepting and reviewing written comments from the parties involved, the Department shall make its final determination and notify both parties, County and applicant, within 30 days of the date of the applicant's request for review by the Department.

If the Department review upholds the County decision, the applicant will be notified of the right to a fair hearing with the DHA.

N. DISENROLLMENT----The County can initiate disenrollment in the Managed Care Program for one of the following reasons (the effective date is the first day of the second month following the request):

1. The enrollee has made substantial progress towards his/her individual goals and no longer is in need of the services provided by the WM managed care system.

2. All enrollees shall have the right to disenroll from the County pursuant to 42 CFR 438.56(b)(1) if the enrollee feels s/he can no longer abide by the service plan and s/he has exhausted all available options provided by County. A voluntary disenrollment shall be effective no later than the first day of the second month after the month in which the enrollee requests termination. The County will promptly forward to the Department or its designee all oral or written requests from enrollees for disenrollment.

3. Other reasons for disenrollment initiated by the County include:

   a. Corrections placement;

   b. Residency change; and

   c. Over the age of 19 years.

   d. Court Order for enrollment is revised or vacated.

4. The County may request and the Department may approve disenrollment 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 enrollee or in which the County cannot provide the enrollee with appropriate medically necessary Contract services for reasons beyond its control. Examples of just cause disenrollment include:

a. Parent, guardian or enrollee repeatedly do not carry out the agreed upon plan of care.

b. Parent, guardian or enrollee refuses to sign the plan of care authorizing services.

c. Parent, guardian or enrollee demand a treatment determined unnecessary by the child and family treatment team.

d. A juvenile court order affecting the enrollee explicitly contradicts the plan of care developed by the child and family team.

e. Enrollee is missing from the community for at least 30 days, (e.g., runaway).

f. Enrollee is unlikely to be available for case management due to extended institutional placement. To be considered under this just cause provision, recipient must be enrolled in WM for at least one (1) year, been in an institution for a minimum of 10 consecutive months, and been recommended for continued, extended residential treatment by institution psychiatric staff.

If the County fails to make a disenrollment within the time frame specified the disenrollment is considered approved.

O. ENROLLMENT/DISENROLLMENT PRACTICES---- The County must permit the Department to monitor its enrollment and disenrollment practices under this Contract. The County will not discriminate in enrollment/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 County will notify the Department's Medicaid Fiscal Agent in writing of all disenrollments and the reason for disenrollment.

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

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

P. PRE-EXISTING CONDITIONS----Assume responsibility for all Contract services of each enrollee as of the effective date of coverage under the Contract. The aforementioned responsibility shall not apply in the case of persons hospitalized at the time of initial enrollment.

Q. HOSPITALIZATION AT THE TIME OF ENROLLMENT OR DISENROLLMENT----

1. County will not enroll recipients under the terms of this Contract when the recipient is hospitalized. The Department will assume financial responsibility and will reimburse all Medicaid covered services on a fee-for-service basis.

   County may begin to provide services during the time of the hospitalization but will not be eligible to receive capitation payments, until the enrollee's date of discharge.

2. The financial liability of the County for recipients disenrolled while they are hospitalized ends on the date of disenrollment.

3. 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-92 manual.

R. NON-DISCRIMINATION----The County must comply with all applicable federal and state laws relating to non-discrimination and equal employment opportunity including 16.765, Wis. Stats., 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 assure 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.

Chapter 16.765 requires that in connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of

compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the non-discrimination clause.

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

S. AFFIRMATIVE ACTION PLAN----The AA/CRC Plan contains three components: Affirmative Action, Equal Opportunity, and Language Access.

1. County's that have more than 25 employees and receive more than $25,000 must submit an Affirmative Action Civil Rights Compliance Plan in accordance to the most recently revised instructions and format requirements for the funding period of July 1, 2005 to June 31, 2007. A new plan will be due on July 15, 2007, for the funding period covering July 1, 2007, to June 31, 2009.

   For agreements of $25,000 or more and with 25 employees or more, HMOs will 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 the aspects of Civil Rights Compliance, HMOs are encouraged 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, Wisconsin 53707-7850.
   (608) 266-9372 (voice)
   (888) 701-1251 (TTY)

2. Counties that have less than 25 employees or receive less than $25,000 must submit a Letter of Assurance and proof that it is exempt from submitting AA information in accordance to s. 16.675, Wis. Stats., and ADM 50, Wis. Adm. Code. Counties meeting this criteria can find the necessary forms and instructions to comply as noted in section 4, a) above.

3. AA/CRC Reporting Requirements:

   a. All Counties must submit language access information as part of the County Certification application.

   b. Established Counties (Counties that submitted a plan in 2004) must submit a new AA/CRC plan by July 15, 2007.

   c. New Counties must file a 2006 AA/CRC Plan within 15 days after the award of the contract.

   d. All Counties must submit a new plan by July 15, 2007.

   e. AA/CRC plans must be submitted to the Department of Health and Family Services, Office of Affirmative Action and Civil Rights Compliance, Box 7850, Madison, Wisconsin 53707-7850.

4. Assurances:

   a. No otherwise qualified person will 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, sex, disability or age. This policy covers eligibility 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.

   b. No otherwise qualified person will 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 of 1990 and Subchapter II Wisconsin Fair Employment Law 111.32), 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.

c. 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.

d. 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.

e. 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 County, 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.

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

T. CULTURAL COMPETENCY----

1. The County shall address the special health needs of enrollees such as those who are low income or members of specific population groups needing specified culturally competent services. The County shall incorporate in its policies, administration, and service such as recognizing member's beliefs, addressing cultural differences in a competent manner, and fostering in staff and providers behaviors that effectively address interpersonal communication styles which respect enrollees' cultural backgrounds.

   County shall have specific policy statements on these topics and communicate them to subcontractors.

2. The County shall encourage and foster cultural competency among providers. When appropriate the County shall permit enrollees to choose

providers from among the County's network based on linguistic/cultural needs. The County shall permit enrollees to change primary providers based on the providers ability to provide services in a culturally competent manner. Enrollees may submit grievances to the County and/or the Department regarding their inability to obtain culturally appropriate care, and the Department may, pursuant to such grievance, permit an enrollee to disenroll into fee-for-service.

U. MENTAL HEALTH EDUCATION AND PREVENTION----(1) The treatment team shall inform all enrollees, parents and involved family members of contributions which they can make to the maintenance of their own mental health and the proper use of mental health care services; (2) Have a program of mental health education and prevention available and within reasonable geographic proximity to its enrollees. The program shall include mental health education and anticipatory guidance provided as a part of the normal course of service delivery.

The program shall provide:

1. An individual responsible for the coordination and delivery of services in the program.

2. Information on how to obtain these services (location, hours, telephone numbers, etc.).

3. Mental health-related educational materials in the form of printed, audiovisual, and/or personal communication.

4. Information for child and involved family members on mental disease and severe emotional disturbance and their prevention and management including specific information for persons who have or who are at risk of developing such health problems.

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

6. Information on and promotion of other available prevention services offered by other resources in the County.

7. Provide information about family support and advocacy services through Family Ties or other similar groups in the area.

Educational materials produced by the County must be at a sixth (6th) grade comprehension level and reflect sensitivity to the diverse cultures served. Also, if the County uses material produced by other entities, the County must review these materials for grade level, comprehension level, and for sensitivity to the diverse

cultures served. Finally, the County must make all reasonable efforts to locate and use culturally appropriate educational material.

V. ENROLLEE HANDBOOK----The County shall mail an enrollee handbook to the enrollee's parent/guardian within one (1) week of initial enrollment notification to the County. Case manager will review handbook contents with the enrollee and his/her family during the first visit with the family and review again with the child and family team.

1. The handbook (or substitute enrollee information approved by the Department that explains County services and how to use WM) will meet the following standards:

   a. "6th grade" reading level (on the Flesch-Kincaid Index) or approved by a committee with representatives from the county, providers and at least 75% of the committee should be current or previously enrolled parents.

   b. Available in Spanish, and other appropriate language translations if the County has enrollees who are conversant only in those languages.

   c. Appropriately transcribed for visual and hearing impaired enrollees.

   d. Culturally sensitive.

2. The handbook will include, at minimum, information about:

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

   b. Information on Contract services offered by the County.

   c. Location of facilities.

   d. Hours of service.

   e. Internal informal and formal grievance procedures, including notification of the enrollee's right to a Department review or the right to a fair hearing.

   f. The telephone number the enrollee and family can use to contact the Contract monitor.

   g. Grievance information, including Department review and fair hearing appeal procedures.

h. HealthCheck.

i. Policies on the use of emergency and urgent care facilities.

j. Specific services and supports that parents may have to pay for, including out-of-home placement costs.

k. Disenrollment.

l. Provisions for reasonable accommodations for a disability or English translation.

The County must provide periodic updates to the handbook, as needed, explaining changes in the handbook policies. The handbook, and all changes to the handbook, must be approved by the Department prior to printing.

Enrollee handbooks shall be submitted by new contractors for review and approval within two (2) weeks of Contract signing.

W. APPROVAL OF EDUCATIONAL MATERIALS----Submit to Department for prior written approval educational materials prepared by the County. The Department will review materials as soon as possible, but within 30 days. Any educational materials referring to Medicaid/BadgerCare must be prior approved in writing by the Department, including mailings sent only to Medicaid/BadgerCare enrollees. Educational materials are deemed approved if there is no response from the Department within 30 days. However, problems and errors subsequently identified by the Department must be corrected by the County when they are identified.

X. APPROVAL OF INFORMING MATERIALS----The County agrees not to market to potential enrollees. Any informing materials for consumers must be preapproved by the Department. The County agrees to submit to the Department for prior written approval any informing materials that refer to Medicaid or Title XIX, BadgerCare or Title XXI or are intended for Medicaid/BadgerCare recipients. This requirement includes informing materials that are produced by providers under Contract to the County.

The Department will review and either approve, approve with modifications, or deny all informing material within 10 working days of receipt of the informing materials.

Y. CHOICE OF HEALTH PROFESSIONAL----Offer each enrollee covered under this Contract the opportunity to choose to receive services from any provider affiliated with the County, to the extent possible and appropriate.

Z. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT (QAPI)----

1. The County Quality Assessment/Performance Improvement (QAPI) program must conform to requirements of 42 CFR, Part 438, Medicaid Managed Care Requirements, Subpart D, Quality Assessment and Performance Improvement. The program must also comply with 42 Code of Federal Regulations (CFR) 438 which states that the County must have a QAPI system that:

   a. Is consistent with the utilization control requirement of 42 CFR 456.

   b. Provides for review by appropriate mental health professionals of the process followed in providing mental health services.

   c. Provides for systematic data collection of performance and patient results.

   d. Provides for interpretation of this data to the practitioners.

   e. Provides for making needed changes.

2. Quality Assessment/Performance Improvement Program

   a. The County must have a comprehensive Quality Assessment/ Performance Improvement Program (QAPI) program that protects, maintains, and improves the quality of mental health care provided to Wisconsin Medicaid/BadgerCare Program recipients. The County must evaluate the overall effectiveness of its QAPI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of mental health care and services provided to its Medicaid/BadgerCare population.

   b. The County 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 County is in compliance with Contract requirements. The review and audit may include: On-site visits; staff and enrollee interviews; mental health case 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.

c. The County must have a written QAPI work plan that is ratified by the Milwaukee County Human Services Board 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.

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

- Approval of the overall QAPI program and 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;
- Directing modifications to the QAPI program on an ongoing basis to accommodate review findings; and
- Issues of concern within the County managed care program.

e. QAPI committee shall be in an organizational location within the County 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 County, including:

1) A variety of human service professions (e.g., social work, mental health, AODA, etc.).

2) A variety of qualified mental health professionals (e.g., psychiatry, psychology, etc.).

3) County management or governing body.

4) At least 50% of the committee should be parents of current or previous enrollees.

5) Enrollees of the County must be able to contribute input to the QAPI Committee. The County must have a system to receive enrollee input on quality improvement, document

the input received, document the County'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 County response must be timely.

f. 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.

g. Documentation of QAPI Committee minutes and activities must be available to the Department upon request.

h. QAPI activities of County providers and subcontractors, if separate from County QAPI activities, shall be integrated into the overall County 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 County QAPI program shall provide feedback to the providers/subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QAPI efforts.

i. Other management activities (utilization management, risk management, customer service, complaints and grievances, etc.) must be integrated with the QAPI program. Psychiatrists and other mental health care practitioners and institutional providers must actively cooperate and participate in the County's quality activities.

j. The County remains accountable for all QAPI functions, even if certain functions are delegated to other entities. If the County delegates any activities to contractors the conditions listed in this agreement must be met:

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

l. The County must designate a senior executive to be responsible for the operation and success of the QAPI program. The designated individual shall be accountable for the QAPI activities of the

County's own providers, as well as the County's subcontracted providers.

m. 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 mental health care and services, facilitating appropriate use of preventive services, monitoring provider performance, provider credentialing, involving members in QAPI initiatives and conducting performance improvement projects.

n. 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.

