

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION**

TEXAS, KANSAS, LOUISIANA,
INDIANA, WISCONSIN, and
NEBRASKA,

Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES INTERNAL
REVENUE SERVICE, and DAVID J.
KAUTTER, in his official capacity as
ACTING COMMISSIONER OF
INTERNAL REVENUE,

Defendants.

§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§

Civil Action No. 4:18-cv-00779-Y

**APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY
RESTRAINING ORDER AND PRELIMINARY INJUNCTION
AND SUPPORTING BRIEF**

Respectfully submitted this the 21st day of September, 2018.

DEREK SCHMIDT
Attorney General of Kansas
JEFF LANDRY
Attorney General of Louisiana
CURTIS HILL
Attorney General of Indiana
BRAD SCHIMEL
Attorney General of Wisconsin
DOUG PETERSON
Attorney General of Nebraska

KEN PAXTON
Attorney General of Texas
JEFFREY C. MATEER
First Assistant Attorney General
BRANTLEY D. STARR
Deputy First Assistant Attorney General
JAMES E. DAVIS
Deputy Attorney General for Civil
Litigation

/s/ David J. Hacker
DAVID J. HACKER
Special Counsel for Civil Litigation
Texas Bar No. 24103323
david.hacker@oag.texas.gov

RANDALL MILLER
Assistant Attorney General
Texas Bar No. 24092838
randall.miller@oag.texas.gov

OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548, Mail Code 001
Austin, Texas 78711-2548
Tel: 512-936-1414

ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I hereby certify that on September 21, 2018, I electronically filed the foregoing document through the Court's ECF system, and will serve a copy of this document with the summons and complaint.

/s/ David J. Hacker
DAVID J. HACKER

H.	Declaration of F. Ronald Ogborne III, partner of Mercer Health & Benefits, LLC and Actuarial Consultant to the Louisiana Department of Health	A0040-43
I.	Declaration of Jeremy Brunssen, Deputy Director of Finance and Program Integrity for the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care	A0045-52
J.	Declaration of Rachel Butler, Chief Actuary of the Texas Health and Human Services Commission	A0054-58
K.	Report by David G. Wilkes, Principal and Senior Actuary with Rudd and Wisdom, Inc. and Actuarial Consultant to Texas	A0060-66
L.	Declaration of Heather Smith, Administrator of the Division of Medicaid Services with the Wisconsin Department of Health Services and Wisconsin Medicaid Director	A0068-487
M.	Declaration of Allison Taylor, Medicaid Director for Indiana's Family and Social Services Administration	A0489-492



STATE OF INDIANA

OFFICE OF THE ATTORNEY GENERAL
302 WEST WASHINGTON STREET, IGCS 5TH FLOOR
INDIANAPOLIS, INDIANA 46204

CURTIS T. HILL, JR.
ATTORNEY GENERAL

July 16, 2018

VIA OVERNIGHT DELIVERY

David J. Kautter, Acting Commissioner
Internal Revenue Service
Department of the Treasury
1111 Constitution Ave, NW
Washington, D.C. 20224

Re: Preliminary Calculations (Letters 5066C) for Managed Care
Organizations that Provide Medicaid and CHIP Services in Indiana

Acting Commissioner Kautter:

I write on behalf of the Indiana Family and Social Services Administration. The Indiana Family and Social Services Administration oversees the administration of Medicaid and the Children's Health Insurance Program (CHIP) in Indiana, which provide medical coverage for more than 1.5 million low-income Hoosiers.

The Indiana Family and Social Services Administration takes seriously the responsibility to assist those who rely upon the Medicaid and CHIP programs. As such, the more resources that are available, the more the Indiana Family and Social Services Administration is able to assist the Hoosiers who need the benefits of these programs.

Your agency will collect \$14,300,000,000 this year for the Health Insurance Providers Fee (HIPF) under the Affordable Care Act (ACA). 26 C.F.R. § 57.4(a)(3). Your current methods for calculating the ratio-based distribution of this predetermined liability yield an unlawful result—one prohibited by the text of the ACA, which exempts governmental entities from liability for the HIPF. ACA § 9010(c)(2)(B).

We respectfully request that your agency alter its approach and not include managed care organization (MCO) premiums for Medicaid and the Children's Health Insurance Program (CHIP) in your HIPF calculations. Doing so will *not* reduce the amount collected, as your agency will still collect \$14,300,000,000. However, making this change will ensure that the liability for HIPF Year 2018 is

A0006

properly distributed and ensure that your agency does not violate the clear language of the ACA.

Your agency recently sent Letter 5066Cs to managed care organizations (MCOs) with whom the Indiana Family and Social Services Administration contracts to provide Medicaid and CHIP services in Indiana. Specifically, your agency's calculations for the HIPF for Fee Year 2018, as reflected in the Letter 5066Cs that your agency sent to these MCOs, are in error.

As a Defendant in the matter, you are aware that Indiana, along with five other States, challenged the prior, unlawful imposition of the Health Insurance Providers Fee (HIPF) on Medicaid and CHIP managed care contracts. On March 5, 2018, the United States District Court for the Northern District of Texas ruled that the imposition of the HIPF on Medicaid managed care contracts is unlawful. *Texas et al. v. United States et al.*, No. 7:15-cv-00151, 2018 WL 1478250 (N.D. Tex. Mar. 5, 2018). The heart of the court's ruling is that, "[i]n the ACA [(Affordable Care Act)], Congress expressly exempted states from paying the HIPF." *Id.* at *2 (citing ACA § 9010(c)(2)(B) (2010); 26 C.F.R. § 57.2(b)(2)(ii)(B)). A copy of the Court's opinion is enclosed for your convenience.

By burdening Indiana's Medicaid and CHIP MCOs with the imposition of the HIPF, you burden Indiana taxpayers and the millions of Hoosiers who rely upon these programs. In other words, if you impose the HIPF on our Medicaid and CHIP MCOs, you functionally impose the HIPF on Indiana and harm the millions of Hoosiers who rely upon these programs for their health care needs. Apart from the direct harm this unnecessarily inflicts on Hoosiers, your agency's protocols also violate the ACA because "[t]he ACA explicitly excludes states from the definition of 'covered entities,' thereby exempting them from paying the HIPF." *Id.* at *5 (citing ACA § 9010(c)(2)(B)).

Given these circumstances, the methodology the IRS is using—including contracts and premiums for Medicaid and CHIP in calculating HIPF allocations—fails to account for the exemption Indiana has from this fee within the ACA, ACA § 9010(c)(2)(B), as well as the recent opinion of the court, *supra*. The efforts of the IRS are presently imposing a direct harm on Medicaid and CHIP programs designed to assist those that need governmental assistance the most.

As you know, the calculations performed by the IRS for the 2018 Fee Year are merely a ratio-based distribution of a predetermined liability of \$14,300,000,000. By whatever measure, the result of your calculations will yield \$14,300,000,000 into the Federal Treasury. Yet your present methodology of calculations functions as a federal tax on programs for the poor—Medicaid and CHIP. However, your agency has the necessary discretion to honor the clear language of Congress and

appropriately exempt Medicaid and CHIP contracts from consideration in your HIPF calculations.

Given Indiana's undeniable statutory exemption from the HIPF, the court's ruling, and the current calculations' negative impact on Medicaid and CHIP, I ask the IRS to change course. IRS should not include premiums for Medicaid and CHIP by Indiana's MCOs in calculating the HIPF for Fee Year 2018, or any other year.

To protect Indiana taxpayers and program beneficiaries, IRS should remove Medicaid and CHIP premiums from the HIPF calculations for the following MCOs in the following amounts:

Provider	Net Indiana Medicaid and CHIP Premiums
Anthem	\$2,398,719,062
CareSource	\$187,040,984
Managed Health Services	\$1,354,591,351

To the extent that this list contains errors, or is otherwise incomplete, we reserve the right to supplement this letter with additional information as it becomes available to us.

Accordingly, the final notice that will be received by these MCOs on or before August 31, 2018, 26 C.F.R. § 57.4(b), should be appropriately amended to exclude from your calculations and allocated amounts the above listed premiums for Medicaid and CHIP in Indiana.

We thank you for your time and attention to correcting this legal wrong, honoring the will of Congress, and ensuring that Indiana is better able to fully serve and provide for the health care needs of its citizens.

Sincerely,

Curtis T. Hill, Jr.
Attorney General of Indiana
Office of the Attorney General
200 West Washington Street, Room 219
Indianapolis, IN 46204

Enclosure

cc: Department of the Treasury
Internal Revenue Service
1973 Rulon White Blvd., Mail Stop 4916 – IPF
Ogden, UT 84201-0051
via overnight delivery
—and—
via facsimile at 877-797-0235
—and—
via e-mail at LBI.IPF@irs.gov

Brett Shumate
Deputy Assistant Attorney General
Federal Programs Branch, Civil Division
U.S. Department of Justice
950 Pennsylvania Ave, NW
Washington, D.C. 20530
via overnight delivery

July 12, 2018

VIA OVERNIGHT DELIVERY

David J. Kautter, Acting Commissioner
Internal Revenue Service
Department of the Treasury
1111 Constitution Ave, NW
Washington, D.C. 20224

Re: Preliminary Health Insurance Provider Fee Calculations for Managed Care Organizations Providing Medicaid and CHIP Services in Kansas

Acting Commissioner Kautter:

For Fee Year 2018, your agency will collect \$14,300,000,000 for the Health Insurance Providers Fee (HIPF), which was enacted as part of the Affordable Care Act (ACA). 26 C.F.R. § 57.4(a)(3). Current Internal Revenue Service (IRS) methods for calculating the ratio-based distribution of this predetermined liability yield an unlawful result—burdening the State of Kansas' Medicaid and Children's Health Insurance Program (CHIP) managed care contracts—not permitted by the text of the ACA, which exempts governmental entities from liability for the HIPF. ACA § 9010(c)(2)(B).

We respectfully request that your agency alter its approach, and not include Kansas managed care organization (MCO) premiums for Medicaid and the CHIP in your HIPF calculations. Doing so will *not* reduce the amount collected as IRS will still collect \$14,300,000,000. However, making this change will ensure that the liability for Fee Year 2018 is properly distributed and does not violate the clear language of the ACA.

The Kansas Department of Health and Environment (KDHE), through its Division of Health Care Finance (DHCF), which I head, oversees the administration of Medicaid and the Children's Health Insurance Program (CHIP) in Kansas. Kansas provides Medicaid and CHIP health care services through three managed care organizations (MCOs): Amerigroup Kansas, Inc.; Sunflower State Health Plan, Inc.; and United Healthcare of the Midwest, Inc.

The State, KDHE, and DHCF take seriously our responsibility to assist those who rely on Medicaid and CHIP for their health care needs. And the more resources the State has to put toward these programs, the more we are able to assist the Kansans who need these programs.

Your agency recently sent a Letter 5066c to each of Kansas' three MCOs. And the Fee Year 2018 calculations reflected in those letters are in error. As a Defendant in *Texas et al. v. United States et al.*, No. 15-cv-151 (N.D. Tex.), you

A0011

should be aware that Kansas, along with five other States, challenged the unlawful imposition of the HIPF on our Medicaid and CHIP managed care contracts. On March 5, 2018, the U.S. District Court for the Northern District of Texas ruled that it is unlawful for the federal government to impose the HIPF on our Medicaid and CHIP managed care contracts. *See Texas v. United States*, No. 15-cv-00151, 2018 WL 1478250 (N.D. Tex. Mar. 5, 2018). The heart of the court's ruling is that, "[i]n the ACA, Congress expressly exempted states from paying the HIPF." *Id.* at *2 (citing ACA § 9010(c)(2)(B) (2010) and 26 C.F.R. § 57.2(b)(2)(ii)(B)). A copy of the Court's opinion is enclosed for your convenience.

By burdening Kansas' Medicaid and CHIP MCOs with the HIPF, you burden Kansas taxpayers and those who rely on these programs. In other words, if you impose the HIPF on Kansas' MCOs, you functionally impose the HIPF on Kansas. This violates the ACA because "[t]he ACA explicitly excludes states from the definition of 'covered entities,' thereby exempting [Kansas] from paying the HIPF." *Id.* (citing ACA § 9010(c)(2)(B)).

Given these circumstances, the methodology your agency is using—including premiums for Medicaid and CHIP in Kansas in calculating HIPF allocations—fails to account not just for the express language of Congress, but also for the court's ruling, which involves your agency as a defendant. Because your preliminary HIPF calculations for the 2018 Fee Year are merely a ratio-based distribution of a predetermined liability of \$14,300,000,000, your agency can and must honor the clear language of Congress and appropriately exclude Kansas and our Medicaid and CHIP contracts from consideration in your HIPF allocations.

Given that Congress has undeniably excluded States from the HIPF, as the court's ruling recognized and enforced, the Internal Revenue Service has no basis for including in its HIPF calculations for Fee Year 2018 (or any other year), the premiums for Medicaid and CHIP services in Kansas.

To protect Kansas taxpayers and program beneficiaries, the IRS should remove Medicaid and CHIP premiums from HIPF calculations for the following MCOs in the following amounts:

- Amerigroup Kansas, Inc.: \$597,314,270
- Sunflower State Health Plan, Inc.: \$645,123,714
- United Healthcare of the Midwest, Inc.: premiums for both Kansas and Missouri were \$876,859,568 for Fee Year 2018, of which Kansas premiums represent roughly 35-40%

If it is discovered that the above list contains errors, or is otherwise incomplete, we reserve the right to supplement this protest with additional information as it becomes available to us.

Accordingly, the final notice that will be received by Medicaid and CHIP MCOs on or before August 31, 2018, 26 C.F.R. § 57.4(b), should be appropriately

amended to exclude from your calculations and allocated amounts the premiums for Medicaid and CHIP in Kansas.

In advance, we thank you for your time and attention to correcting this legal wrong, honoring the will of Congress, and ensuring that Kansas is better able to fully serve and provide for the health care needs of Kansans.

Sincerely,



Jonathan J. Handorf
Director, Division of Health Care Finance

cc: Department of the Treasury
Internal Revenue Service
1973 Rulon White Blvd., Mail Stop 4916 – IPF
Ogden, UT 84201-0051
via overnight delivery
—and—
via facsimile to 877-797-0235
—and—
via e-mail to LBI.IPF@irs.gov

Brett Shumate
Deputy Assistant Attorney General
Federal Programs Branch, Civil Division
U.S. Department of Justice
950 Pennsylvania Ave, NW
Washington, D.C. 20530



State of Louisiana
DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
P.O. BOX 94005
BATON ROUGE
70804-9005

Jeff Landry
Attorney General

July 13, 2018

David J. Kautter, Acting Commissioner
Internal Revenue Service
Department of the Treasury
1111 Constitution Ave, NW
Washington, D.C. 20224
Via FedEx Overnight: 813393414575

Re: Preliminary Calculations (Letters 5066C) for Managed Care Organizations that Provide Medicaid and CHIP Services in Louisiana

Acting Commissioner Kautter:

I write on behalf of the State of Louisiana and its Department of Health (LDH). LDH oversees the administration of Medicaid and the Children's Health Insurance Program (CHIP) in Louisiana. A significant proportion of the State's annual budget provides funds to support these programs, funds which come from Louisiana taxpayers.

Your agency will collect \$14,300,000,000 this year for the Health Insurance Providers Fee (HIPF) under the Affordable Care Act (ACA). 26 C.F.R. § 57.4(a)(3). Your current methods for calculating the ratio-based distribution of this predetermined liability yield an unlawful result—one belied by the text of the ACA, which exempts governmental entities from liability for the HIPF. ACA § 9010(c)(2)(B).

We respectfully request that your agency alter its approach, and not include managed care organization (MCO) premiums for Medicaid and the Children's Health Insurance Program (CHIP), in your HIPF calculations. Doing so will *not* reduce the amount collected as IRS will still collect \$14,300,000,000. However, making this change will ensure that the liability for HIPF Year 2018 is properly distributed and does not violate the clear language of the ACA.

You are aware that Louisiana, along with Texas, Indiana, Wisconsin, Nebraska, and Kansas, challenged the prior, unlawful imposition of the Health Insurance Providers Fee (HIPF) on Medicaid and CHIP managed care contracts. On March 5, 2018, the United States District Court for the Northern District of Texas ruled that the imposition of the HIPF on Medicaid managed care contracts is unlawful. *Texas et al. v. United States et al.*, No. 7:15-cv-00151, 2018 WL 1478250 (N.D. Tex. Mar. 5, 2018). The heart of the court's ruling is that, "[i]n the ACA [(Affordable Care Act)], Congress expressly exempted states from paying the HIPF." *Id.* at *2 (citing ACA § 9010(c)(2)(B) (2010); 26 C.F.R. § 57.2(b)(2)(ii)(B)).

Your agency recently sent Letter 5066Cs to the managed care organizations (MCOs) with whom LDH contracts to provide Medicaid and CHIP services in Louisiana. Specifically, your agency's Letter 5066Cs calculations for the HIPF for Fee Year 2018 are in error.

A0015

As you can understand, Louisiana takes seriously the responsibility to assist those who rely upon the Medicaid and CHIP programs for their health care needs. As such, the more resources that are available, the more the LDH is able to assist our residents who need the benefits of these programs.

By burdening our Medicaid and CHIP MCOs with the imposition of the HIPF, you burden Louisiana taxpayers and the millions of our residents who rely upon these programs. In other words, if you impose the HIPF on our Medicaid and CHIP MCOs, you functionally impose the HIPF on Louisiana and harm the millions of our residents who rely upon these programs for their health care needs. Apart from the direct harm this unnecessarily inflicts on our residents, your agency’s protocols also violate the ACA because “[t]he ACA explicitly excludes states from the definition of ‘covered entities,’ thereby exempting [Louisiana] from paying the HIPF.” *Id.* (citing ACA § 9010(c)(2)(B)).

Given these circumstances, the methodology the IRS is using—including contracts and premiums for Medicaid and CHIP in calculating HIPF allocations—fails to account for the exemption Louisiana has from this fee within the ACA, ACA § 9010(c)(2)(B), as well as the recent opinion of the court. The efforts of the IRS are presently imposing a direct harm on Medicaid and CHIP programs designed to assist those that need governmental assistance the most.