3. Monitoring and Evaluation

a. The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Quality indicators as listed and described in this Contract must be used to monitor adherence to practice guidelines. Standardized quality indicators must be used to assess improvement, assure achievement of minimum performance levels, monitor adherence to guidelines, and identify patterns of over utilization and under utilization. The measurement of quality indicators selected by the County must be supported by appropriate data collection and analysis methods to improve clinical care and services.

b. Provider performance must be measured against practice guidelines and standards adopted by the QAPI Committee. Areas identified for improvement must be tracked and corrective actions taken when warranted. The effectiveness of corrective actions must be monitored until problem resolution occurs. Reevaluation must occur to assure that the improvement is sustained.

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

d. The County must also monitor and evaluate mental health care and services in certain priority clinical and non-clinical areas as specified.

e. The County must make documentation available to the Department, upon request, regarding quality improvement and assessment studies on plan performance, which relate to the enrolled population.

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

4. Access

a. The County must provide mental health care to its Medicaid/ BadgerCare enrollees that is as accessible to them, in terms of timeliness, amount, duration, and scope, as those services are to non-enrolled Medicaid/BadgerCare recipients within the area served by the County.

b. The County must have written protocols to ensure that enrollees have access to screening, diagnosis, referral, and treatment agreed upon by the child and family team for those conditions and services covered under this Contract. The County must have written standards for the accessibility of care and services, which are communicated to providers and monitored.

The County must assure the provision for a second opinion from a qualified network provider upon enrollee requests, subject to referral procedures approved by the Department. (If an appropriately qualified provider is not available within the network, arrangements must be made for a second opinion outside the network at no charge to the enrollee.)

c. The County must assure that its delivery network is sufficient to provide adequate access to all services covered under this agreement. In establishing the network, the County must consider:

1) The anticipated Medicaid/BadgerCare enrollment with particular attention to children with serious emotional disturbance.

2) The expected utilization of services, considering enrollee characteristics and mental health care needs.

3) The number and types of providers (in terms of training, experience and specialization) required to furnish the contracted services.

4) The number of network providers not accepting new patients.

5) 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.

If the entity's network is unable to provide necessary medical services covered under the Contract to a particular enrollee, the entity must adequately and timely cover these services out of network for the enrollee for as long as the entity is unable to provide them.

5. Provider Selection (credentialing) and Periodic Evaluation (recredentialing)

a. The County 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 County's enrollees, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under Medicaid and certified for Medicaid, where applicable. The County's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.

b. The County 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, enrollee complaints, and the utilization management system.

c. The County must have a formal process of peer review of care delivered by providers and active participation of the County'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 County must supply documentation of its peer review process upon request. The County may delegate this responsibility to meet the standards outlined in this Contract.

d. The selection process must not discriminate against providers such as those serving high-risk populations, or who specialize in conditions that require costly treatment. The County must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners from practitioners in the County's network. If the County declines to include individual or groups of providers in its network, it must give the affected provider written notice of the reason for its decision.

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

f. The County 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.).

g. In addition to the requirements in this section, the names of individual practitioners and institutional providers who have been terminated from the County 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 etc. Seq.).

h. Institutional Provider Selection—For each provider, other than an individual practitioner, the County determines, and verifies at specified intervals, that the provider is:

1) Licensed to operate in the State, if licensure is required, and in compliance with any other applicable state or federal requirements.

2) Reviewed and approved by an approved accrediting body (if the provider claims accreditation); or is determined by the County to meet standards established by the County itself.

6. Enrollee Feedback on Quality Improvement

a. The County must have a process(es) to maintain a relationship with its enrollees that promotes two (2) way communication and contributes to quality of care and service. The County must show a commitment to treating members with respect and dignity.

b. The County is encouraged to find additional ways to involve Medicaid/BadgerCare enrollees in quality improvement initiatives and in soliciting enrollee feedback on the quality of care and services the County provides. Other ways to bring Medicaid enrollees into the County'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 Committee or other committees, or task forces related to evaluating services. All efforts to solicit feedback from enrollees must be prior approved by the Department.

7. Mental Health Records

a. The County 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' mental health records based on the County'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 County 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 that:

1) The enrollees may review and obtain copies of medical records information that pertains to them.

2) The policies above must be made available to enrollees upon request.

b. Enrollee mental health records must be maintained in an organized manner (by the County, and/or by the County's subcontractors) that permits effective patient care. They must reflect all aspects of

patient care and be readily available for patient encounters, for administrative purposes, and for Department review.

c. Because counties are considered contractors of the State and are therefore (only for the limited purpose of obtaining mental health records of its enrollees) entitled to obtain mental health records according to Wis. Adm. Code, HFS 104.01(3), the Department will require Medicaid-certified providers to release relevant records to the County to assist in compliance with this section. Where counties have not specifically addressed photocopying expenses in their provider contracts or other arrangements, the counties are liable for charges for copying records only to the extent that the Department would reimburse on a fee-for-service basis.

d. The County must have written confidentiality policies and procedures in regard to confidential patient information. Policies and procedures must be communicated to County staff, members, and providers. The transfer of mental health records to out-of-plan providers or other agencies not affiliated with the County (except for the Department) are contingent upon the receipt by the County 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.

e. The County must have written quality standards and performance goals for participating provider mental health record documentation and be able to demonstrate, upon request of the DHFS, that the standards and goals have been communicated to providers. The County must actively monitor established standards and provide documentation of standards and goals upon request of the Department.

f. Mental health records must be readily available for Countywide QAPI and Utilization Management (UM) activities and provide adequate medical and other clinical data required for QAPI-UM, and Department use.

g. The County must have adequate policies in regard to transfer of mental health records to ensure continuity of care when enrollees are treated by more than one (1) provider. This may include transfer to local health departments subject to the receipt of a signed authorization form.

h. Requests for completion of residual functional capacity evaluation forms and other impairment assessments, such as queries as to the presence of a listed impairment, shall be provided within 10 working days of 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 County 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.

i. Minimum mental health record documentation per chart entry or encounter must conform to the Wis. Adm. Code, Chapter HFS 106.02, (9)(b) mental health record content and contain at least the following items:

1) Date.

2) Department (if the organization is departmentalized).

3) Practitioner's signature and profession (for example, PT, MD, RN, DDS).

4) Written case note of each interaction with child, family member, or collateral contact and the contents of the interaction.

5) Objective findings (if applicable).

6) Clinical impression.

7) Disposition, recommendations, and instructions to consumers.

8) Written record of each of the treatment team meetings including subject matters discussed, members present, and conclusions, if any.

8. Utilization Management (UM)

a. The County must have documented policies and procedures for all UM activities that involve determining medical necessity, and the approval or denial of mental health services. Qualified mental health 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). Criteria used to determine medical necessity and appropriateness must be communicated to

providers. The criteria for determining medical necessity may not be more stringent than HFS 101.03 (96m) Wis. Adm. Code.

b. If the County utilizes telephone triage, nurse lines or other demand management systems, the County 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.

c. The prior authorization policies must specify time frames for responding to requests for initial and continued service determinations, specify information required for authorization decision, 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 County must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (inter-rater reliability).

Within the time frames specified, the County 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 review by the Department, or request a fair hearing through the Division of Hearing and Appeals.

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 (3) working days if the physician indicates or the County 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 County justifies the need for more information.

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

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

e. The County oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

9. External Quality Review Contractor

a. The County must assist the Department and the external quality review organization under contract with the Department in completing all county reviews in accordance with protocols found as part of the Balanced Budget Act of 1997 (BBA). These protocols guide the external, independent review of the quality outcomes and timeliness of, and access to, services provided by the County under this contract.

b. The County must assist the Department and the external quality review organization under contract with the Department in identification of provider and enrollee information required to carry out annual, external independent reviews of access, timeliness and quality outcomes based on on-site or off-site reviews. This includes arranging orientation meetings for physician office staff concerning medical chart review, and encouraging attendance at these meetings by county and physician office staff as necessary. The provider of service may elect to have charts reviewed on-site or off-site.

c. The purposes of the EQRO review are:

1) To validate data and information including performance measures submitted by the counties to the DHCF for the purpose of quality assessment. Validation may include the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

2) To validate county Performance Improvement Projects (PIPs) to ensure that PIPs are designed, conducted and reported in a methodologically sound manner.

3) To review compliance with structural and operation standards established by the state.

4) To provide DHCF and the county with information about their performance that is not available from other sources of data.

5) To provide information that will aid DHCF and the county in interpreting other sources of data, such as encounter data.

6) To provide insight and information about factors that influenced differences in program performance among similar populations.

7) To provide information that is useful to programs for their ongoing quality improvement processes.

8) To provide information that will be useful to DHCF in fulfilling its oversight role for developing the county's contract requirements.

d. When the external quality review organization under contract with the Department identifies an adverse quality finding that needs to be followed up on, the county must:

1) Assign a staff person(s) to conduct follow-up with the provider(s) concerning each adverse quality finding identified by the Department's external quality review organization, including informing the provider(s) of the finding and monitoring the provider's resolution of the finding.

2) Inform the county's QAPI committee of the final finding and involve the QAPI committee in the development, implementation and monitoring of the corrective action plan.

3) Submit a corrective action plan or an opinion in writing to the Department within 60 days that addresses the measures that the county and the provider intend to take to resolve the finding. County's final resolution of all potential Quality Improvement cases must be completed within six (6) months of county notification. A case is not considered resolved by the Department until the Department approves the response provided by the county and provider.

e. The county will facilitate training provided by the Department to its providers.

f. The results of the review will be made available to the Department, and county providers in a manner that does not disclose the identity of any individual enrollee, unless such identification is required to resolve an issue.

10. Performance Improvement Priority Areas and Projects

a. The County must develop and ensure implementation of program initiatives to address the specific clinical or non-clinical needs of the County's enrolled population served under this agreement. The Department strongly advocates the development of collaborative relationships among the County, 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.

Annually, for the priority areas specified by the Department and listed below, the County must monitor and evaluate the quality of care and services through at least one performance improvement project. The County may propose an alternative topic to be addressed by making a request in writing to the Department. The final or ongoing status report must be submitted by December 1 of each contract year. The County must ensure that improvements are sustained through periodic audits of relevant data and maintenance of the interventions that resulted in the improvement.

The report for each performance improvement project should include consideration of each of the ten performance improvement project criteria outlined in Addendum III in order for the Department to evaluate the soundness and results of the projects submitted. The BCAP quality framework (outlined below) is allowable as an alternative format for performance improvement project design and reporting. Other formats may be used as well, as long as the ten performance improvement project criteria outlined in Addendum III are addressed.

BCAP Framework:

- Identification
- Stratification
- Outreach
- Intervention
- Rapid Cycle Improvement
- Measurement and Evaluation
- Sustainability and Diffusion

b. The County must implement a performance improvement project in the area if a quality improvement opportunity is identified. The

County must report to the Department on each of these areas, including those areas where the County will not pursue a performance improvement project.

c. Clinical and Non-Clinical Priority Areas

Clinical Priority Areas:

Clinical Priority Areas include prevention and/or care of acute and high volume/high risk services for improved continuity and coordination of care. .

Non-Clinical Priority Areas include:

1) Grievances, appeals and complaints;
2) Access to and availability of services;
3) Enrollee satisfaction with county customer service;
4) Satisfaction with services for enrollees with special health care needs;
5) Cultural competency of the County and its providers.

In addition, the County may be required to conduct performance improvement projects specific to the county and to participate in one (1) annual statewide project that may be specified by the Department.

d. The Department's Approved Performance Measures

The Department will evaluate the county's performance using the Department's approved performance measures, based on county-supplied encounter data and other relevant data (for selected measures). Evaluation of county performance on each measure will be conducted on timetables determined by the Department. The technical specifications for each measure are established by the Department with county and other stakeholder input.

The Department will inform the county of its performance on each measure, whether the County's performance satisfied the goal requirements set by the Department, and whether a performance improvement initiative by the County is required. The County will have 60 business days to review and respond to the Department's performance report. When a performance improvement initiative is required due to sub-goal performance on the measure, the County may request recalculation of the performance level based on new or additional data the County may supply, or if the County can demonstrate material error in the calculation of the performance level. The Department will provide a tentative

schedule of measure calculation dates to the County within 90 days of the beginning of each calendar year in the contract period.

Unless otherwise noted within a specific performance improvement measure, the Department may specify minimum performance levels and require that the County develops a plan to respond to levels below the minimum performance levels. Additions, deletions or modifications to the Performance Improvement Measures must be mutually agreed upon by the parties. The Department will give 90 days notice to the County of its intent to change any of measures, technical specifications or goals. The county shall have the opportunity to comment on the measure specifications, goals and implementation plan within the 90-day notice period. The Department reserves the right to require the county to report such performance measure data as may be deemed necessary to monitor and improve county-specific or program-wide quality performance.