The IRS should not include premiums for Medicaid and CHIP by Louisiana’s MCOs in calculating the HIPF for Fee Year 2018. Your agency has the necessary discretion to honor the clear language of Congress and exempt Medicaid and CHIP contracts from consideration in your HIPF calculations. Given Louisiana’s undeniable statutory exemption from the HIPF, the court’s ruling, and the current calculations’ negative impact on Medicaid and CHIP, I ask the IRS to remove Medicaid and CHIP premiums from HIPF calculations for the following services providers and in the following amounts:

EIN(s)	Provider	LA Medicaid & CHIP Premiums
72-1074008 (on Form 8963 filed by 41-1321939)	United Healthcare/United Healthcare of LA	1,074,023,886
EIN Not Available ¹	Centene/La. Health Care Connections, Inc.	\$2,103,706,383
74-2381406 (on Form 8963 filed by 23-2229683)	Aetna, Inc./Aetna Health, Inc. (LA)	\$102,144,404
80-0629718 (on Form 8963 filed by 23-2229683)	Aetna Inc./Aetna Better Health, Inc. (LA)	\$592,308,463
EIN Not Available ²	Independence Health Group Inc./AmeriHealth Caritas Louisiana, Inc.	\$1,020,347,401
35-2145715 (on Form 8963 filed by 35-2145715)	Anthem, Inc. and Subsidiaries/AMERIGROUP Louisiana, Inc.	\$947,539,326

¹ Louisiana can supplement with the provider’s EIN if necessary.

² Louisiana can supplement with the provider’s EIN if necessary.

52-2459969 (on Form 8963 filed by 45-2542951)	MCNA Health Care Holdings, LLC/MCNA Ins. Co.	\$816,810,206 <i>(total reported – LA premiums not separately reported)</i> ³
65-0303864 (on Form 8963 filed by 45-2542951)	MCNA Health Care Holdings, LLC/ Managed Care of North America Inc.	\$11,155,976 <i>(total reported – LA premiums not separately reported)</i> ⁴

To the extent that the above list contains errors or is otherwise incomplete, we reserve the right to supplement this protest with additional information as it becomes available to us.

Accordingly, the final notice that will be received by Medicaid and CHIP MCOs on or before August 31, 2018, 26 C.F.R. § 57.4(b), should be appropriately amended to exclude from your calculations and allocated amounts the above listed premiums for Medicaid and CHIP in Louisiana.

In advance, we thank you for your time and attention to correcting this legal wrong, honoring the will of Congress, and ensuring that Louisiana is better able to fully serve and provide for the health care needs of its citizens.

Sincerely,



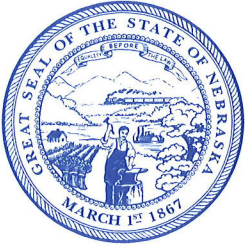
Jeff Landry
Attorney General

cc: Department of the Treasury
Internal Revenue Service
1973 Rulon White Blvd., Mail Stop 4916 – IPF
Ogden, UT 84201-0051
via FedEx: 813393414586
—and—
via facsimile at 877-797-0235
—and—
via e-mail at LBI.IPF@irs.gov

Brett Shumate
Deputy Assistant Attorney General
Federal Programs Branch, Civil Division
U.S. Department of Justice
950 Pennsylvania Ave, NW
Washington, D.C. 20530

³ Louisiana can supplement this request with the portion of these premiums attributed to Louisiana.

⁴ Louisiana can supplement this request with the portion of these premiums attributed to Louisiana.



STATE OF NEBRASKA
Office of the Attorney General

2115 STATE CAPITOL BUILDING
LINCOLN, NE 68509-8920
(402) 471-2682
TDD (402) 471-2682
FAX (402) 471-3297 or (402) 471-4725

DOUGLAS J. PETERSON
ATTORNEY GENERAL

August 30, 2018

Mr. David J. Kautter
Acting Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224
VIA OVERNIGHT DELIVERY

Re: Preliminary Calculations (Letters 5066C) for Managed Care
Organizations that Provide Medicaid Services

Dear Commissioner Kautter:

I write on behalf of the State of Nebraska and its Department of Health and Human Services (NDHHS). NDHHS oversees the administration of Medicaid and the Children's Health Insurance Program (CHIP) in Nebraska. A significant portion of the State's annual budget provides funds to support these programs, funds which come from Nebraska taxpayers.

We take seriously our responsibility to assist those that rely upon Medicaid for their health care needs. As such, the more resources we have available, the more we are able to assist members of our programs. It was therefore disappointing to see the Letter 5066Cs that you sent to our Medicaid managed care organizations (MCOs) regarding your agency's calculations for the Health Insurance Providers Fee for Fee Year 2018.

As a Defendant in the matter, you are aware that Nebraska, along with five other States, challenged the Health Insurance Providers Fee (HIPF) as reimbursed by the states to the Medicaid managed care contracts. On March 5, 2018, the United States District Court for the Northern District of Texas ruled that "[i]n the ACA [(Affordable Care Act)], Congress expressly exempted states from paying the HIPF." *Id.* at *2 (citing ACA § 9010(c)(2)(B) (2010); 26 C.F.R. § 57.2(b)(2)(ii)(B)). *Texas et al. v. United States et al.*, No. 7:15-cv-00151, 2018 WL 1478250 (N.D. Tex. Mar. 5, 2018).

By burdening our Medicaid MCOs with the imposition of the HIPF, you burden Nebraska and the members that rely upon the program and services. As the court found, "[s]ince the HIPF is a non-deductible tax, ASOP 49 effectively required states

A0019

to pay MCOs the full amount of the HIPF in their capitation rates, because an AAA actuary could no longer certify the capitation rate as actuarially sound unless it did so.” *Id.* at *5 (footnote omitted). Therefore, if you impose the HIPF on our Medicaid MCOs, you impose the HIPF on Nebraska and harm both the members of the Medicaid program and the taxpayers of the state who contribute to the state share of Medicaid costs. Apart from the direct harm, imposition of the HIPF against MCOs that will be reimbursed by Nebraska Medicaid fails to recognize that “[t]he ACA explicitly excludes states from the definition of ‘covered entities,’ thereby exempting them from paying the HIPF.” *Id.* (citing ACA § 9010(c)(2)(B)).

Given these circumstances, the IRS inclusion of contracts for Medicaid in calculating HIPF allocations fails to account for the express language of Congress, and also for the court’s ruling (which involves your agency as a Defendant), as well as the needs of Medicaid members. In as much as the ACA is designed to help more Americans with their health care needs, the efforts of the IRS are presently imposing a direct harm upon the Medicaid program that assists those most in need.

As you know, the calculations performed by the IRS for the 2018 Fee Year are a ratio-based distribution of a predetermined liability of \$14,300,000,000. By whatever measure, the result of your calculations still yields \$14,300,000,000 into the Federal Treasury. Your present methodology of calculations functions as a federal tax upon Medicaid despite IRS discretion to honor the clear language of Congress and appropriately exempt Medicaid and CHIP contracts from consideration.

Given the undeniable exemption from the HIPF provided by Congress, the ruling of the court, and considering the negative impact your calculations are having upon Medicaid and CHIP, the Internal Revenue Service should not calculate the HIPF in the manner currently being employed. Accordingly, IRS should not include premiums for public health care programs for the six States involved in the lawsuit (Texas, Indiana, Kansas, Louisiana, Nebraska, and Wisconsin) in its calculations for the HIPF for Fee Year 2018, or any other year.

The final notice that the IRS will provide to MCOs on or before August 31, 2018 should be appropriately amended to exclude from calculations and allocated amounts all premiums for public health care programs in Texas, Indiana, Kansas, Louisiana, Nebraska, and Wisconsin.

In advance, we thank you for your time and attention to correcting this legal wrong.

Sincerely,



David Bydalek
Chief Deputy Attorney General

cc: Department of the Treasury
Internal Revenue Service
1973 Rulon White Blvd., Mail Stop 4916-IPF
Ogden, UT 84201-0051
via overnight delivery
--and--
via facsimile at 877-797-0235
--and--
via email at LBI.IPF@irs.gov

Brett Shumate
Deputy Assistant Attorney General
Federal Programs Branch, Civil Division
U.S. Department of Justice
950 Pennsylvania Ave., NW
Washington, D.C. 20530

A0021



KEN PAXTON
ATTORNEY GENERAL OF TEXAS

July 13, 2018

VIA OVERNIGHT DELIVERY

David J. Kautter, Acting Commissioner
Internal Revenue Service
Department of the Treasury
1111 Constitution Ave, NW
Washington, D.C. 20224

Re: Preliminary Calculations (Letters 5066C) for Managed Care Organizations that
Provide Medicaid and CHIP Services in Texas

Acting Commissioner Kautter:

Your agency will collect \$14,300,000,000 this year for the Health Insurance Providers Fee (HIPF) under the Affordable Care Act (ACA). 26 C.F.R. § 57.4(a)(3). Your current methods for calculating the ratio-based distribution of this predetermined liability yield an unlawful result—one belied by the text of the ACA, which exempts governmental entities from liability for the HIPF. ACA § 9010(c)(2)(B).

We respectfully request that your agency alter its approach, and not include managed care organization (MCO) premiums for Medicaid and the Children's Health Insurance Program (CHIP), in your HIPF calculations. Doing so will *not* reduce the amount collected as IRS will still collect \$14,300,000,000. However, making this change will ensure that the liability for HIPF Year 2018 is properly distributed and not violate the clear language of the ACA.

I write on behalf of the Texas Health and Human Services Commission. The Texas Health and Human Services Commission oversees the administration of Medicaid and the Children's Health Insurance Program (CHIP) in Texas. Medicaid and CHIP provide medical coverage for more than 4 million low-income Texans. The programs cover half of all children in Texas and help provide care for two-thirds of those in Texas nursing homes.

As you can understand, the Texas Health and Human Services Commission takes seriously the responsibility to assist those who rely upon the Medicaid and CHIP programs for their health care needs. As such, the more resources that are available, the more the Texas Health and Human Services Commission is able to assist the Texans who need the benefits of these programs.

Your agency recently sent many Letter 5066Cs to the managed care organizations (MCOs) with whom the Texas Health and Human Services Commission contracts to provide Medicaid and CHIP services in Texas. Specifically, your agency's calculations for the HIPF for Fee Year 2018, as reflected in the many Letter 5066Cs that your agency sent to the Texas MCOs, are in error.

A0023

You are aware that Texas, along with five other States, challenged the prior, unlawful imposition of the Health Insurance Providers Fee (HIPF) on Medicaid and CHIP managed care contracts. On March 5, 2018, the United States District Court for the Northern District of Texas ruled that the imposition of the HIPF on Medicaid managed care contracts is unlawful. *Texas et al. v. United States et al.*, No. 7:15-cv-00151, 2018 WL 1478250 (N.D. Tex. Mar. 5, 2018). The heart of the court's ruling is that, "[i]n the ACA [(Affordable Care Act)], Congress expressly exempted states from paying the HIPF." *Id.* at *2 (citing ACA § 9010(c)(2)(B) (2010); 26 C.F.R. § 57.2(b)(2)(ii)(B)). A copy of the Court's opinion is enclosed for your convenience.

By burdening our Medicaid and CHIP MCOs with the imposition of the HIPF, you burden Texas taxpayers and the millions of Texans who rely upon these programs. In other words, if you impose the HIPF on our Medicaid and CHIP MCOs, you functionally impose the HIPF on Texas and harm the millions of Texans who rely upon these programs for their health care needs. Apart from the direct harm this unnecessarily inflicts on Texans, your agency's protocols also violate the ACA because "[t]he ACA explicitly excludes states from the definition of 'covered entities,' thereby exempting [Texas] from paying the HIPF." *Id.* (citing ACA § 9010(c)(2)(B)).

Given these circumstances, the methodology the IRS is using—including contracts and premiums for Medicaid and CHIP in calculating HIPF allocations—fails to account for the exemption Texas has from this fee within the ACA, ACA § 9010(c)(2)(B), as well as the recent opinion of the court, *supra*. The efforts of the IRS are presently imposing a direct harm on Medicaid and CHIP programs designed to assist those that need governmental assistance the most.

As you know, the calculations performed by the IRS for the 2018 Fee Year are merely a ratio-based distribution of a predetermined liability of \$14,300,000,000. By whatever measure, the result of your calculations still yields \$14,300,000,000 into the Federal Treasury. Yet, your present methodology of calculations functions as a federal tax on programs for the poor—Medicaid and CHIP. However, your agency has the necessary discretion to honor the clear language of Congress and appropriately exempt Medicaid and CHIP contracts from consideration in your HIPF calculations.

Given Texas's undeniable statutory exemption from the HIPF, the court's ruling, and the current calculations' negative impact on Medicaid and CHIP, I ask the IRS to change course. IRS should not include premiums for Medicaid and CHIP by Texas's MCOs in calculating the HIPF for Fee Year 2018.

To protect Texas taxpayers and program beneficiaries, IRS should remove Medicaid and CHIP premiums from HIPF calculations for the following services providers and in the following amounts:

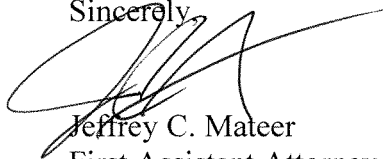
EIN(s)	Provider	Net Premiums	Texas Medicaid & CHIP Premiums
36-2739571 (on Form 8963 filed by 41-1321939)	UnitedHealthcare Insurance Company	38,597,929,955	543,654,232
91-2008361 (on Form 8963 filed by 41-1321939)	UnitedHealthcare Community Plan of Texas, LLC	1,550,539,163	1,106,962,302
39-0993433 (on Form 8963 filed by 42-1406317)	Bankers Reserve Life Insurance Company of Wisconsin	1,393,803,314	1,393,803,314
74-2770542 (on Form 8963 filed by 42-1406317)	Superior HealthPlan, Inc.	2,704,193,113	2,537,162,351
74-2052197	Scott & White Health Plan	701,120,890	121,718,612
27-0522725 (on Form 8963 filed by 13-4204626)	Molina Healthcare of Texas Insurance Company	39,937,267	39,937,267
20-1494502 (on Form 8963 filed by 13-4204626)	Molina Healthcare of Texas, Inc.	1,722,146,705	822,654,286
52-2459969 (on Form 8963 filed by 45-2542951)	MCNA Insurance Company	816,810,206	581,634,658
20-8534298 (on Form 8963 filed by 06-1059331)	Healthspring Life & Health Insurance Company, Inc.	1,501,292,380	283,227,934
72-2569094	SHA LLC	569,086,557	276,679,796
20-2970185 (on Form 8963 filed by 04-6143185)	DentaQuest USA Insurance Company, Inc.	799,401,899	780,122,886

47-5395483 (on Form 8963 filed by 06-1341715)	Seton Insurance Company	511,301	511,301
74-2725348	Seton Health Plan Inc.	58,106,336	58,106,336
36-1236610	Health Care Service Corporation, a Mutual Legal Reserve Company (d/b/a Blue Cross and Blue Shield of Texas)	218,318,408 (part of the 30,208,507,118 reported on line 1 of the Schedule A of the Form 8963)	218,318,408
75-2603231 (on Form 8963 filed by 35-2145715)	AMERIGROUP Texas, Inc.	2,514,229,022	1,985,584,291
45-2485907 (on Form 8963 filed by 35-2145715)	Amerigroup Insurance Company	965,450,480	762,453,735
74-1844335 (on Form 8963 filed by 23-2229683)	Aetna Better Health of Texas Inc.	282,317,038	282,317,038

To the extent that the above list contains errors, or is otherwise incomplete, we reserve the right to supplement this protest with additional information as it becomes available to us.

Accordingly, the final notice that will be received by Medicaid and CHIP MCOs on or before August 31, 2018, 26 C.F.R. § 57.4(b), should be appropriately amended to exclude from your calculations and allocated amounts the above listed premiums for Medicaid and CHIP in Texas.

In advance, we thank you for your time and attention to correcting this legal wrong, honoring the will of Congress, and ensuring that Texas is better able to fully serve and provide for the health care needs of its citizens.

Sincerely,

 Jeffrey C. Mateer
 First Assistant Attorney General

Enclosure

cc: Department of the Treasury
 Internal Revenue Service

1973 Rulon White Blvd., Mail Stop 4916 – IPF
Ogden, UT 84201-0051

via overnight delivery

—and—

via facsimile at 877-797-0235

—and—

via e-mail at LBI.IPF@irs.gov

Brett Shumate

Deputy Assistant Attorney General

Federal Programs Branch, Civil Division

U.S. Department of Justice

950 Pennsylvania Ave, NW

Washington, D.C. 20530

via overnight delivery

Scott Walker
Governor



1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711

July 13, 2018

Mr. David J. Kautter
Acting Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Preliminary Calculations (Letters 5066C) for Managed Care Organizations that Provide Medicaid Services

Dear Commissioner Kautter:

The Wisconsin Department of Health Services (DHS), Division of Medicaid Services (DMS) oversees the administration of the Medicaid program in Wisconsin. Medicaid provides health care coverage for more than 1.2 million low-income residents of Wisconsin. The programs cover half of all children in Wisconsin and helps provide care for two-thirds of Wisconsin nursing home residents. Most Medicaid services are currently delivered through managed care health plans under contract with the Department.

We take seriously our responsibility to assist those that rely upon Medicaid for their health care needs. As such, the more resources we have available, the more we are able to assist members of our programs. It was, thus, disappointing to see the Letter 5066Cs that you sent to our Medicaid managed care organizations regarding your agency's calculations for the Health Insurance Providers Fee for Fee Year 2018.

As a Defendant in the matter, you are aware that Wisconsin, along with five other States, challenged the Health Insurance Providers Fee (HIPF) as reimbursed by the states to the Medicaid managed care contracts. On March 5, 2018, the United States District Court for the Northern District of Texas ruled that "[i]n the ACA [(Affordable Care Act)], Congress expressly exempted states from paying the HIPF." *Id.* at *2 (citing ACA § 9010(c)(2)(B) (2010); 26 C.F.R. § 57.2(b)(2)(ii)(B)). *Texas et al. v. United States et al.*, No. 7:15-cv-00151, 2018 WL 1478250 (N.D. Tex. Mar. 5, 2018).

By burdening our Medicaid MCOs with the imposition of the HIPF, you burden Wisconsin and the members that rely upon the program and services. As the court found, "[s]ince the HIPF is a non-deductible tax, ASOP 49 effectively required states to pay MCOs the full amount of the HIPF in their capitation rates, because an AAA actuary could no longer certify the capitation rate as actuarially sound unless it did so." *Id.* at *5 (footnote omitted). Therefore, if you impose the HIPF on our Medicaid MCOs, you impose the HIPF on Wisconsin and harm

A0029

both the members of the Medicaid program and the taxpayers of the state who contribute to the state share of Medicaid costs. Apart from the direct harm, imposition of the HIPF against MCOs that will be reimbursed by Wisconsin Medicaid fails to recognize that “[t]he ACA explicitly excludes states from the definition of ‘covered entities,’ thereby exempting them from paying the HIPF.” *Id.* (citing ACA § 9010(c)(2)(B)).