AA. ACCESS TO PREMISES----The County must allow duly authorized agents or representatives of the state or federal government access to the County or County subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the County's or subcontractor's contractual activities and will produce all records requested as part of such review or audit within a reasonable time, but not more than ten working days. Upon request for such right of access, the County 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 County's or subcontractor's activities. The County 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.

BB. SUBCONTRACTS----The County must assure that all subcontracts are in writing, shall comply with the provisions of this Contract, and include any general requirements of this Contract that are appropriate to the service or activity identified, and to ensure that all subcontracts shall not terminate legal liability of the County under this Contract. The County may subcontract for any function covered by this Contract, subject to the requirements of this Contract.

CC. COMPLIANCE WITH APPLICABLE LAWS, RULES, OR REGULATIONS---- 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 and Title XXI of the Social Security Act and Title 42 of the CFR., except as specified in Article IV, Section A., 3

DD. USE OF PROVIDERS CERTIFIED BY MEDICAID/BADGERCARE PROGRAM----Except in emergency situations, the County must use only providers who have been certified by the Medicaid program for services or items covered by Wisconsin Medicaid. The Department reserves the right to withhold from capitation payments the monies related to services provided by non-Medicaid-certified providers, at the Medicaid fee-for-service 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 Medicaid program at the time the HMO reimbursed the provider for service provision. The Wis. Adm. Code, Chapter HFS 105, contains information regarding provider certification requirements. Every Medicaid HMO must require every physician providing services to enrollees to have a unique physician identifier, as specified in Section 1173(b) of the Social Security Act.

For services not covered under the Medicaid/BadgerCare state plan, the County must have written policies to ensure things such as safety, provider and employee qualifications, services description and intent (e.g., use of state certified provider or accredited by a national organization) and ensure they are available for review.

EE. REPRODUCTION AND DISTRIBUTION OF MATERIALS----Reproduce and distribute at County expense, according to a reasonable Department timetable, information or documents sent to the County from the Department that contain information County-affiliated providers must have in order to implement fully this Contract.

FF. PROVISION OF INTERPRETERS----As soon as it is determined that the enrollee is of limited English proficiency the County 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 County must:

a. Provide for 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 County or its providers.

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

c. 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.

d. 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.

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

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

As part of the certification application, the County must submit the policies and procedures for interpreters, a list of interpreters the County uses, and the language spoken by each interpreter. The County 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 County's process for assessing the preferred method of communication of each hearing-impaired enrollee. The County 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..

GG. COORDINATION AND CONTINUATION OF CARE----Have systems in place to ensure well-managed consumer care, including at a minimum:

1. Management and integration of mental health care and community support services through a primary care coordinator.

2. Development of a child and family treatment team for each enrollee, which includes both professionals and significant people important in the lives of the child and family. Team members should be chosen by the child, and parent (or guardian or primary caregiver, whichever is applicable). The members of the team shall be documented in the case record and any change of team membership shall be recorded. Family can request a change in the members of the team including the care coordinator without negative consequences. A request for a membership change shall be considered an informal grievance and should be treated as such. The ability for a family to request a change in membership without reproach should be detailed in the grievance procedure written in the family handbook.

3. Upon enrollment, the child and family treatment team will promptly perform or compile an assessment to identify the child and family's strengths and needs.

4. The County will use a standardized plan of care for all enrollees. Within the standardized format, the child and family treatment team will develop an individualized service and support plan of care based upon the strengths and needs of the child and family as identified in the assessment. This plan of care will be developed within 30 days of enrollment, and it will detail the intended providers and treatment actions. Each plan shall have measurable short and long term goals and measurable program completion criteria. At least every 90 days the treatment team will meet to review and, if necessary, revise the plan of care to meet the changing needs of the child and family. The case record shall document for each child and family team meeting the issues discussed, action to be taken or conclusions reached, and members attending.

5. Assure a crisis plan is included in the plan of care for emergency situations, including an education process to help assure that enrollees and providers know where and how to obtain medically necessary care in emergency situations.

6. Assure that each plan of care will be reviewed and signed by a psychiatrist or psychologist. For the purpose of this Contract, a psychologist is a person who is a licensed psychologist and who is listed or able to be listed in the national register of health care providers in Psychology. A parent or guardian shall also sign each plan of care and the County shall make every effort to have the enrollee and other team members sign the plan. The County shall involve and engage the enrollee and his or her parent, guardian, or primary caregiver in the process used to select providers and treatment options. The purpose of the participation is to get a good match between the enrollee's needs and the provider(s) who will seek to meet these needs. This section does not require the County to use providers who are not qualified to treat the individual enrollee or who are not contracted providers. If a specific service or support by a non-contracted provider is determined necessary by the child and family treatment team, efforts should be made to contract with the provider identified.

7. Assure an adequate network of qualified providers to provide the services identified in the annual utilization report in this Contract. The County will develop a cooperative working relationship with providers or agencies involved in the provision to enrollees of health services other than mental health and community support services (i.e., physical health care).

8. Have systems to assure provision of a clinical determination within 10 working days, at the request of the enrollee, of the medical necessity and appropriateness of an enrollee to continue with MH or substance abuse

providers who are not subcontracted by the County. If the County determines that the enrollee does not need to continue with the non-contracted provider, it must develop a transition plan to ensure an orderly transition of care.

9. The County shall clearly specify referral requirements and authorize approved services and supports identified within the plan of care to providers and subcontractors and keep copies of referrals (approved and denied) in a central file or the patient's medical records.

10. Enrollment beyond 16 months requires child and family specific written justification within the individual chart unless extended enrollment has been court ordered.

11. All children must have a written transition plan at the time of disenrollment.

12. Assess the training needs of direct providers, such as the care coordinators, and arrange for the training needs of key individuals, including parents and other team members.

HH. PHYSICIAN INCENTIVE PLAN----A physician incentive plan is any compensation arrangement between the County 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 county.

The County shall fully comply with the physician incentive plan requirements set forth 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.

II. ID CARDS----The County may issue their own ID cards. The County may not deny services to an enrollee solely for failure to present a County issued card. The Forward cards will always determine enrollment, even when the County issues an ID card.

JJ. INELIGIBLE ORGANIZATIONS----Upon obtaining information or receiving information from the Department or from another verifiable source the County must exclude from participation in the County's Managed Care Program all organizations which could be included in any of the categories defined in 1) through 3) of this section (references to the Act in this section refer to the Social Security Act):

1. Entities Which 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:

a. Been convicted of the following crimes:

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

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

3) Fraud (i.e., a state or federal crime involving fraud, theft, embezzlement, breach of judiciary 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 (see Section 1128(b)(1) of the Act));

4) 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 (see Section 1128(b)(2) of the Act)); or

5) 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 (see Section 1128(b)(3) of the Act)).

b. Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person described 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 12549 or under guideline implementing such order.

c. 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. (See Section 1128(b)(8)(B)(ii) of the Act.)

2. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in Subsection A. A substantial

contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

a. The administration, management, or provision of medical services;

b. The establishment of policies pertaining to the administration, management, or provision of medical services; or

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

3. 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, County must exclude from contracting any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

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

KK. COUNTY ATTESTATION----The County Executive Officer, the County Financial Officer, 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 or any other data in which the County paid claims.

LL. FRAUD AND ABUSE INVESTIGATIONS----The County agrees to cooperate with the Department on fraud and abuse investigations. In addition, the County 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 County. Failure on the part of the County to cooperate or report fraud and/or abuse may result in any application sanctions.

MM. SCHOOL BASED SERVICES (SBS) PROVIDERS----The County must use its best effort to sign a MOU with all SBS providers in the County service area to ensure continuity of care and to avoid duplication of services. School based services are paid FFS by Medicaid when provided by a Medicaid 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 County is responsible for providing and paying for all Medicaid covered services.

ARTICLE V

V. FUNCTIONS AND DUTIES OF THE DEPARTMENT

In consideration of the functions and duties of the County contained in this Contract, the Department shall:

A. ELIGIBILITY DETERMINATION----Verify, at the time of enrollment, that recipients identified on the enrollment requests from the County are:

1. Medicaid eligible, including Medicaid/BadgerCare, if all other enrollment eligibility requirements are met.

2. Under 18 years of age.

3. Not currently residing in a psychiatric hospital.

4. Residents of Milwaukee County.

5. Verified, during on-site medical record reviews conducted by the Department, that the individuals enrolled in the County meet the definition of severely emotionally disturbed.

6. At imminent risk of placement in a psychiatric hospital, a residential care center, or a juvenile correction facility.

7. Are residents of Milwaukee County and, if necessary to access services, a client of the County Human Services Department.

B. ENROLLMENT----Promptly notify the County of all Medicaid/BadgerCare recipients enrolled under this Contract. Notification shall be effected through County Enrollment Reports. All recipients listed as an ADD or CONTINUE on either the Initial or Final County Enrollment Report are members of the County Managed Care Program during the enrollment month. The reports shall be generated in the sequence specified under County Enrollment Reports. These reports shall be in both tape and hard copy formats or available through electronic file transfer capability and shall include medical status codes.

C. DISENROLLMENT----Promptly notify the County of all Medicaid/BadgerCare recipients no longer eligible to receive services through the County under this Contract. Notification shall be effected through County Enrollment Reports which the Department will transmit to the County for each month of coverage throughout the term of the Contract. The reports shall be generated in the sequence under COUNTY ENROLLMENT REPORTS. Any recipient who was enrolled in the County's Managed Care Program in the previous enrollment month, but does not appear as an ADD or CONTINUE on either the Initial or

Final County Enrollment report for the current enrollment month, is disenrolled from County's Managed Care Program effective the last day of the previous enrollment month. Enrollees will be disenrolled if either:

1. Enrollee loses Medicaid/BadgerCare eligibility.
2. Enrollee loses Milwaukee County eligibility.
3. Enrollee is disenrolled upon their request.
4. Enrollee completes the program.
5. Court ordered correctional placements.
6. Enrollee is 19 years of age or older.
7. The Department approves a Just Cause Disenrollment.
8. Court Order for enrollment has been revised or vacated.

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

E. COUNTY ENROLLMENT REPORTS---- For each month of coverage throughout the term of the Contract, the Department shall transmit "County Enrollment Reports" to the County. These reports will provide the County with ongoing information about its Medicaid/ BadgerCare enrollees and disenrollees and will be used as the basis for the monthly capitation claims. County Enrollment Reports will be generated in the following sequence:

1. The Initial County Enrollment Report will list all of the County's enrollees and disenrollees for the enrollment month that are known on the date of report generation. The Initial County Enrollment Report will be available to the County on or about the twenty-first day 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 County prior to the end of the month will appear CONTINUE on the Final Report, and a capitation claim shall be generated according to the conditions of this Contract.

2. The final County Enrollment Report will list all of the County's enrollees for the enrollment month that were not included in the Initial County Enrollment Report. The Final County Enrollment Report will be available to the County by the first day of the capitation month. A capitation claim shall be generated for each recipient listed as an ADD or CONTINUE on this report according to the conditions of this Contract. Enrollees in PENDING status will not be included on the final report.

3. Recipients will be enrolled effective the date the enrollment request is received by the Department. The County will not receive a regular capitation payment for the month of enrollment. The DHFS will reimburse the County for partial months of enrollment through payment of a daily rate. The daily rate will be equal to the monthly capitation multiplied by 12 and divided by 365.

F. COUNTY REVIEW----Submit to the County for prior approval materials that describe the County and that will be distributed by the Department or the County to recipients.

G. COUNTY REVIEW OF STUDY OR AUDIT RESULTS----Submit to the County for a 30 business day review/comment period, any Medicaid audits, comparison reports, consumer satisfaction reports, or any other studies the Department releases to the public. The review/comment period will commence on the fifth business day after the audit report was mailed. The County may request an extension and the Department will exercise reasonable discretion in making the determination to waive the 30 business day review/comment requirement.

H. FRAUD AND ABUSE TRAINING----The Department will provide fraud and abuse detection training to the County annually.

ARTICLE VI

VI. PAYMENTS TO COUNTY

A. CAPITATION RATES----In consideration of full compliance by the County with contract requirements, the Department agrees to pay the County monthly payments based on the capitation rate specified and subject to the conditions of this Contract. The capitation rate shall not include any amount for recoupment of losses incurred by the County under previous Contracts nor does it include services that are not covered under the State Plan.

B. ACTUARIAL BASIS OF CAPITATION RATE----The capitation rate is calculated on an actuarial basis recognizing the payment limits set forth in federal law 42 CFR 438.6(c).

C. RENEGOTIATION----The monthly capitation rates set forth in this article are recalculated on an annual basis. The County will have 30 calendar 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 County may obtain a risk-sharing arrangement from an insurer other than the Department for coverage of enrollees under this Contract, provided that the County remains substantially at risk for providing services under this Contract.

E. RESPONSIBILITY TO PROVIDE SERVICES----The County is responsible for the provision of Contract and administrative services covered under this Contract from the date the recipient is enrolled in the County, regardless of whether or not the County receives a capitation payment for that recipient for the initial month pursuant to the conditions agreed upon.

F. PAYMENT SCHEDULE----Capitation payments to the County shall be based on County Enrollment Reports, which the Department will transmit to the County. Payment for each person listed as an ADD or CONTINUE on County Enrollment Reports shall be made within 134 days of the date the report is generated.

G. COORDINATION OF BENEFITS (COB)----The County 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 County can reasonably expect to receive is less than the estimated cost of recovery. COB recoveries will be done by post-payment billing (pay and chase) for certain preventive pediatric services. Post-payment billing will also be done in situations where the third party liability 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 County 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 County determines seeking reimbursement would not be cost effective, upon request of the Department.

2. To assure compliance, records shall be maintained by the County of all COB collections and reports shall be made annually on the form designated by the Department. The County 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 County must seek from all enrollees information on other available resources.

    a. Other available resources may include, but are not limited to, all other state or federal medical care programs which are primary to Medicaid, 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/workers compensation collections.

    b. Subrogation collections are any recoverable amounts arising out of settlement of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the County under s. 49.89(9), Act 31, Laws of 1989. After attorneys' fees and expenses have been paid, the County shall 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 to except to the extent that Medicaid (or the County on behalf of Medicaid) is reimbursed for its costs. The County 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 Medicaid fee schedule, an estimate of what a capitated physician would charge on a fee-for-service 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 County chooses to define that cost) must be returned to the beneficiary. Counties may not collect from amounts allotted to the

beneficiary in a judgment or court-approved settlement. The County is to follow the practices outlined in the DHFS Casualty Recovery Manual.

4. Where the County has entered a risk-sharing arrangement with the Department, the COB collection and distribution shall follow the procedures described in this Contract. Act 27; Laws of 1995 extended assignment rights to HMOs under s. 632.72.

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

6. The following requirement shall apply 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 shall comply in full with the provision of subsection 49.475 of the Wis. Stats. Such compliance shall 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 shall be consistent with the Department's written specifications.

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

7. If, at any time during the Contract term, any of the insurers or third party administrators fail, in whole or in part, to adhere to the requirements of (6(a.)) or (6(b.)) above, the Department may take the remedial measures specified in this Contract.

H. RECOUPMENTS----The Department will not normally recoup County per capita payments when the County actually provided service. However if the Medicaid enrollee cannot use County facilities, the Department will recoup County capitation payments. Such situations are described more fully below.

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

   a) Enrollee moves out of the County's service area; or

   b) Enrollee enters a public institution; or

   c) Enrollee dies.

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

   a) For the correction of computer or human error, where the person was never really enrolled in the county.

   b) Disenrollments of enrollees for reasons of pregnancy and continuity of care.

3. If an enrollee moves out of the County, as verified by the eligibility worker, the enrollee will be disenrolled from WM on the date the enrollee moved unless the enrollee continues under the jurisdiction of the Milwaukee County Children's Court despite having moved from the County. If the eligibility worker is unable to verify the enrollee's move, the County must 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 returned registered receipt requested letter was sent. Documentation that fails to meet the 20-day criteria will result in disenrollment the first of the month in which the County supplied information to the Department of its designee. This policy does not apply to extended service area requests that have been approved by the County unless the enrollee moves out of the extended service area or the County's service area. Any capitation payment made for periods of time after disenrollment will be recouped.

ARTICLE VII

VII. REPORTS AND DATA

A. ACCESS TO AND/OR DISCLOSURE OF FINANCIAL RECORDS----The County and any subcontractors shall 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 County or subcontractors that relate to the County's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this Contract. The County shall comply with applicable recordkeeping requirements specified in HFS 105.02(1)-(7) Wisconsin Administrative Code, as amended.

B. PERIODIC REPORTS----The County agrees to furnish within the Department's time frame and within the Department's stated form and format, information and/or data from its records to the Department, and to the Department's authorized agents, which the Department may require to administer this Contract, including but not limited to the following:

1. Copies of all written complaints by Medicaid/BadgerCare enrollees processed by the County through its grievance procedure, and actions taken to resolve such complaints.

2. Summaries of amounts recovered through the Coordination of Benefits for services rendered to enrollees under this Contract in the format specified.

3. Enrollee utilization and outcome data in the formats described in Addendum II and Addendum XI.

4. Oral complaint logs must be available on request.

C. ACCESS TO AND AUDIT OF CONTRACT RECORDS----Throughout the duration of the Contract, and for a period of five years after termination of the Contract, the County shall provide duly authorized representatives of the state or federal government access to all records and material relating to the Contractor'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 the Contract. All information so obtained will be accorded confidential treatment as provided under applicable laws, rules, or regulations.

D. RECORDS RETENTION----The County shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms, for a period of not less than five years from the date of termination of the 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, provided that the microfilming procedures are approved by the Department as reliable and are supported by an effective retrieval system.

Upon expiration of the five (5) year retention period, the subject records shall, upon request, be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

E. INSURANCE INFORMATION DISCLOSURE----The following requirements shall apply if the Contractor (or the contractor's parent firm and/or any sub-division 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 Insurance Commissioner 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):

1. Throughout the Contract term, these insurers and third party administrators shall comply in full with the provisions of s. 49.475 of the Wis. Stats. Such compliance shall 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 shall be consistent with the Department's written specifications.

2. Throughout the Contract term, these insurers and third party administrators shall also accept and properly process post-payment billings from the Department's fiscal agent for health care services and items received by Wisconsin Medicaid recipients.

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

ARTICLE VIII

VIII. GRIEVANCE PROCEDURES

The grievance process refers to the overall system that includes complaints, grievances and appeals as defined in Article I. Medicaid and BadgerCare enrollees may grieve any aspect of service delivery provided or arranged by the County to the County and to the Department (described in Sections A and B below). The enrollee may appeal an action as defined in Article I to the County, the Department and/or to the Division of Hearings and Appeals as described in section C below.

A. PROCEDURES----The County shall:

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 County to receive grievances and be responsible for routing/processing.

3. Operate an informal grievance/complaint process which enrollees can use to get problems resolved without going through the formal, written grievance process.

4. Operate a formal written grievance process which enrollees can use.

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 written 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 County must resolve the grievance or appeal within two business days of receipt of an expedited grievance or sooner if possible. More complete procedures are described in Section B of this Article.

8. Operate a grievance process within the County that enrollees can use to grieve or appeal any negative response to the County Executive. The County Executive may delegate this authority to review appeals and grievances to the County grievance committee, but the delegation must be in writing.

9. Provide the enrollee and his or her representative 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 this meeting. The County must inform the enrollee in writing of the time and place of the meeting at least seven calendar days before the meeting.

11. Maintain a record keeping "log" of complaints and grievances that includes a short, dated summary of each of the problems, the response, and the resolution. The log shall distinguish Medicaid/ BadgerCare from other enrollees, if the County does not have a separate log for Medicaid. The County must submit annual 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 benefits 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. This system shall distinguish Medicaid/BadgerCare from other enrollees.

13. At the time of the County's initial grievance denial of an action decision the County must notify the enrollee that the grievance denial decision may be appealed to the Department and/or to the Division of Hearings and Appeals..

14. Ensure that individuals with the authority to require corrective action are involved in the grievance process.

15. Distribute to advocate groups the informational flyer on enrollee grievances and appeal rights (the Ombudsman brochure). When a new brochure is available, the County shall distribute copies to advocates within three weeks of receipt of the new brochure.

16. Ensure that subcontractors and provider network have written procedures for describing how enrollees are informed of denied services. The County will make copies of subcontractors' grievance procedures available for review upon request by the Department.

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 County's grievance and appeal process or appeal directly to the DHA. If the enrollee chooses to use the County's process, the County must provide an initial response within 10 business days and a final response within 30 calendar days of receiving the grievance. If the County is unable to resolve the grievance within 30 calendar days, the time period may be extended another 14 calendar days from receipt of the grievance if the County notifies the enrollee in writing that the County has not resolved the grievance, when the resolution may be expected, and why the additional time is needed. The total timeline for the County to finalize a formal grievance may not exceed 45 calendar days from the date of the receipt of the grievance.

Any grievance or appeal decision by the County may be appealed by the enrollee to the Department. The Department shall review such appeals and may affirm, modify, or reject any formal grievance decision of the County at any time after the enrollee files the formal appeal. The Department will give final response within 30 days from the date the Department has all information needed for a decision. Also, an enrollee can submit a formal, written grievance directly to the Department at any time during the grievance process. Any formal 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 enrollee and the County in considering appeals.

For an expedited grievance or appeal, the County must resolve all issues within two business days of receiving the written request for an expedited grievance. The County must make reasonable effort to provide oral notice, in addition to written notice for the resolution.

The County must ensure that punitive action is not taken against anyone who either requests an expedited resolution or supports an enrollee's an appeal.

C. NOTIFICATIONS TO ENROLLEES----When the County, its subcontractors or provider network denies participation, discontinues, terminates, suspends, limits, or reduces a service (including services authorized by the County the enrollee was previously enrolled in or services received by the enrollee on a Medicaid fee-for-service basis), the County shall notify the affected enrollee(s) in writing, at least 10 days before:

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 County.

3. The fact that the enrollee, if appealing the action, must do so within 45 days.

4. Enrollee has the right to examine the documentation used when the County made its decision.

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. The enrollee may bring a representative, including a provider, with him/her to the hearing.

7. The enrollee may present "new" information during the grievance and appeal process.

8. The process for requesting an oral or written expedited grievance or appeal.

9. An explanation of the enrollee's right to appeal the County's decision to the Department at any point in the process.

10. The fact that the enrollee or a provider, if appealing the County action, may file a request for a hearing with the Division of Hearing and Appeals (DHA) and the address of the DHA.

11. The fact that the enrollee can receive help in filing a grievance or appeal by calling either the Enrollment Specialist or the Ombudsman.

12. The telephone number of both the Enrollment Specialist and the Ombudsman.

13. The circumstance under which a benefit will continue during the grievance and appeal process.

14. 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 County, or its subcontractors 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 County. Department review and approval will occur during the Medicaid certification process of the County and prior to any change of the notice language by the County.

D. CONTINUATION OF BENEFITS----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

County mailing of the notice of action to reduce, limit, terminate or suspend benefits, upon notification by the DHA the County will notify the enrollee they are eligible to continue receiving care but may be liable for care if DHA overturns the County'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 County's decision the County is responsible to cover services provided to the enrollee during the administrative hearing process.

2. If the DHA upholds the County's decision, the County 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. NOTIFICATIONS OF DENIAL OF NEW BENEFITS TO ENROLLEES---- When a County, or its subcontractors, deny a new service, the County shall notify the affected enrollee(s) in writing of:

1. The nature of the intended action.

2. The reasons for the intended action.

3. The fact that the enrollee, if appealing the action, must do so within 45 days.

4. An explanation of how the enrollee may request an expedited grievance, orally or in writing.

5. The enrollee may bring a representative with him/her to the hearing.

6. The enrollee may present "new" information during the grievance process.

7. The enrollee may review the documents used to make the decision.

8. An explanation of the enrollee's right to appeal the County's decision to the Department.

9. The fact that interpreter services are available free of charge during the grievance process and how the enrollee can access those services.

10. The fact that the enrollee can receive help in filing an appeal to the Department by calling either the Enrollment Specialist or the Ombudsman.

11. The telephone number of both the Enrollment Specialist and the Ombudsman.

If the enrollee was not receiving the service prior to the denial, the County is not required to provide the benefit while the decision is being appealed.

County grievance procedures must be reviewed and approved by the Department prior to signing the County Contract. All changes to County grievance procedures require prior review and approval by the Department.

F. REPORTING OF GRIEVANCES TO THE DEPARTMENT----County's shall forward both the complaint, and grievance reports to the Department within 30 days of the end of a quarter in the format specified in Addendum VIII, G. Failure on the part of a County 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 as specified in this Contract.

ARTICLE IX

IX. REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

A. SUSPENSION OF NEW ENROLLMENT----Whenever the Department determines that the County is out of compliance with this Contract, the Department may suspend the County's right to enroll new participants under this Contract. When exercising this option, the Department must notify the County in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension period will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that the enrollee's health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department or may be indefinite. The suspension period may extend up to the expiration of the Contract.

B. WITHHOLDING OF CAPITATION PAYMENTS AND ORDERS TO PROVIDE SERVICES----Notwithstanding the provisions of this Contract, the Department may withhold portions of capitation payments or liquidated damages or otherwise recover damages from the County on the following grounds:

1. Whenever the Department determines that the County has failed to provide one or more of the Medicaid covered Contract services under Addendum VIII or failed to comply with the provisions contained in this Contract, the Department may either order the County to provide such service, or withhold a portion of the County'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. County shall be given at least seven days written notice prior to the County being required to comply with either: a) Department direction to the County to pay, or b) The withholding of any capitation payments, except that in case of an emergency, no such seven-day notice is required.

   If the Department orders the County to provide services under this section and the County fails to provide the services within the timeline specified by the Department, the Department may withhold from the County's capitation payments an amount up to 150% of the fee-for-service amount for such services.