Given these circumstances, the IRS inclusion of contracts for Medicaid in calculating HIPF allocations fails to account for the express language of Congress, and also for the court’s ruling (which involves your agency as a Defendant), as well as the needs of Medicaid members. In as much as the ACA is designed to help more Americans with their health care needs, the efforts of the IRS are presently imposing a direct harm upon the Medicaid program that assists those most in need.

As you know, the calculations performed by the IRS for the 2018 Fee Year are a ratio-based distribution of a predetermined liability of \$14,300,000,000. By whatever measure, the result of your calculations still yields \$14,300,000,000 into the Federal Treasury. Your present methodology of calculations functions as a federal tax upon Medicaid despite IRS discretion to honor the clear language of Congress and appropriately exempt Medicaid and CHIP contracts from consideration.

Given the undeniable exemption from the HIPF provided by Congress, the ruling of the court, and considering the negative impact your calculations are having upon Medicaid and CHIP, the Internal Revenue Service should not calculate the HIPF in the manner currently being employed. Accordingly, IRS should not include premiums for public health care programs for the six States involved in the lawsuit (Texas, Indiana, Kansas, Louisiana, Nebraska, and Wisconsin) in its calculations for the HIPF for Fee Year 2018, or any other year.

The final notice that the IRS will provide to MCOs on or before August 31, 2018 should be appropriately amended to exclude from calculations and allocated amounts all premiums for public health care programs in Texas, Indiana, Kansas, Louisiana, Nebraska, and Wisconsin.

In advance, we thank you for your time and attention to correcting this.

Sincerely,

A handwritten signature in black ink, appearing to read "Heather K. Smith". The signature is fluid and cursive, written over a white background.

Heather K. Smith

Wisconsin Medicaid Director

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION**

TEXAS,
KANSAS,
LOUISIANA,
INDIANA,
WISCONSIN, and
NEBRASKA,

Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, ALEX AZAR,
in his Official Capacity as
SECRETARY OF HEALTH AND
HUMAN SERVICES, UNITED
STATES INTERNAL REVENUE
SERVICE, and DAVID J. KAUTTER,
in his Official Capacity as
ACTING COMMISSIONER OF
INTERNAL REVENUE,

Defendants.

CIVIL ACTION NO. 7:15-CV-00151-O

DECLARATION OF ADAM C. PROFFITT

My name is Adam C. Proffitt. I am over the age of 18 and fully competent to make this declaration and state the following:

Background

1. I am the Director of Program Finance and Informatics in the Division of Health Care Finance (DHCF or Division) of the Kansas Department of Health and Environment (KDHE).
2. I am not retained or specially employed to provide expert testimony in this case, nor do my duties as an employee of the State of Kansas regularly involve giving expert testimony in cases.
3. The statutory mission of the DHCF is to develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies. The DHCF includes Electronic Health Records, Health Information Technology and Health Information Exchange, Kansas's Managed Medicaid and CHIP Programs (known as KanCare), Medicaid Program Integrity, Office of Inspector General, Projections and Informatics, and the State Employee Health Plan.
4. The Office of the Director of Program Finance and Informatics provides oversight to numerous State programs and activities that spend Medicaid funds and are managed by other State agencies to ensure adherence to State and federal regulations. It is responsible for computing the fiscal impact of proposed health care-related policies, providing analytical support to KDHE program managers, performing program reviews, and responding to analytical requests related to the Medical Management Information Systems (MMIS) from stakeholders within and outside of DHCF. Additional information is available at http://www.kdheks.gov/hcf/sehp/proj_informatics.htm.

5. Kansas provides nearly all of its Medicaid and CHIP health care services through managed care arrangements. In Kansas's Managed Medicaid and CHIP Programs (KanCare), Kansas enters into contracts with managed care organizations (MCOs), whereby the MCOs agree to deliver healthcare services in exchange for a fixed monthly payment, known as a "capitation payment" or "capitation rate."
6. In my position as the Director of Program Finance and Informatics I am aware of the Managed Care Organizations (MCOs) that contract with the State and the Health Insurances Providers Fee (HIPF) that the MCOs are required to pay the Internal Revenue Service (IRS).
7. I and my Office are involved in Medicaid and CHIP capitation rate development, contract negotiations, health care policy, financial management of Managed Care Organizations (MCOs), and health care financial reporting.
8. In Kansas, Medicaid and CHIP are jointly funded by both Kansas and the United States.

Affordable Care Act Health Insurance Providers Fee

9. Under Section 9010 of the Affordable Care Act, the HIPF is imposed on certain health insurance providers ("covered entities"). Historically, the HIPF has been imposed on the MCOs Kansas contracts with for its Medicaid and CHIP services.
10. The HIPF is assessed annually based on the prior year's premiums received. Covered entities report their company's net premiums written for health insurance on the IRS Form 8963.
11. The IRS began collecting the HIPF in 2014. In calculating the HIPF for each covered entity the IRS starts with the total amount of money it is directed to raise through the HIPF. For 2018, that amount is \$14.3 billion. The IRS then

allocates to the non-exempted “covered entities” their share of the HIPF based on the aggregate net premiums the covered entity has written for health insurance of United States health risks.

12. The Affordable Care Act exempts governments from the HIPF. See ACA § 9010(c)(2)(B). However, to date, the IRS has not excluded from HIPF liability Kansas Medicaid and CHIP program premiums reported by Kansas MCOs.
13. I am aware that the Affordable Care Act prohibits the HIPF from being imposed on States, other governmental entities, and certain non-profit organizations, but to date the IRS has not exempted from its calculations of liability for the HIPF the MCO premiums attributable to State Medicaid and CHIP programs.
14. All three of Kansas’ MCOs have been subject to the HIPF in the past, including in fee year 2018.

Impact of the HIPF on Kansas Medicaid and CHIP Programs

15. Because the IRS has included Kansas’s MCOs’ Medicaid and CHIP premiums in its calculation of HIPF liability, Kansas Medicaid and CHIP premiums have created HIPF liability for Kansas MCOs.
16. In previous years, Kansas has reimbursed its MCOs for the amount of the HIPF attributable to Kansas Medicaid and CHIP premiums. KDHE did so because federal regulations, which Kansas since has successfully challenged in court, purported to require the State to reimburse the HIPF in addition to the capitation rates necessary to provide Medicaid and CHIP services.
17. Kansas has reimbursed its MCOs for HIPF liability in the following amounts for the following fee years:

2014: \$32,837,960

2015: \$57,227,731

2016: \$52,056,085

There was a statutory moratorium on the HIPF for 2017. But it is being imposed for fee year 2018. If not exempted, I estimate that the 2018 HIPF reimbursements for Kansas Medicaid and CHIP programs will be approximately \$68.8 million.

18. I have reviewed the Form 8963s that the Kansas MCOs submitted to the IRS on or before April 17, 2018, as well as the Letter 5066Cs that the IRS issued to the Kansas MCOs. Through these documents, I was able to confirm that the IRS included the Medicaid and CHIP premiums of Kansas MCOs in its calculation of the overall 2018 HIPF liability and the portions assessed against Kansas MCOs.
19. In July 2018, DHCF sent a letter to IRS that objected to the inclusion of the Medicaid and CHIP premiums of its MCOs in the IRS's calculation of the overall 2018 HIPF liability for the Kansas MCOs. To date, DHCF has received no response from the IRS, other than a confirmation of receipt.
20. On or about August 31, 2018, the IRS issued the final HIPF calculations (Letter 5067Cs) to the Kansas MCOs. I have reviewed these final HIPF calculations and can verify that they continue to include the value of Kansas's Medicaid and CHIP premiums as part of the basis upon which the HIPF liability is calculated.
21. In order for its Medicaid and CHIP contracts with its MCOs to be actuarially sound, DHCF has determined that it must reimburse the Kansas MCOs for the HIPF that they are expected to pay to the IRS no later than October 1, 2018.

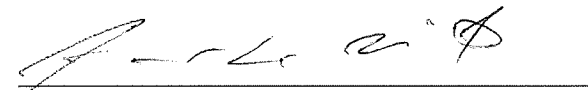
Actuarial Soundness

22. As determined by Congress and standards of practice within managed medical care, actuarial soundness is an important requirement in Medicaid and CHIP managed care rate setting.
23. Kansas has contracted with Aon Consulting, Inc., an Aon Hewitt company, to assist DHCF in developing actuarially sound rate ranges for MCOs participating in KanCare.
24. It is my opinion that for Kansas's capitation rates to continue to be actuarially sound for 2018, the HIPF must still be added to the capitation rates. My opinion is based on facts and data I have been made aware of or personally observed. Experts in the field of health care finance would reasonably rely on those kinds of facts or data in forming an opinion on the subject.
25. Aon Hewitt has informed KDHE as follows:
"Section 9010 of ACA requires each non-exempt health insurer to pay a portion of the total [health insurance providers tax (HIT)] amount based on the insurer's share of total non-exempt net written health insurance premiums. This includes Medicaid MCOs. This fee and the tax consequence of the fee being non-tax deductible must be included in the capitation rates to maintain the actuarial soundness of the capitation rates. Therefore, a HIT adjustment to the capitation rate range to cover the expected cost of the fee is included as part of the capitation rate development."
26. It is my opinion that for Kansas's capitation rates to be actuarially sound, as required by 42 U.S.C. § 1396b, the HIPF must be added to the capitation rates negotiated with the MCOs.
27. My opinions have been developed in my official capacity as Director of Program Finance and Informatics for KDHE. All of the facts and data utilized by me in

preparing my opinions and the information contained herein are the type and kinds of data that professionals within my fields of expertise typically rely upon. Any information and documents I consulted were kept in the regular course of business, and many were public records in Kansas. They were created by personnel, with knowledge of the act, event, condition, opinion, diagnosis, or information recorded made the record, or transmitted the information to be included in the record or document. Finally, these documents were created at or near the time of the act, event, condition, or information recorded.

28. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 11th day of September, 2018.



Adam C. Proffitt
Director of Program Finance and Informatics
Division of Health Care Finance
Kansas Department of Health and Environment

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION**

TEXAS,
KANSAS,
LOUISIANA,
INDIANA,
WISCONSIN, and
NEBRASKA,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, AND DAVID J. KAUTTER, in his Official Capacity as ACTING COMMISSIONER OF INTERNAL REVENUE,

Defendants.

§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§

Civil Action No. 7:15-CV-00151-O

DECLARATION OF F. RONALD OGBORNE III

My name is **F. Ronald Ogborne III** and I am over the age of 18 and fully competent to make this declaration, and state the following:

1. I am a partner of Mercer Health & Benefits, LLC (“Mercer”), and an actuarial consultant with Mercer’s Government Health Services Consulting group. I have provided actuarial consulting services to numerous state Medicaid agencies since 2008. Since 2017, I have provided actuarial consulting services to the Louisiana Department of Health (LDH). I am the lead actuarial consultant on this engagement. My duties include overseeing the development of the Medicaid and CHIP managed care capitation rates paid to the managed care organization that contract with LDH, and assisting LDH with other matters requiring actuarial expertise.
2. I hold a Bachelor of Science degree in Mathematics and a Bachelor of Arts in Economics from the State University of New York at Fredonia as well as a Masters of Arts in Mathematics from Arizona

State University. I am a Member of the American Academy of Actuaries, a Fellow of the Society of Actuaries, and a Chartered Enterprise Risk Analyst.

3. I am making this declaration at the request of my client in connection with the captioned proceeding. The actuarial opinions expressed in this declaration have been developed in my capacity as Mercer's lead actuarial consultant for LDH. All of the facts, data and documents utilized by me in preparing my opinions and the information contained herein are the type and kinds of data that professionals within my field of expertise typically rely upon. The documents I have reviewed are listed elsewhere in this declaration.
4. My regular duties as an employee of Mercer Health and Benefits, LLC do not regularly involve giving expert testimony. I have not published any articles, nor have I previously been deposed. I am not receiving any additional personal compensation for providing this declaration, which is within the regular course and scope of my duties. Mercer will be billing its client, LDH, standard hourly rates under our client contract for time spent on this engagement. My standard hourly rate on this engagement is \$459/hr.
5. Louisiana provides nearly all of its Medicaid and CHIP health care services through managed care arrangements. To do this, Louisiana enters into contracts with managed care organizations (MCOs), whereby the MCOs agree to deliver healthcare services to covered persons in exchange for a fixed monthly payment, known as a "capitation payment" or "capitation rate."
6. In my position as lead actuarial consultant for LDH, I am aware of all the MCOs that contract with Louisiana Medicaid and which of those MCOs pay the Health Insurance Providers Fee ("HIPF") that the MCOs are required to pay the Internal Revenue Service under the Affordable Care Act. Mercer is responsible for Medicaid and CHIP capitation rate development for Louisiana's Medicaid managed care programs. I am the actuary who certifies the capitation rates to the Department of Health & Human Services, Centers for Medicare & Medicaid Services ("CMS") as meeting the federal requirements.
7. The HIPF is a federally mandated fee that is applied to the health insurance industry. In essence, it functions as a federal premium tax on certain health insurers. It is assessed annually, with the amount of each insurer's fee being based on the prior year's premiums. The insurers subject to the HIPF ("covered entities") report their company's net premiums written for health insurance on the IRS Form 8963.
8. The annual HIPF for years through 2018 has been fixed each year by §9010 of the Affordable Care Act. The total nationwide amount of the HIPF that the IRS will collect is known. The Internal Revenue Service (IRS) began collecting the HIPF in 2014. In calculating the HIPF for each "covered entity," the IRS starts with the total amount of money it is directed to raise through the HIPF. For 2018, that amount is \$14.3 billion. The IRS then allocates to the non-exempted "covered entities" their share of the nationwide HIPF based on the aggregate net premiums the covered entity has written for health insurance of United States health risks.
9. I am aware that the Affordable Care Act exempts governments from the HIPF. See ACA §9010(c)(2)(B). However, to date, the IRS has not excluded Medicaid and CHIP program premiums reported by covered entities from HIPF liability.

10. Because the IRS has historically included the Louisiana MCOs' Medicaid and CHIP premiums in its calculation of HIPF liability, the premiums that Louisiana has paid for Medicaid and CHIP have resulted in HIPF costs for Louisiana.
11. In previous years, LDH has incorporated into the capitation rates for its MCOs the amount of the HIPF attributable to the Louisiana Medicaid and CHIP premiums. LDH did so because federal regulations, which Louisiana has successfully challenged in court, purported to require LDH to include the HIPF as a cost in the determination of the capitation rates for Medicaid and CHIP services.
12. Louisiana has recognized the cost of the HIPF in capitation rates paid to its MCOs for the HIPF paid in the prior HIPF years of 2014, 2015, and 2016. There was a statutory moratorium on the HIPF for 2017. However, the HIPF is being imposed for fee year 2018. If not exempted, I estimate that the additions that LDH will be required to make to recognize the 2018 HIPF costs for Louisiana Medicaid and CHIP programs will be approximately \$191.1 million.
13. I reviewed the Forms 8963 that the Louisiana Medicaid MCOs submitted to the IRS on or before April 17, 2018, as well as the Letters 5066C (preliminary notice of 2018 HIPF liability) that the IRS issued to the Louisiana MCOs. Through these documents, I was able to confirm that the IRS included the Medicaid and CHIP premiums of the Louisiana Medicaid MCOs in its calculation of the overall 2018 HIPF liability and the portions assessed against the Louisiana Medicaid MCOs.
14. I am aware that the Louisiana Attorney General sent a letter to IRS that objected to the inclusion of the Medicaid and CHIP premiums of its MCOs in the IRS's calculation of the overall 2018 HIPF liability for the Louisiana MCOs. To date, my understanding is that neither the Louisiana Attorney General nor Louisiana Medicaid has received a response from the IRS.
15. On August 29, 2018, the IRS issued the final HIPF calculations (Letters 5067C) to the Louisiana MCOs. I have reviewed these final HIPF calculations and can verify that they continue to include the value of the Louisiana Medicaid and CHIP premiums as part of the basis upon which the HIPF liability is calculated. Per the Letters 5067C, the MCOs are to pay the IRS the HIPF amount due by October 1, 2018.
16. In order for its Medicaid and CHIP contracts with its MCOs to be actuarially sound, I understand that LDH has determined that it must include in the capitation rates the cost of the HIPF to the extent that they are expected to pay such amounts to the IRS.
17. As required by law (42 CFR §438.4(a)), actuarial soundness¹ is required in Medicaid and CHIP managed care rate setting.

¹ For this purpose Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For the purpose of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, cost of capital, and government mandated assessments, fees, and taxes.

18. To meet this requirement, Louisiana contracts with actuaries at Mercer Health & Benefit, LLC to assist LDH in ensuring that capitation rates for Medicaid and CHIP are actuarially sound, and as noted in a paragraph 5 of this declaration, I make this certification to CMS on LDH's behalf.
19. I have reviewed the capitation rate structure for the Louisiana Medicaid and CHIP contracts. It is my opinion that for 2018, even if ASOP 49 did not exist, given current law, and regulatory guidance (see Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans, October 2014 <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf>), the Louisiana Medicaid and CHIP capitation rates would not be actuarially sound unless HIPF liability incurred by the Louisiana Medicaid and CHIP MCOs is incorporated in the capitation rates paid by LDH.
20. Pursuant to 28 U.S.C. §1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 13th day of September, 2018.



F. Ronald Ogborne III, FSA, CERA, MAAA

Partner

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION**

TEXAS,
KANSAS,
LOUISIANA,
INDIANA,
WISCONSIN, and
NEBRASKA,

Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
ALEX AZAR, in his Official Capacity as
SECRETARY OF HEALTH AND
HUMAN SERVICES, UNITED STATES
INTERNAL REVENUE SERVICE, AND
DAVID J. KAUTTER, in his Official
Capacity as ACTING COMMISSIONER
OF INTERNAL REVENUE,

Defendants.

§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§

Civil Action No. 7:15-cv-00151-O

**APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY
RESTRAINING ORDER AND PRELIMINARY INJUNCTION
AND SUPPORTING BRIEF**

Exhibit I

My name is Jeremy Brunssen and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Deputy Director of Finance and Program Integrity for the Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC). My job duties include directing and performing complex financial analysis and budgeting for the medical assistance program generally known as Nebraska Medicaid. I have held this position since February 2018.
2. For purposes of creating a common understanding of terms in this declaration, I will use the term Medicaid to refer to both the Medicaid and CHIP programs. I will also use the term Covered Entity (as defined in Section 9010 of the ACA) to refer to a health insurance company that is subject to the HIPF.
3. In short, it is my position that Nebraska is required to reimburse the full amount of any HIPF liability incurred by Medicaid MCOs for 2018. Additionally, the financial impact to Nebraska is significant, estimated at \$32.8 million for 2018.
4. My assessment of the financial impact to Nebraska is based on my understanding of the HIPF, as described in paragraphs 5 through 8 of this Declaration.
5. The ACA included a number of new fees and taxes. Among those was the HIPF (Section 9010 of the ACA). The HIPF is assessed to the Covered Entity (an MCO regarding Medicaid), not to the employer, state, or plan directly. In the commercial sector, in general, Covered Entities fund the HIPF through increased premiums to their insured policyholders. Medicaid programs differ because the Covered Entity does not set the premium rates, the state does.

6. The liability for the HIPF is distributed based on premiums received by Covered Entities. The ACA provides that governmental entities and certain non-profit insurance organizations are exempt from the HIPF. The Internal Revenue Service (IRS) has not historically exempted premiums from MCOs for State Medicaid programs from the HIPF calculations. In the past, one of the four MCOs currently participating in the Nebraska Medicaid program has been subject to the HIPF.
7. The Internal Revenue Service (IRS) began collecting the HIPF in 2014. The fee is calculated based on the preceding calendar year's premiums. Covered Entities are notified of their final HIPF obligations by August 31 and payment is due by September 30. Under the ACA, the nationwide aggregate HIPF amount for all Covered Entities is as follows:

2014 \$ 8.0 billion
2015 \$ 11.3 billion
2016 \$ 11.3 billion
2017 \$ 13.9 billion
2018 \$ 14.3 billion
2019 Indexed for CY2019 and thereafter

More recent legislation has suspended collection of the HIPF for both 2017 and 2019. As a result, Covered Entities were not required to pay the fee in 2017 and will not be required to do so in 2019. However, those organizations will be required to pay the fee in 2018.

8. The HIPF is treated by the IRS as an excise tax. As such, Covered Entities may not deduct the HIPF for federal corporate income tax purposes. As a result, when a Covered Entity is reimbursed for the HIPF, net revenues rise and federal income tax liability increases as well, generally at the 2018 marginal

rate of 21%. In addition, when a Covered Entity is reimbursed through premiums for the cost of the HIPF, an additional Nebraska state tax of 7.81% is incurred. Principles of actuarial soundness generally require an actuary to include such federal and state tax implications in discerning whether the amounts paid to the MCO are actuarially sound.

9. As noted above, because the IRS has not exempted state Medicaid programs from its calculations of HIPF liability, premiums paid to Covered Entities under state Medicaid programs have been subject to the HIPF. In other words, for years 2014, 2015, and 2016, the portion of the HIPF assessed to each Covered Entity has been subsequently attributable to the state Medicaid programs in which they participate.
10. To this point, Nebraska has reimbursed Medicaid-participating Covered Entities for HIPF amounts paid by the organization and attributable to the Nebraska Medicaid program. Nebraska Medicaid has historically chosen to reimburse the HIPF liability because of the requirements of federal regulations. In addition, under Actuary Standard of Practice (ASOP) #49, the Actuarial Standards Board further refined the definition of actuarial soundness and included a specific requirement (Section 3.2.12.d) that the actuary must include such taxes and fees in the reimbursement, removing any actuarial discretion that may have existed in this regard.
11. As a result of the HIPF requirements, Nebraska has reimbursed participating Covered Entities the following aggregate amounts by year:
 - 2014 \$ 12.4 million
 - 2015 \$ 12.1 million
 - 2016 \$ 11.7 million
 - 2017 HIPF was suspended for 2017

12. The 2018 HIPF amounts from IRS are not yet finalized. Nebraska Medicaid estimates that the 2018 HIPF reimbursements for the Nebraska Medicaid program will total approximately \$32.8 million.
13. A critical concept in Medicaid managed care rate setting is that of actuarial soundness. In determining what services or costs should be included in Medicaid premium rates or what fees are determining what services or costs should be included in Medicaid premium rates or what fees are eligible for reimbursement, the actuary must make a judgment decision on whether the services or cost is reasonable and appropriate under the circumstances. The Center for Medicare and Medicaid Services (CMS) and the Actuarial Standards Board (ASB) have both provided guidance to the actuary regarding actuarial soundness. According to CMS, "Actuarial soundness requires that capitation payments cover reasonable, appropriate and attainable costs in providing covered services to enrollees in Medicaid managed care programs."
14. The ASB establishes and improves standards of actuarial practice. These Actuarial Standards of Practice (ASOPs) identify what the actuary should consider, document, and disclose when performing an actuarial assignment. The ASB's goal is to set standards for appropriate practice for the U.S.
15. ASOP #49, for example, from the ASB includes the following: "Medicaid capitation rates are 'actuarially sound' if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, cost include, but are

not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, *and government-mandated assessments, fees, and taxes* [emphasis added].”

16. The HIPF is a function of premiums paid to the Covered Entity. Premium amounts paid to the Covered Entity from state Medicaid programs is a component of the formula used to determine HIPF for each MCO. For purposes of determining the HIPF, Medicaid premium dollars receive the same treatment as all other funds used in the calculations, i.e., their impact on the HIPF amount is proportional to that for all other funds. As a result, IRS practice makes a portion of the HIPF charged to a Covered Entity that participates in the Nebraska Medicaid program directly attributable to services provided by the Covered Entity under the Nebraska Medicaid program.
17. The formula used by the IRS to determine a Covered Entity’s HIPF liability produces a single dollar amount. It does not produce separate amounts for each of the Covered Entity’s clients. However, as the HIPF formula treats each client’s premium dollar exactly the same, Covered Entities will allocate their HIPF liability to each of their clients in proportion to the client’s percentage of the Covered Entity’s total premium. For example, if the Nebraska Medicaid program comprises 5% of the Covered Entity’s total premium, then the Nebraska’s Medicaid program will also assume 5% of the MCO’s HIPF liability. As such, if the IRS assesses HIPF liability to an MCO based on premiums for Nebraska Medicaid, the amount attributable to the Nebraska Medicaid program is reasonably determinable.
18. The requirement for Covered Entities to pay the HIPF and the method used to determine the amount of the fee for each Covered Entity is included in federal

law. The IRS has issued the HIPF assessments for 2018 to each Covered Entity, as required prior to August 31, 2018. Covered Entities are required to pay the fee and have no flexibility in the determination of the fee amount. In other words, actuarial soundness principles require Covered Entities to be reimbursed for the cost of the fee since it is directly attributable to services provided to Nebraska Medicaid and the Covered Entity has no flexibility in the determination of the amount of the fee.

19. Based on the analysis summarized herein, in order for the Nebraska Medicaid program's premium rates to be deemed actuarially sound, it is my position that Nebraska must reimburse participating Covered Entities for the program's share of their 2018 HIPF, adjusted for any federal and state tax implications. Nebraska Medicaid has already worked with Nebraska Medicaid's contracted actuary to include the program's anticipated share of 2018 HIPF in the prospective capitation rates for the July – December 2018 rating period and payments to the MCOs. HIPF liability has been an expense of Nebraska Medicaid MCOs in the past and is directly attributable to services delivered under the Nebraska Medicaid program. The state's portion of the Covered Entity's HIPF is easily determinable and in order for Nebraska Medicaid managed care premium rates to be actuarially sound, Nebraska must reimburse the Covered Entities for the state's share of the 2018 HIPF. If Nebraska or other states wish to avoid 2018 HIPF liability for its Medicaid programs, HIPF liability for Medicaid premiums must not be assessed upon, or paid by, Medicaid MCOs in the first instance.

20. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 10th day of September, 2018.



Jeremy Brunssen

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION

TEXAS,
KANSAS,
LOUISIANA,
INDIANA,
WISCONSIN, and
NEBRASKA,

Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, ALEX AZAR, in his
Official Capacity as SECRETARY OF
HEALTH AND HUMAN SERVICES,
UNITED STATES INTERNAL
REVENUE SERVICE, AND DAVID
J. KAUTTER, in his Official Capacity
as ACTING COMMISSIONER OF
INTERNAL REVENUE,

Defendants.

Civil Action No. 7:15-CV-00151-O

DECLARATION OF RACHEL BUTLER

My name is Rachel Butler and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Chief Actuary of the Texas Health and Human Services Commission (HHSC). My job duties include overseeing the development of the Medicaid and CHIP managed care capitation rates paid to the managed care organization that contract with HHSC and assisting HHSC with other matters requiring actuarial expertise. I have held this position since October 1, 2013.
2. I hold a Bachelor of Science degree from the University of Texas at Austin in Mathematics, with a concentration in Actuarial Sciences. I am a member of the

American Academy of Actuaries and the Society of Actuaries.

3. I was not retained or specially employed to provide expert testimony in this matter, nor do my regular duties as an employee of HHSC regularly involve giving expert testimony in cases. I am not receiving any additional compensation. Providing this report is within the regular course and scope of my duties. I have not published any articles. I have been deposed on one occasion. The deposition was given in *Diana D. et al. v. HHSC*. I did provide testimony previously in this matter. By and through this Declaration, I hereby incorporate by reference my prior testimony in this matter.
4. Texas provides nearly all of its Medicaid and CHIP health care services through managed care arrangements. To do this, Texas enters into contracts with managed care organizations (MCOs), whereby the MCOs agree to deliver healthcare services in exchange for a fixed monthly payment, known as a “capitation payment” or “capitation rate.”
5. In my position as Chief Actuary I am aware of all the Managed Care Organizations (“MCOs”) that contract with HHSC and which of those MCOs pay the Health Insurance Providers Fee (“HIPF”) that the MCOs are required to pay the Internal Revenue Service under the Affordable Care Act. I and my Office are responsible for Medicaid and CHIP capitation rate development.
6. The HIPF is federally mandated against the health insurance industry. In essence, it functions as a federal premium tax on certain health insurers. It is assessed annually based on the prior year’s premiums received. The insurers subject to the HIPF (“covered entities”) report their company’s net premiums written for health insurance on the IRS Form 8963.
7. The annual HIPF is fixed each year. In other words, the total amount of the HIPF that the IRS will collect is known. The Internal Revenue Service (IRS)

began collecting the HIPF in 2014. In calculating the HIPF for each “covered entity,” the IRS starts with the total amount of money it is directed to raise through the HIPF. For 2018, that amount is \$14.3 billion. The IRS then allocates to the non-exempted “covered entities” their share of the HIPF based on the aggregate net premiums the covered entity has written for health insurance of United States health risks.