   When it withholds payments under this section, the Department must submit to the County 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 non-covered services:

a. If the Department withheld payments it shall restore to the County the full capitation payment; or

b. If Department ordered the County to provide services under this section it shall pay the County the actual documented cost of providing the services.

2. If the County 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 County 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 County's capitation payments.

3. Whenever the Department determines that the County 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 County 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 Medicaid/BadgerCare program's costs of providing mental health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.

4. 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.

5. Not withstanding the provisions of this subsection, in any case where the Department deducts a portion of capitation payments under Section 2. above, the following procedures shall be used:

a. The Department will notify the County Contract administrator no later than the second business day after the Department's deadline that the County 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 County 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 Wisconsin Medicaid/BadgerCare HMO Encounter Data User Manual. The Department will not edit the data until the process period in the subsequent month.

d. If the County 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 County repeatedly fails to submit required data or reports, or data that cannot be processed, the Department will require the County to develop an action plan to comply with the Contract requirements that must meet Department approval.

f. After a corrective action plan has been implemented, if the County continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under SUSPENSION OF NEW ENROLLMENT, or WITHHOLDING OF CAPITATION PAYMENTS AND ORDERS TO PROVIDE SERVICES sections, or both, in addition to liquidated damages that may have been imposed for a current violation.

g. If the County notifies the Department that it will discontinuing 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 County which will not be released to the County 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.

C. CONTRACTUAL REMEDIES----The remedies provided in this Contract are not intended to act as a waiver of any other contractual remedies existing in law or

equity that the Department may have for breach of contract, including recovery of damages.

D. DEPARTMENT-INITIATED ENROLLMENT REDUCTIONS----The Department may reduce the maximum enrollment level and/or number of current enrollees whenever it determines that the County has failed to provide one or more of the Contract services required, or that the County has failed to maintain or make available any records or reports required under this Contract that the Department needs to determine whether the County is providing contract services. The County shall be given 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 the enrollee health or welfare is jeopardized.

E. INAPPROPRIATE PAYMENT DENIALS---- Counties that inappropriately fail 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 on the nature of the services in question, whether the failure or denial was an isolated instances or a repeated pattern of practice, and whether the health of an enrollee was injured, threatened or jeopardized by the failure or denial. This applies not only to cases where DHFS has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the Department is knowledgeable 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 Medicaid payments to the County for enrollees who enroll after the date on which the County has been found to have committed one of the violations identified in federal law. State payments for enrollees of the contracting organization are automatically denied whenever, and for so long as, federal payment for such enrollees has been denied as a result of the commission of such violations. The following violations can trigger denial of payment pursuant to s.1903(m)(5) of the Social Security Act:

1. Substantial failure to provide required medically necessary items and services when the failure has adversely affected (or has substantial likelihood of adversely affecting) an enrollee;

2. Imposition of premiums on Medicaid enrollees in excess of permitted premiums;

3. Discrimination among Medicaid recipients with respect to enrollment, reenrollment, or disenrollment on the basis of their health status or requirements for health care services; or

4. Misrepresentation or falsification of certain information.

G. REMEDIAL ACTIONS----The Department may pursue all sanctions and remedial actions with the County that are taken with Medicaid fee-for-service providers including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997 P.L. 105-33 s. 4707(a) [42 U.S.C. 1396v(d)(2)]. The Department will work with the County and their providers to change and correct problems and will recoup funds only if the County fails to correct a problem, unless otherwise allowed in this Contract.

ARTICLE X

X. TERMINATION AND MODIFICATION OF CONTRACT

A. MUTUAL CONSENT----This Contract may be terminated at any time by mutual written agreement of both the County 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 will 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 will 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 County program. 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 will 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 will attempt to give notice of suspension of performance of any or all of the Contractor's obligations by 60 calendar 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 calendar days from the date the funds are reinstated. In the event the Contractor elects not to reinstate services, the Contractor will give the Department written notice of its reasons for such decision, to be made within 30 calendar days from the date the funds are reinstated. The Contractor will 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 will terminate without termination costs to either party.

C. OBLIGATIONS OF CONTRACTING PARTIES UPON TERMINATION---- When termination of the Contract occurs, the following obligations shall be met by the parties:

1. Where this Contract is terminated unilaterally by the Department, due to non-performance by the County or by mutual consent with termination initiated by the County:

   a. The Department shall 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 County shall be responsible for all expenses related to said notification.

   c. The Department shall grant the County a hearing before termination by the Department occurs. The Department shall notify the enrollees of the hearing and allow them to disenroll from the County managed care program without cause.

2. Where this Contract is terminated on any basis not given in 1 above including non-renewal of the contract for a give contract period:

   a. The Department shall 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 shall 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 County for coverage of enrollees for periods after the date of termination shall be returned to the Department within within 90 days of Contract termination.

b. The County shall supply all information necessary for the reimbursement of any outstanding Medicaid 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 County within 90 days of Contract termination.

D. MODIFICATION----This Contract may be modified at any time by written mutual consent of the County 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 County, the County will receive written notice.

If the Department exercises its right to renew this Contract, as allowed by Article XIX, the Department will recalculate the capitation rate for succeeding calendar years. The County 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 County will have 180 days to comply with such changes or to initiate termination of the Contract

ARTICLE XI

XI. CONFIDENTIALITY OF RECORDS

The parties agree that all information, records, and data collected in connection with this Contract shall be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, Wis. Stats., HFS 108.01, Wis. Adm. Code, and 42 CFR 431 Subpart F. Except as otherwise required by laws, rules, or regulations, access to such information shall be limited by the County 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.

Regarding services provided under this Contract, the County 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 HIPPA.

ARTICLE XII

XII. DOCUMENTS CONSTITUTING CONTRACT

The Contract between the parties to this Contract shall include, in addition to this document, Medicaid Provider Bulletins addressed to the County and Contract Interpretation Bulletins issued pursuant to this Contract. In the event of any conflict in provisions among these documents, the terms of this Contract shall prevail. In addition, the Contract shall incorporate the following Addenda:

I. Subcontracts and Memoranda of Understanding

II. Utilization Requirements

III. Performance Improvement Project Outline

IV. State of Wisconsin – Wisconsin Medicaid County Report on Coordination of Benefits

V. Actuarial Basis of Capitation Rate

VI. Compliance Agreement: Affirmative Action/Civil Rights

VII. Reporting Requirements and Due Dates

VIII. Description of Medicaid Covered Services Provided by County

IX. Compliance Agreement On Evaluation

X. Definition of "Serious Emotional Disturbance" and Eligibility Criteria

XI. Formal Grievance Experience Summary Report

XII. Protocol Manual

The documents listed above constitute the entire Contract between the parties and no other expression, whether oral or written, constitutes any part of this Contract.

ARTICLE XIII

XIII. MISCELLANEOUS

A. INDEMNIFICATION----The County 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 County or any of its subcontractors to provide Contract services.

2. The negligent provision of Contract services by the County or any of its subcontractors; or

3. Any failure, inability or refusal of the County to pay any of its subcontractors for Contract services.

B. INDEPENDENT CAPACITY OF CONTRACTOR----The Department and the County agree that the County and any agents or employees of the County, in the performance of this Contract, shall act in an independent capacity, and not as officers or employees of the Department.

C. OMISSIONS----In the event that either party hereto discovers any material omission in the provisions of this Contract is essential to the successful performance of this Contract, said party may so inform the other party in writing. The parties hereto shall thereafter promptly negotiate the issues in good faith in order to make all reasonable adjustments necessary to perform the objectives of this Contract.

D. CENTER FOR MEDICAID/MEDICARE SERVICES REVIEW----This Contract shall be forwarded to the Center for Medicaid/Medicare Services (CMS), Region V, for review and comment. The parties hereto agree to renegotiate this Contract, giving due consideration to the comments of CMS, and making such adjustments as deemed necessary by the parties.

E. CHOICE OF LAW----This Contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The County shall be required to bring all legal proceedings against the Department in Wisconsin State courts.

F. 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 shall impair such right or power or be construed to be 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 shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

G. CONFLICT OF INTEREST----The County covenants that its officers, members or employees presently have no interest and shall not acquire any interest, direct or indirect, which would conflict or compromise in any manner of degree with the performance of its services hereunder. The County further covenants that in the performance of this agreement, the County shall periodically inquire of its officers, members and employees concerning such interests. Any such interests discovered shall be promptly presented in detail to the Department.

The Department may, by written notice to the County, terminate the right of the County to proceed under this agreement, if it is found by the Department that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the County, any employee, agent, or representative of the County under this paragraph.

H. LOSS OF KEY PERSONNEL----The County agrees to notify the Department immediately of the loss of personnel responsible for administering this contact.

I. SEVERABILITY----If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision. If such provision does not relate to payments or services to Medicaid/BadgerCare enrollees and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

J. 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.

K. HEADINGS----The article and section headings used herein are for reference and convenience only and shall not effect its interpretation.

L. ASSIGNABILITY----Except as allowed under subcontracting, the Contract is not assignable by the County either in whole or in part, without the prior written consent of the Department.

M. RIGHT TO PUBLISH----The County must obtain prior written approval from the Department before publishing any material on subjects addressed by this Contract.

N. INTERPRETATIONS----When disputes arise, the Department has the right to final interpretation of the Contract .The County shall abide by the interpretation of the Department.

O. CONTRACT ADMINISTRATION----

1. The Department designates the Administrator of the Division of Health Care Financing (DHCF) as the Contract Administrator. The Contract Administrator shall exercise all of the Department's rights under this Contract. The Associate Administrator of the DHCF shall serve as Deputy Contract Administrator. In the absence or unavailability of the DHCF Administrator, the DHCF Associate Administrator shall act as Contract Administrator and shall exercise the powers and duties of the DHCF Administrator.

2. With respect to the scope of work under this Contract and the Contractor's performance thereof, the Contract Administrator will issue, from time to time, such written specifications and instructions as may be necessary for the contractor to carry out its obligations. The Contract Administrator will periodically evaluate the Contractor's performance improvements under this Contract. The Contractor shall promptly undertake such corrections as may be reasonably necessary to correct the problems and/or deficiencies identified in the Contract Administrator's periodic evaluations.

3. The Contract Administrator shall designate a DHCF staff person as contract monitor. For the purposes of daily communications and the informal discussion of questions and problems, this contract monitor will serve as the principal contact person for the Contractor. The Contract Administrator may change the contract monitor at any time and may designate a deputy contract monitor and/or separate contract monitors and/or deputy contract monitors for different aspects of the scope of work.

ARTICLE XIV

XIV. COUNTY SPECIFIC CONTRACT TERMS

1. COUNTY IN WHICH ENROLLMENT IS ACCEPTED: Milwaukee.

2. MAXIMUM ENROLLMENT LEVEL: 800. The number of Medicaid/ BadgerCare enrollees may exceed the maximum by up to 5% on a temporary basis. The Department does not guarantee any minimum enrollment level.

3. CAPITATION RATE: The monthly capitation rate for each enrollee is $1,588.30 for the period from October 1, 2007, through June 30, 2009. The county has agreed to waive the 30 day review to accept the new rate.

4. THIS CONTRACT SHALL BECOME EFFECTIVE ON OCTOBER 1, 2007, AND SHALL TERMINATE ON JUNE 30, 2009.

IN WITNESS WHEREOF, the State of Wisconsin and Milwaukee County have executed this agreement:

Signature from County	Signature from State
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM I
SUBCONTRACTS AND MEMORANDA OF UNDERSTANDING

SUBCONTRACTS

1. The Department will review and approve the County's Subcontract(s).

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 recipients, including but not limited to the proposed subcontractor's past performance. DHFS will give the County: (1) 120 days to implement a change that requires the County to find a new subcontractor, and (2) 60 days to implement any other change required by DHFS. DHFS will acknowledge the approval or disapproval of a subcontract within 14 days after its receipt from County.

The Department will review and approve or disapprove each subcontract before Contract signing. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to Article IX of this Contract. The Department's subcontract review will assure that County has inserted the following standard language in subcontracts:

Subcontractor(s) agrees to abide by all applicable provisions of County's Contract with the Department of Health and Family Services, hereafter referred to as the County Contract. Subcontractor(s) compliance with County Contract specifically includes but is not limited to the following requirements:

a. Subcontractor uses only Medicaid/BadgerCare certified providers for services that are covered by Medicaid/BadgerCare fee-for-service. For services not covered under the Medicaid/BadgerCare state plan, the County must have written standards established by the County and available for review.

b. No terms of this subcontract are valid which terminate legal liability of the County.

c. Subcontractor agrees to participate in and contribute required data to the County QAPI programs.

d. Subcontractor agrees to abide by the terms of the County 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 County.

e. Subcontractor agrees to submit encounter data in the format specified by the County. The County will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.

f. Subcontractor agrees to comply with all non-discrimination requirements.

g. Subcontractor agrees to comply with all record retention requirements stipulated.

h. Subcontractor agrees to provide representatives of the County, as well as duly authorized agents or representatives of DHFS and the federal Department of Health and Human Services, access to its premises and its contract and/or medical records. Subcontractor agrees otherwise to preserve the full confidentiality of medical records.

i. Subcontractor agrees to the requirements for maintenance and transfer of medical records.

j. Subcontractor agrees not to create barriers of access to care by imposing requirements on enrollees that are inconsistent with the provision of medically necessary and covered Medicaid benefits (e.g., COB recovery procedures that delay or prevent care).

k. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

l. Subcontractor agrees not to bill a Medicaid/BadgerCare enrollee for medically necessary Medicaid/BadgerCare covered services covered under the County Contract and provided during the enrollee's period of County enrollment. Subcontractor also agrees not to bill enrollees for any missed appointments while an enrollee is eligible under the Medicaid/BadgerCare Program. This provision shall continue to be in effect even if the County becomes insolvent. However, if an enrollee agrees in writing to pay for a non-Medicaid covered service, then the County or County subcontractor can bill.

m. Subcontractors must forward to the County medical records pursuant to grievances, within 15 working days of the County's request. If the subcontractor does not meet the 15-day requirement, the subcontractor must explain why and indicate when the medical records will be provided.

n. The subcontractor holds the Department harmless for failure of the County to pay for covered services performed by the subcontractor pursuant to the subcontract.

o. Subcontractor agrees to abide by the terms of the Contract regarding appeals to the County and to the Department for the County non-payment of service providers.

p. Subcontract agrees to abide by the County's marketing/informing requirements. Subcontractor will forward to the County for prior approval all flyers, brochures, letters, and pamphlets the subcontractor intends to distribute to its Medicaid/ BadgerCare enrollees concerning its County affiliation, changes in affiliation, or relate directly to the Medicaid/BadgerCare population. Subcontractor will not distribute any "marketing" or recipient informing materials without the consent of the County and the Department.

2. Review and Approval of New Subcontracts and Changes in Approved Subcontracts during the Contract Period.

New subcontracts and changes in approved subcontracts shall be reviewed and approved by the Department before taking effect. This requirement will be considered met if the Department has not responded within 15 consecutive days of the date of departmental receipt of request.

a. This review requirement applies to changes which affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved.

b. Changes in rates paid do not have to be approved, with the exception of changes in the amounts paid to County management services subcontractors.

c. The County must send written notification not less than 30 days prior to the effective date of the termination, to enrollees whose primary mental health provider or gatekeeper terminates their Contract with the County. The Department must approve the notifications before they are sent to enrollees.

3. The County shall notify the Department within seven (7) days of any notice by the County to a subcontractor, or any notice to the County from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce Medicaid/BadgerCare enrollees 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 provided for in this Contract. These remedies include Contract termination (notice to the County and opportunity to correct are provided for) and suspension of new enrollment.

4. The County shall submit MOUs referred to in this Contract to the Department upon the Department's request.

5. The County shall submit to the Department copies of new MOUs, or changes in existing MOUs within 15 days of signing.

   The County shall not pay non-subcontracted providers more than Medicaid/BadgerCare rates for services provided, unless the Department approves a higher level of payment based on the County's justification of a higher level of payment for a proportionately higher level of services.

6. A managed care entity may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non procurement activities as a director, officer, partner, or a person with beneficial ownership of more than 5% of the entity's equity, or have 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.

ADDENDUM II

UTILIZATION REQUIREMENTS

The County must submit utilization data requested on the Annual Utilization Report (attached) on an annual basis in a computer readable format. The County must provide utilization data on services delivered to all enrollees. Reports must be submitted to the Department according to the schedule listed in this Contract.

All County subcontracts with providers must have provisions for assuring that the data required on the County Utilization Report is reported to the County by the subcontractor(s).

The Department agrees to involve the County in the planning process prior to implementing any changes in format and will request the County review and comment on format changes before they go into effect.

The County is subject to the remedies for violation, breach or non-performance of the Contract, outlined in the Contract, for non-compliance with these data reporting requirements. Conditions which constitute non-compliance with the reporting requirements include the following: Failure to submit the Annual Utilization Report identified by the Department or its subcontractor; failure to meet the Department's County Utilization Report production schedule (attached); and failure to provide all data requested through the County Utilization Report.

The County must specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting the County utilization data, and the staff person that should be contacted in the event that the primary contact person is not available.

All data should be reported by the unit specified in the Annual Utilization Report. For auditing purposes, the County should retain data which will allow the Department to verify for any given enrollee that the units of service reported matches the units of service documented in the enrollee's record(s).

Annual Utilization Report

The County must provide the following utilization data for services provided in a 12-month period. Unless otherwise stated, the information is asked for all enrollees regardless of Medicaid eligibility. Data is due July 31 of each year, for services provided during the previous calendar year.

WRAP AROUND MILWAUKEE/CHILDREN COME FIRST/MEDICAID ENCOUNTER DATA EDIT REQUIREMENTS AND FILE LAYOUT - 2007

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
1	CCF or WM Medicaid ID Number	NUMERIC	RIGHT	ZERO	1	8	8	This is the Medicaid provider number for the plan. This field is required for each record. A blank field will cause the record to error. The plan will resubmit the corrected record.
2	Record Identification Number	ALPHA NUMERIC	LEFT	SPACE	9	38	30	This is the unique record identification number assigned by each plan. This field is required for each record. This number is used for tracking purposes on error reports. A blank field will cause the record to error. The plan will resubmit the corrected record.
3	Recipient Identification Number	NUMERIC	RIGHT	ZERO	39	48	10	This is the recipient's ten digit Medicaid identification number. This field is required for each record. Recipient must be MA eligible to receive services on date of service. A blank field will cause the record to error. The plan will resubmit the corrected record.
4	SSN	NUMERIC	RIGHT	ZERO	49	57	9	This is the nine digit social security number of the client receiving services. Zero fill when not used. Required field.
5	Last Name	ALPHA	LEFT	SPACE	58	91	34	This is the last name of the person receiving services and is required for each record. If recipient name is listed, it must match the eligibility file.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
6	First Name	ALPHA	LEFT	SPACE	92	115	24	This is the first name of the person receiving services and is required for each record. If recipient name is listed, it must match the eligibility file.
7	Middle Initial	ALPHA	LEFT	SPACE	116	116	1	This is the middle initial of the person receiving services and is an optional field. If recipient name is listed, it must match the eligibility file. Zero fill if not used.
8	Gender	ALPHA	LEFT	SPACE	117	117	1	This is the gender of the person receiving services and is a required field. M = male and F = female.
9	Date of Birth	NUMERIC	RIGHT	ZERO	118	125	8	This is the date of birth of the person receiving services and is a required field. Use the date format mmddyyyy.
10	Race Primary	ALPHA	RIGHT	ZERO	126	126	1	This is the race field for the person receiving services, as determined by the recipient. It is a required field. A = Asian or Pacific Islander. All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. B =Black. All persons having origins in any of the Black racial groups of Africa. H =Hispanic. All persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race. I = Native American or Alaska Native. All persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal association or community recognition. W = All persons having origins in any of the original peoples of Europe, North Africa or the Middle East. 7 = Not provided. E = Other.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
11	Race Secondary	ALPHA	RIGHT	ZERO	127	127	1	This is the secondary race field for the person receiving services and is a supplemental field. Zero fill when not used. Use coding scheme from above.
12	Ethnicity	ALPHA	RIGHT	ZERO	128	128	1	This is the ethnicity of the person receiving services and is a required field. Zero fill when not used. Use the coding scheme: 1 = Hispanic or Latino; N = Non Hispanic or Latino; M = Ethnicity missing.
13	Procedure Code	ALPHA NUMERIC	LEFT	ZERO	129	133	5	This is the HCPCS code used to identify the service provided. Must use the HCPCS code identified on the WM/CCF/Medicaid Service Code Crosswalk List. This is a required field.
14	Procedure Code Modifier	NUMERIC	RIGHT	ZERO	134	136	3	This is the three digit HCPCS modifier code used to identify the service provided. Must use the HCPCS modifier code identified on the WM/CCF/Medicaid Service Code Crosswalk List. This is a required field.
15	Service From Date	NUMERIC	RIGHT	ZERO	137	144	8	This is the 8 digit date field used to identify services such as a procedure or a hospital admission date. Zero fill when not used. Use the mmddyyyy format.
16	Service To Date	NUMERIC	RIGHT	ZERO	145	152	8	This is the 8 digit date field used to identify a hospital discharge date. Zero fill when not used. Use the mmddyyyy format.
17	Number of Service Units	NUMERIC	RIGHT	ZERO	153	155	3	This is the number of units (e.g., days, visits, time increments) associated with the procedure code.
18	Axis 1 Diagnosis (A1A)	ALPHA NUMERIC	LEFT	ZERO	156	160	5	This field holds the first Axis 1 diagnosis code for which the service is provided. Use a five digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
19	Axis 1 Diagnosis (A1B)	ALPHA NUMERIC	LEFT	ZERO	161	165	5	This field holds the second Axis 1 diagnosis code for which the service is provided. Use a five digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.
20	Axis 1 Diagnosis (A1C)	ALPHA NUMERIC	LEFT	ZERO	166	170	5	This field holds the third Axis 1 diagnosis code for which the service is provided. Use a five digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.
21	Axis 1 Diagnosis (A1D)	ALPHA NUMERIC	LEFT	ZERO	171	175	5	This field holds the fourth Axis 1 diagnosis code for which the service is provided. Use a five digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.
22	Axis 2 Diagnosis (A2A)	ALPHA NUMERIC	LEFT	ZERO	176	180	5	This field holds the first Axis 2 diagnosis code for which the service is provided. Use a five digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.
23	Axis 2 Diagnosis (A2B)	ALPHA NUMERIC	LEFT	ZERO	181	185	5	This field holds the second Axis 2 diagnosis code for which the service is provided. Use a five digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.
24	Axis 2 Diagnosis (A2C)	ALPHA NUMERIC	LEFT	ZERO	186	190	5	This field holds the third Axis 2 diagnosis code for which the service is provided. Use a five digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.
25	Axis 2 Diagnosis (A2D)	ALPHA NUMERIC	LEFT	ZERO	191	195	5	This field holds the fourth Axis 2 diagnosis code for which the service is provided. Use a five digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
26	Contractor Service Code	ALPHA NUMERIC	LEFT	ZERO	196	200	5	This is the internal CCF or WM service code used to identify the service provided. This is a required field.
27	Paid Amount	NUMERIC	RIGHT	ZERO	201	208	8	This is the charge amount by service code. This is a required field.
28	Unit Cost	NUMERIC	RIGHT	ZERO	209	216	8	This is the unit cost by service code. This is a required field.
29	Performing Provider ID Number	NUMERIC	RIGHT	ZERO	217	226	10	This is the Medicaid provider identification number of the performing provider. Zero fill unused portion of the field. This is a required field.
30	Performing Provider Last Name, First Name	NUMERIC	RIGHT	ZERO	227	256	30	This is the last name, first name of the performing provider. Do not use title. Zero fill unused portion of the field. This is a required field.
31	Encounter Data Submission Date	NUMERIC	RIGHT	ZERO	257	264	8	This is the date encounter data was submitted to the Medicaid program. Use the mmddyyyy format.
32	Program Enrollment Date	NUMERIC	RIGHT	ZERO	265	272	8	This is the program enrollment date. Use the mmddyyyy format.
33	Program Disenrollment Date	NUMERIC	RIGHT	ZERO	273	280	8	This is the program disenrollment date. Use the mmddyyyy format.

Crosswalk between Medicaid, County, and ISP Coding Systems.

Indicator	Medicaid-EDS	HSRS	ISP
I. Demographics:			
A. # of Unduplicated Clients			
B. # of Clients with Medicaid			
C. # of Clients without MA			
D. # of Clients by Race Census			
E. # of Clients by Case Management Agency			
F. Special Children's Services Categories – Client Characteristics		SC Module Field 7: 02-05, 10, 12, 61-66, 68, 69, 70, 73, 74,	
G. Diagnosis	ICD9 291-316	MH Module Field 10, Field 11	
II. Residential and Inpatient:			
A. Inpatient Psychiatric or AODA Hospital Admissions	UB-92: 900-919; 944, 945 Revenue Codes DRGs 424-437 (Diagnoses 291-316) Institutes 10063400 or 10063000 CTYP=40,49	MH-50300, 50310, 50320, 92500	5350
III. Placement Services:		SC- Field 12, Field 15	
A. Crisis Home/Bed			5299, 5300, 5302
B. Treatment Foster Care		MH-203	5311, 5312
C. Residential Treatment-CCIs		MH-504, 506	5340, 5344, 5345, 5346
D. Foster Care			5307, 5308, 5309, 5312, 5390
E. Group Home Care			5400, 5402
F. Other Placement Services		MH-205, 705	5380, 5499
G. In Own Home			
H. Detention/Corrections		MH-303	

Indicator	Medicaid-EDS	HSRS	ISP
IV. Outpatient Services:			
A. Psychotherapy	90801-90899	MH-507, 50720, 50730, 50740	5100, 5120A, 5130, 5131
B. Mental Health Day Treatment	H2012, H0025	MH-704	5172
C. Adolescent Day Treatment			
D. Non-MA Day Treatment	H0025		5170
E. In Home Treatment	99082, S9584, H0004, H0022, T1006	MH-50450	5160, 5161,
F. Medication Management	90862	MH-50710	5050
G. Substance Abuse	H0022, H0005, T1006		5101A, 5121A
H. ER or Crisis visits with no Inpatient Admit	99228	MH-50320	5355
I. Case Management	T1017	MH-604	5500A
J. CSP		M-509	
K. Limit Exceeded Evaluation			
L. Crisis Intervention	S9484, S9485	MH-501	5303
M. Assessments/Evaluations	90801, 90802, H0022, H0039		5000A, 5180A, 5182A, 5001A
V. Community Supports:			
A. Teacher Aide			
B. Parent Aide		MH-50760	5522A
C. Mentor			5524
D. Respite		SPC-103	5410, 5411, 5412, 5414
E. Behavioral Monitoring			5541
F. Recreational Support		SPC-403	5201, 5202
G. Personal Services/Supports			5560, 5561, 5562, 5590, 5595
H. Transportation		SPC-107	5571, 5572, 5573, 5574
I. Natural Supports			
J. Discretionary Funds			5580

ADDENDUM III

PERFORMANCE IMPROVEMENT PROJECT OUTLINE

The design, implemention and reporting format for each performance improvement project should include consideration of each of the ten criteria listed below in order for the Department to evaluate the reliability and validity of the data and the conclusions described in the study. The following is a recommended guideline for completing a performance improvement project:

1. Select a Study Topic

    a) Is the topic important to the enrolled population?
    b) Does the topic affect a significant portion of the enrollees and reflect a high-volume or high-risk condition of the population served?
    c) Can it be affected by the actions of the County?
    d) Was the process of the topic selection described?

2. Define a Study Question

    a) Was the method and procedure used to study the topic clear?
    b) Was the study question clearly stated and consistent throughout the study?
    c) Is the study question specific and answerable?

3. Select Study Indicators

    a) Were the indicators objective, clear, and unambiguously defined?
    b) Are the indicators based on current clinical knowledge or health services research? (Healthcare guidelines)
    c) Do the indicators objectively measure either enrollee outcomes such as health or functional status, enrollee satisfaction, or valid proxies of these outcomes?

4. Identify the Study Population

    a) Is there a clear definition of who to include in the study?
    b) Did the study define an “at risk” population?
    c) Was the entire population included or was a sample used?
    d) If the entire population was included, were all enrollees captured by the data collection process used?

5. Utilize Sampling Methods (if applicable)

    a) Was a valid sample size calculated?
    b) Were valid sampling techniques used?

6. Data Collection

a) Were the data described in detail?
b) Were the data appropriate to answer the study question?
c) Was the data collection process clearly described?
d) Was the data collection process appropriate to answer the study question?
e) Was interrater reliability adequate?
f) Did the loss of data or subjects affect validity?
g) Was the study time clear?
h) Was enrollee confidentiality protected?

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

a) Were interventions related to causes/barriers identified through data analysis?
b) Was the intervention fully described?
c) Can the intervention be widely implemented?
d) Was the implementation of the intervention monitored for effectiveness?

8. Results and Interpretation

a) Was the data collected fully reported?
b) Did the study include comparisons to give meaning to the results?
c) Is the norm or standard expressed in a specific numerical manner?
d) Is the goal, norm or standard appropriate to this population and study?
e) ?
f) Did the study appropriately use statistical testing? (x^2 t-test, regression analysis, etc.)?
g) Were the conclusions consistent with the results?
h) Were data tables, figures and graphs consistent with the text?
i) Did the study consider its limitations?
j) Did the study conclude or imply causality when the supporting data is only correlational?
k) Did the study include how to improve the study?
l) Did the study present recommendations on the results?
m) Did the report clearly state whether performance improvement goals were met (if an intervention was carried out)? If the goals were not met, was there an analysis of why not and a plan for future action?

9. Real Improvement Achieved

a) Was statistically significant improvement achieved?
b) Does the improvement in performance appear to be due to the planned intervention?
c) What if any additional questions did the study raise? What are the next steps, if any, to study this question/topic?
d) What will you do differently as a result of your study?

10. Sustained Improvement

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

ADDENDUM IV

STATE OF WISCONSIN
WISCONSIN MEDICAID/BADGERCARE
COUNTY REPORT ON COORDINATION OF BENEFITS

Name of County ______________________ Mailing Address______________________

Office Telephone _____________________ ____________________________________

Provider Number _____________________ ____________________________________

Please designate below the annual period for which information is given in this report.

____________________________, 20____ through ________________________, 20________

INSTRUCTIONS

For the purposes of this report, an enrollee is any Medicaid recipient listed on the monthly enrollment reports coming from the fiscal agent, and who is an ADD or CONTINUE.

Subrogation may include collections from auto, homeowners, or malpractice insurance, as well as restitution payments from the Division of Corrections. In addition, subrogation should include collections from Workers' Compensation.

Birth costs are not a third party right, and consequently are not included in this report.

Coordination of Benefits Reports are to be completed on a calendar year basis.

The report is to be for the entire County, aggregating all separate service areas if the County has more than one service area.

Please complete and return this report by May 15th for the previous year to:

DHFS - Managed Care Section
P.O. Box 309
Madison, WI 53701-0309

Attn: COB Report from ____________________County

COB REPORT

The following information is **REQUIRED** in order to comply with CMS reporting requirements:

Cost Avoidance

Indicate the dollar amount of the claims you denied as a result of your knowledge of other insurance being available for the enrollee. The provider did not indicate at the time of the claim submission (with an EOB, etc.) that the other insurance was billed prior to submitting the claim to you. Therefore, you denied the claim. Please indicate the dollar amount of these denials.

Amount Cost Avoided:____

(Including claims denied for third party liability.)

Recovery (Post-Pay Billing/Pay and Chase)

Indicate the dollar amount you recovered as a result of billing enrollees' other insurance.

____

Subrogation/Worker's Compensation____

Recovery (Dollars) This Year: ____

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 County, except as noted on the report.

Signed: ____
Original Signature of Director or Administrator

Printed Name: ____

Title: ____

Date Signed: ____

ADDENDUM V

ACTUARIAL BASIS OF CAPITATION RATE

The capitation rate under this Contract is based on calendar year 2006 utilization data for enrollees submitted by the WM integrated service program. In addition, calendar year 2006 data on eligible months for enrollees in the WM program from the managed care data system component of the Medicaid Management Information System (MMIS) maintained by EDS and the Bureau of Health Care Systems and Operations (BHCSO) in DHFS were utilized. Moreover, information on the costs of mental health services provided in residential care centers (RCC's) and group homes provided by WM was utilized to develop estimates of the costs of those services covered under the Wisconsin Medicaid State Plan as part of RCC and group home placements. Calendar year 2006 actual paid amounts for services provided to enrollees in the WM program were priced at Medicaid Maximum Allowable Fee Rates detailed in Wisconsin Medicaid and BadgerCare Updates to reflect the estimated costs of these services in a fee-for-service environment. Data for recipients without capitation payments and claims data for services not covered under the Wisconsin Medicaid State Plan were excluded. An average annual trend of 1.0% was applied to the managed care equivalents developed from this data. In addition, an administrative load of 5.0% was applied to reflect the costs of providing administrative services in these programs.

ADDENDUM VI

COMPLIANCE AGREEMENT

THE COUNTY HEREBY AGREES THAT it will comply with the following:

1. The County agrees to comply with Public Law 103-227, also known as the Pro-Children Act of 1994, which prohibits tobacco-smoke in any portion of a facility owned or leased or contracted for by an entity which receives federal funds, either directly or through the State, for the purpose of providing services to children under the age of 18.

2. The County shall implement and adhere to rules and regulations prescribed by the United States, Department of Labor and in accordance with 41 Code of Federal Regulations, Chapter 60.

3. The County shall comply with regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741 and the Federal Rehabilitation Act of 1973. The County shall ensure compliance by any and all subcontractors engaged by Contractor under the Contract with said regulations.

Affirmative Action Plan/Civil Rights

1. The County assures that they have submitted to the Department Affirmative Action/Civil Rights Compliance Office a current copy of an Affirmative Action Plan and Civil Rights Compliance Action Plan for Meeting Equal Opportunity Requirements under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title VI and XVI of the Public Service Health Act, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 and the Americans with Disabilities Act (ADA) of 1990, the Wisconsin Fair Employment Act, and any or all applicable federal and state nondiscrimination statutes as may be in effect during the term of this Contract. If an approved plan has been reviewed during the previous calendar year, a plan update must be submitted during this Contract period. The plan may cover a two (2) year period.

   a. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities.

   b. 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, religion, color, sex, national origin, or ancestry, handicap [as defined in Section 504 and the American With Disabilities Act (ADA)], physical condition, developmental disability [as defined in

s.51.05(5) Wis. Stats.], arrest or conviction record [in keeping with s.111.32 Wis. Stats.], sexual orientation, marital status, or military participation. All employees are expected to support goals and programmatic activities relating to nondiscrimination in employment.

2. The County shall 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 and made available in languages and formats understandable to applicants, clients and employees. The County will continue to provide appropriate translated state procedures, mandated brochures and forms for local distribution.

3. The County agrees to comply with guidelines in the Civil Rights Compliance Standards and a Resource Manual for Equal Opportunity in Service Delivery and Employment for the Wisconsin Department of Health and Family Services, its Service Providers and their Subcontractors (September 1997 Edition).

4. Requirements herein stated apply to any subcontracts. The County has primary responsibility to take constructive steps, as per the CRC Standards and Resource Manual, to ensure compliance of subcontractors. However, where the Department has a direct contract with another community agency or vendor, the County need not obtain a Subcontractor Affirmative Action Plan and Civil Rights Compliance Action Plan or monitor that agency or vendor.

5. The Department will monitor the Civil Rights Compliance of the County and will conduct reviews to ensure that the County is ensuring compliance of its subcontractors in compliance with guidelines in the CRC Standards and Resource Manual. The County agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the County, as well as interviews with staff, clients, applicants for services, subcontractors and referral agencies.

6. The County agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or other monitoring efforts.

Access to Agency

1. The County agrees to hire staff, contract with, or identify community individuals with special translation or sign language skills and/or provide staff with special translation or sign language skills training or find persons who are available within reasonable time and who can communicate with non-English speaking or hearing impaired clients; train staff in human relations techniques, sensitivity to persons with disabilities and sensitivity to cultural characteristics; and make programs and facilities accessible, as appropriate, through outstations, authorized

representatives, adjusted work hours, ramps, doorways, elevators or ground floor rooms, and Braille, large print or taped information for the visually impaired. Informational materials will be posted and/or available in languages and formats appropriate to the needs of the client population.

2. The County shall ensure the establishment of safeguards to prevent employees, consultants or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties as specified in Wis. Stats. 946.10 and 946.13.

3. The applicant gives assurance that it will immediately take any measures necessary to effectuate this agreement.

4. The applicant shall comply with Conflict of Interest (Section 946.10 and 946.13, Wis. Stats., and DHFS Employee Guidelines DMB-Pers. 102-7/1/71).

ADDENDUM VII

REPORTING REQUIREMENTS AND DUE DATES

Due Date*	Type of Report	Reporting Period
Within 14 days of Contract signing	Enrollee Handbook - New Contractors	Contract Period
Within 15 days after the award of Contract	Affirmative Action Plan - Unless prior approved by the Department	Contract Period
Within 30 days after the award of Contract	MOUs for Emergency Services	Contract Period
When Notified	Notices About Provider Changes	Contract Period
15 Days Prior to Effective Date	New Subcontracts/Changes in Approved Subcontracts or MOUs	Contract Period
When Prepared	Educational Materials referring to Medicaid/BadgerCare	Contract Period
When Notified	Personal Injury Settlements	Contract Period
2007		
Dec 1	Performance Improvement Project Report	Contract Period
2008		
April 10	Annual Grievance Summary Report	Jan – Dec 2007
April 15	Outcome Indicator Data	Jan – Dec 2007
May 15	Annual Coordination of Benefits	Jan – Dec 2007
May 15	Utilization Data Report	Jan – Dec 2007
Dec 1	Performance Improvement Project Report	Contract Period
2009		
April 10	Annual Grievance Summary Report	Jan – Dec 2008
April 15	Outcome Indicator Data	Jan – Dec 2008
May 15	Annual Coordination of Benefits	Jan – Dec 2008

*Any reports due on a weekend or holiday are due the following workday.

MAIL REPORTS TO: Bureau of Managed Health Care Programs, Room 265
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

OR FAX REPORTS TO: (608) 261-7792

ADDENDUM VIII

MEDICAID COVERED SERVICES PROVIDED BY COUNTY

Mental health and alcohol and other drug abuse treatment services are covered under this Contract when they have been determined by the child and family treatment team, through the process of evaluation and case planning, to be necessary for the treatment and rehabilitation of the recipient to facilitate the maximum reduction of the enrollee's disability and restoring the recipient to his or her best possible functional level. The services will be identified on the recipient treatment plan. The plan will indicate the measurable goal to be achieved through provision of the service and the provider(s) who will administer the service. Emergency services may be provided as needed to ensure the safety of the individual for a reasonable period of time until an emergency case plan can be developed. Emergency services should be billed on a fee-for-service basis, as they are not included in the capitated rate. Case management activities need not be specifically identified on the treatment plan in order to be covered under this Contract. Services include, but are not limited to, the following services.

I. All services provided by the County under this Contract must meet the requirements for covered services as described in the Medicaid State Plan, Medicaid publications and under HFS 107.13 Wis. Admin. Code. Any limitations found on the place of service or the amount of service allowed are not applicable to the County. Limitations on collateral contacts are not applicable to the County. Any prior authorization requirements are not applicable to the County.

The following services are covered under the Medicaid state plan and must be provided by Medicaid certified providers. Medicaid provider publications found on the Medicaid web site at dhfs.wisconsin.gov/Medicaid/index provide information on the following:

- Targeted Case Management
- Inpatient Services
- Medical Day Treatment
- Outpatient Clinic Services
- Substance Abuse Day Treatment
- CSP
- Case Management

The following services are covered under the Medicaid state plan and must be provided by Medicaid-certified providers:

Inpatient Services

Mental Health Services including DRGs 701-878.

Outpatient Clinic Services

Assessment/Evaluation/Diagnostic Testing
Individual/Family Psychotherapy
Group Psychotherapy
Collateral Contacts
Medication Management
Individual/Family AODA therapy
Group AODA therapy

Medical day treatment for children (through age 18)

Substance Abuse Day Treatment

Community Support Program Services

Targeted Case Management Services

Emergency Service. As noted above, these services are to be billed fee-for-service until such time as crisis service costs can be incorporated into the Medicaid capitation rate.

II. The following services are covered by Medicaid under the HealthCheck other services option and must be provided by Medicaid-certified providers. Information on these services can be found in Medicaid publications on the Medicaid web site at dhfs.wisconsin.gov/Medicaid/index. Limitations on the amount of services and prior authorization requirements are not applicable to County. HealthCheck referrals are not required when these services are provided through this Contract although the County agrees to facilitate the child's involvement in the HealthCheck screening process.

Intensive In-Home Treatment

ADDENDUM VIII COVERED SERVICES				
PROCEDURE/HCPCS CODE /DRG	MODIFIER REQUIRED (YES/NO)			DESCRIPTION
	Professional	Program	Service	
90801, 90802, 90804 - 90809, 90810 - 90819, 90821 - 90824, 90826 - 90829, 90845 - 90847, 90849, 90853, 90857, 90862, 90865, 90870, 90871, 90875, 90876, 90880, 90887, 90899, H0046, 99228	Y	N	N	Outpatient mental health services
H0047, H0022, H0005, T1006	Y	N	N	Outpatient substance abuse services
H2012	N	Y	N	Child/adolescent day treatment
H0004, H0022, T1006, 99082	Y	Y	N	Intensive in-home treatment

ADDENDUM VIII COVERED SERVICES				
PROCEDURE/HCPCS CODE /DRG	MODIFIER REQUIRED (YES/NO)			DESCRIPTION
	Professional	Program	Service	
90801, 90802, 90804 - 90815, 90845 - 90847, 90849, 90853, 90857, 90862, 90875, 90876, 90880, 90887, 90899	Y	Y	N	Outpatient mental health in the home or community
H0022, T1006, H0005	Y	Y	N	Outpatient substance abuse in the home or community
H0039	Y	N	N	Community support program service
T1017	N	Y	Y	Case management services
H2012	N	Y	Y	Substance abuse day treatment services
DRG: 424 -432 (Diagnoses 291 - 316) Excluding billing provider number 10063400 or 10063000 (CTYP = 40, 49)	N	N	N	Inpatient mental health
DRG 433 - 437 (Diagnoses 291 - 316) Excluding billing provider number 10063400 or 10063000 (CTYP = 40, 49)	N	N	N	Inpatient substance abuse
Billing provider number 10063400 or 10063000 (CTYP = 40, 40)	N	N	N	Mental health institutes
UB 92: 0900 - 0919 Revenue codes	N	N	N	Mental health institutional outpatient
UB 92: 0944 - 0945 Revenue codes	N	N	N	Substance abuse institutional outpatient

ADDENDUM IX

COMPLIANCE AGREEMENT ON EVALUATION

For the purpose of evaluating quality, cost effectiveness and possible replication of this program statewide, an evaluation of the Contract will be conducted.

COUNTY AND ITS SUBCONTRACTOR(S) HEREBY AGREES they will comply with the following:

> County and its subcontractor(s) agree to participate with the Department in the evaluation of Wraparound Milwaukee. County and its subcontractor(s) agree to provide information relating to cost, quality, and any other information collected under the terms of this Contract necessary to complete the evaluation.

For purposes of the evaluation, the following indicators will be collected and reviewed:

Outcome Indicators
(Where applicable, measures will be taken prior to enrollment, during enrollment and six (6) months post-enrollment.)

1. Functioning
   - The functioning levels of children in WM will improve.
     How Measured:
     - Compare Child Behavior Checklist Score (CBCL) at intake to CBCL scores after enrollment, with subscores at six (6) month intervals, and at discharge.

2. Community Safety
   - The criminal offenses and juvenile justice contacts decrease.
     How Measured:
     - Compare number of adjudications and formal charges one (1) year prior to enrollment to number of adjudications and formal charges during enrollment, and at one (1) year post-completion.

3. School
   - Number of unexcused absences decrease.
     How Measured:
     - Compare number of days possible to number of days attended during enrollment and at identified intervals.

4. Living Environment
   - Restrictiveness of living environment decreases.
     How Measured:
     – Compare restrictiveness of living data at intake to living environment during enrollment at six (6) months, one (1) year, two (2) years, and three (3) years, or disenrollment.

5. Costs
   - Expenses incurred by WM to keep child in the community.
     How Measured:
     – Collect and price out all services and supports provided to the child and family by WM and compare to alternate children's mental health systems of care (e.g., fee-for-service WM systems).

6. Satisfaction
   - Parents and children are satisfied with WM support.
     How Measured:
     – Through satisfaction survey administered by contractor.

Process Indicators
Evaluated through program audit and case plan review and MIS system.

1. Coordination and Teamwork
   - Among child, family and network of formal and informal supports.

2. Family and Community-Based Delivery
   - Support and services are provided in the child's natural environment; including, home, school and community.
   - Also measured through utilization review.

3. Plan of Care
   - Updated every 90 days covering all applicable life domains.
   - Access to clinical and process supervision.

4. Service Authorization Plan
   - Projected costs and natural support documented every 30 days.

Structure Indicators
Evaluated through program audit and case plan review.

1. Child and Family Team
   - Treatment team made up of formal and informal supports with the child and family having input and direction to the plan.

2. Service/Care Coordinator
   - Team led by a care coordinator to organize and coordinate care.

3. Intake Team
   - Team made up of multi-agency and school personnel and at least two (2) current or former parents involved in Wraparound to screen potential candidates for WM support.

4. Community Team
   - Team composed of community people involved in services and supports for children as well as non-agency/service individuals and at least 25% of current or former parents involved in Wraparound to access informal community resources (e.g., clergy members and area business leaders).

5. Training Plan
   - Written plan detailing the training needs of providers, administrators and parents and how the ongoing training need will be addressed.

6. Data Collection System
   - Database collection and tracking system to process incoming evaluation information.

County and subcontractor(s) are not responsible for the costs of the evaluation.

ADDENDUM X

DEFINITION OF "SERIOUS EMOTIONAL DISTURBANCE"
ELIGIBILITY CRITERIA FOR WRAPAROUND MILWAUKEE

For the purposes of this Contract, the following definition will be used for a "serious emotional disturbance," "severe emotional disturbance," "severely emotionally disturbed," or "SED." Severe emotional disturbance in an individual under the age of 21 requires acute treatment and may lead to institutional care. The disability must show evidence of 1, 2, 3 and 4.

1. The disability must have persisted for six (6) months and be expected to persist for a year or longer.

2. A condition of severe emotional disturbance as defined by: A mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

   Adult diagnostic categories appropriate for children and adolescents are substance related disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somata form disorders, dissociative disorders, sexual and gender identity disorders, impulse-control disorders, adjustment disorders and personality disorders. Disorders usually first evident in infancy, childhood and adolescence including pervasive developmental disorders, attention deficit and disruptive behavior disorders, tic disorders, stereotypic movement disorder, feeding and eating disorders, separation anxiety disorder, selective mutism and reactive attachment disorder.

3. Functional symptoms and impairments. The individual must have A or B.

   A. *Symptoms*. The individual must have one of the following:

      1) <u>Psychotic symptoms</u>. Serious mental illness, (e.g., schizophrenia characterized by defective or lost contact with reality, often with hallucinations or delusions).

      2) <u>Danger</u> to self, others and property as a result of emotional disturbance. The individual is self destructive, (e.g., at risk for suicide, runaway, promiscuity, and/or at risk for causing injury to persons or significant damage to property).

   B. *Functional Impairment* in <u>two</u> (2) of the following capacities (compared with expected developmental level):

      1) <u>Functioning in selfcare</u>. Impairment in selfcare is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

2) Functioning in the community. Impairment in community function is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which results in potential involvement or involvement with the juvenile justice system.

3) Functioning in social relationships. Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

4) Functioning in the family. Impairment in family function is manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations) which may result in removal from the family or its equivalent.

5) Functioning at school/work.

   a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

   b) Meeting the definition of "child with exceptional educational needs" under ch. PI 11 and 115.76(3), Wis. Stats.; or

   c) Impairment at work is the inability to be consistently employed at a self-sustaining level, (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

4. The individual is receiving services from two (2) or more of the following service systems: Mental health, social services, child protective services, juvenile justice, or special education.

ADDENDUM XI

FORMAL GRIEVANCE EXPERIENCE SUMMARY REPORT

Summarize each Medicaid/BadgerCare grievance reviewed in the past year.

I. Grievances Related to Program Administration

Medicaid Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

II. Grievances Related to Benefits Denials/Reduction

Medicaid Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

III. Summary

SUBTOTAL: Program Administration _____________
SUBTOTAL: Benefit Denials _____________
TOTAL NUMBER OF GRIEVANCES: _____________

Return the completed form to:

Division of Health Care Financing
Bureau of Managed Health Care Programs
P.O. Box 309
Madison, WI 53701-0309

ADDENDUM XII

PROTOCOL MANUAL

Department and County staff will jointly develop a protocol manual to define contractual terms and detail specific procedures described in the Contract.

ADDENDUM XIII

SCHOOL-BASED SERVICES (SBS) MOU

The County must sign an MOU with all School-Based Services (SBS) providers in the HMO service area who are Medicaid-certified. The MOU will be effective on the date when both the County and the SBS provider have signed it or when the SBS provider is Medicaid-certified, whichever is later.

Refer to the sample SBS MOU following this page**.**

MODEL MEMORANDUM OF UNDERSTANDING BETWEEN COUNTY AND SCHOOL DISTRICT OR CESA MEDICAID CERTIFIED FOR THE SCHOOL BASED SERVICES BENEFIT

School-based services (SBS) are a benefit paid FFS by Wisconsin Medicaid for all school-enrolled recipients, including those enrolled in the County. The SBS provider is responsible for services provided in the schools such as occupational/physical/speech therapies, private duty or home care individualized nursing services, mental health services, testing services, school Individual Education Plan (IEP) services, and Individualized Family Service Program (IFSP) services. The County is responsible for providing and managing medically necessary services outside of school settings. However, the schools cannot provide services in some situations, such as after school hours, during school vacations, and during the summer. Therefore, avoidance of duplication of services and promotion of continuity of care for Medicaid County enrollees requires cooperation, coordination and communication between the County and the SBS provider.

The County and the SBS provider agree to facilitate effective communication between agencies, work to resolve inter-agency coordination and communication problems, and inform staff from both the County and the SBS provider about the policies and procedures for this cooperation, coordination and communication. Recognizing that these “clients-in-common” could receive duplicate services and could suffer from problems in continuity of care (e.g., when the school year ends in the middle of a series of treatments), the County and the SBS provider agree to cooperate in communicating information about the provision of services and in coordinating care.

This agreement becomes effective on the date when the SBS provider is certified by Wisconsin Medicaid or when both the County and the SBS provider have signed it, whichever is later. It may be terminated in writing with two weeks notice by either signer. The SBS provider is the School District.

County	SBS Provider
Name of County	Name of SBS Provider
Authorizing Signature	Authorizing Signature
Printed Name	Printed Name
Title	Title
Date	Date