8. I am aware that the Affordable Care Act exempts governments from the HIPF. *See* ACA § 9010(c)(2)(B). However, to date, the IRS has not excluded Medicaid and CHIP program premiums reported by covered entities from HIPF liability.
9. The Internal Revenue Service (IRS) began collecting the HIPF in 2014. In calculating the HIPF for each “covered entity,” the IRS starts with the total amount of money it is directed to raise through the HIPF. For 2018, that amount is \$14.3 billion. The IRS then allocates to the non-exempted “covered entities” their share of the HIPF based on the aggregate net premiums the covered entity has written for health insurance of United States health risks.
10. Because the IRS has historically included Texas’s MCOs’ Medicaid and CHIP premiums in its calculation of HIPF liability, the premiums that Texas has paid for Medicaid and CHIP have resulted in HIPF liability for Texas.
11. In previous years, HHSC has reimbursed its MCOs for the amount of the HIPF attributable to Texas’s Medicaid and CHIP premiums. HHSC did so because federal regulations, which Texas successfully challenged in court, purported to require HHSC to reimburse HIPF liability, in addition to paying the capitation rates, to provide Medicaid and CHIP services.
12. Texas has reimbursed its MCOs for HIPF liability in the prior HIPF years of 2014, 2015, and 2016. There was a statutory moratorium on the HIPF for 2017. But it is being imposed for fee year 2018. If not exempted, I estimate that the


2018 HIPF reimbursements HHSC will be required to make for Texas's Medicaid and CHIP programs will be approximately \$300 million.

13. I reviewed the Form 8963s that the Texas MCOs submitted to the IRS on or before April 17, 2018, as well as the Letter 5066Cs (preliminary notice of 2018 HIPF liability) that the IRS issued to the Texas MCOs. Through these documents, I was able to confirm that the IRS included the Medicaid and CHIP premiums of Texas's MCOs in its calculation of the overall 2018 HIPF liability and the portions assessed against Texas's MCOs.
14. I am aware that the Texas Attorney General sent a letter to IRS that objected to the inclusion of the Medicaid and CHIP premiums of its MCOs in the IRS's calculation of the overall 2018 HIPF liability for Texas's MCOs. To date, neither the Texas Attorney General nor HHSC has received a response from the IRS.
15. On or about August 31, 2018, the IRS issued the final HIPF calculations (Letters 5067C) to the Texas MCOs. I have reviewed these final HIPF calculations and can verify that they continue to include the value of Texas's Medicaid and CHIP premiums as part of the basis upon which the HIPF liability is calculated.
16. In order for its Medicaid and CHIP contracts with its MCOs to be actuarially sound, HHSC has determined that it must reimburse the Texas MCOs for the HIPF that they are expected to pay to the IRS no later than October 1, 2018.
17. As determined by Congress, and as affirmed by standards of practice within managed medical care, actuarial soundness is required in Medicaid and CHIP managed care rate setting.
18. To meet this expectation, Texas contracts with actuaries at Rudd & Wisdom to assist HHSC in ensuring that capitation rates for Medicaid and CHIP are

actuarially sound.

19. I have reviewed the capitation rate structure for Texas's Medicaid and CHIP contracts. For 2018, even if ASOP 49 did not exist, Texas's Medicaid and CHIP capitation rates cannot be actuarially sound unless HIPF liability incurred by Texas's Medicaid and CHIP MCOs is reimbursed by HHSC.
20. It is my opinion that for Texas's capitation rates for 2018 to be actuarially sound, as required by 42 U.S.C. § 1396b, the 2018 HIPF liability must be added to the capitation rates negotiated with the MCOs.
21. My opinions have been developed in my official capacity as Chief Actuary. All of the facts and data utilized by me in preparing my opinions and the information contained herein are the type and kinds of data that professionals within my fields of expertise typically rely upon. Any information and documents I consulted were kept in the regular course of business, and many were public records in Texas. They were created by personnel, with knowledge of the act, event, condition, opinion, diagnosis, or information recorded made the record, or transmitted the information to be included in the record or document. Finally, these documents were created at or near the time of the act, event, condition, or information recorded.
22. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 11th day of September, 2018.



Rachel Butler

Rudd and Wisdom, Inc.

CONSULTING ACTUARIES

Mitchell L. Bilbe, F.S.A.
Evan L. Dial, F.S.A.
Philip S. Dial, F.S.A.
Philip J. Ellis, A.S.A.
Charles V. Faerber, F.S.A., A.C.A.S.
Mark R. Fenlaw, F.S.A.
Brandon L. Fuller, F.S.A.

Shannon R. Hatfield, A.S.A.
Christopher S. Johnson, F.S.A.
Oliver B. Kiel, F.S.A.
Dustin J. Kim, A.S.A.
Edward A. Mire, F.S.A.
Rebecca B. Morris, A.S.A.
Amanda L. Murphy, F.S.A.
Michael J. Muth, F.S.A.

Khiem Ngo, F.S.A., A.C.A.S.
Elizabeth A. O'Brien, F.S.A.
Timothy B. Seifert, A.S.A.
Chelsea E. Stewart, A.S.A.
Raymond W. Tilotta
Ronald W. Tobleman, F.S.A.
David G. Wilkes, F.S.A.

August 29, 2018

Mr. Austin R. Nimocks
Special Counsel for Civil Litigation
Texas Attorney General's Office
209 W. 14th Street
Austin, TX 78701

Re: Health Insurance Providers Fee for 2018

Dear Mr. Nimocks:

This correspondence is in response to your request for an actuarial opinion regarding the Texas Medicaid and CHIP programs' potential liability for the 2018 Health Insurance Providers Fee (HIPF) as required under the Patient Protection and Affordable Care Act of 2010 (ACA). Specifically, you asked whether a legal requirement that contracts for Medicaid and CHIP with MCOs must be "actuarially sound" requires Texas to reimburse its Medicaid and CHIP managed care organizations (MCOs) for the 2018 HIPF liability incurred by the MCOs.

For purposes of presenting this opinion, we will use the term Medicaid to refer to both the Medicaid and CHIP programs. We will also use the term Covered Entity (as defined in Section 9010 of the ACA) to refer to a health insurance company that is subject to the HIPF.

In short, it is my opinion that principles of actuarial soundness require Texas to reimburse the full amount of any HIPF liability incurred by Medicaid MCOs for 2018. While Actuarial Standard of Practice No. 49 (ASOP #49, adopted March 2015) has been beneficial to actuaries working for state Medicaid programs, my opinion here does not turn based on ASOP #49. Even if ASOP #49 did not exist, my opinions expressed herein would remain.

Qualifications

I am a Fellow of the Society of Actuaries (F.S.A., since 1988) and a member of the American Academy of Actuaries (M.A.A.A., since 1987). I am a senior principal of the firm Rudd and Wisdom, Inc., where I have been employed since 1991. I have served as consulting actuary to the Texas Health and Human Services Commission (HHSC, the agency responsible for administering the Texas Medicaid program) and its predecessor agencies since 1991. I have participated in the

state's managed care rate setting process since its inception in 1993. I have authored actuarial certification reports (federally required reports which certify that the managed care capitation rates satisfy all federal requirements including actuarial soundness) for HHSC for more than ten years.

A copy of my résumé is attached to this report.

Prior Testimony

I have not testified at trial or by deposition during the past four years. I did, however, provide an expert opinion by written report in *Texas v. United States*, Case No. 7:15-cv-00151, in the United States District Court for the Northern District of Texas.

Compensation

I am being compensated at a rate of \$380/hour for services rendered, in accordance with my firm's fee schedule, a copy of which is attached to this report.

Materials Reviewed

In addition to my qualifications and expertise, particularly regarding managed care rate setting and related topics, as well as my history with HHSC, my report also draws upon my involvement in and the history of *Texas v. United States*, Case No. 7:15-cv-00151, in the United States District Court for the Northern District of Texas, including the various expert opinions (and related materials), as well as the various rulings of the court.

Background

The ACA included a number of new fees and taxes. Among those was the HIPF (Section 9010 of the ACA). The HIPF is assessed to the Covered Entity (an MCO regarding Medicaid), not to the employer, state, or plan directly. In the commercial sector, in general, Covered Entities fund the HIPF through increased premiums to their insured policyholders. Medicaid programs differ because the Covered Entity does not set the premium rates, the state does.

The liability for the HIPF is distributed based on premiums received by Covered Entities. The ACA provides that governmental entities and certain non-profit insurance organizations are exempt from the HIPF. The Internal Revenue Service (IRS) has not historically exempted premiums from MCOs for State Medicaid programs from the HIPF calculations. In the past, twelve of the 22 MCOs currently participating in the Texas Medicaid program have been subject to the HIPF.

The Internal Revenue Service (IRS) began collecting the HIPF in 2014. The fee is calculated based on the preceding calendar year's premiums. Covered Entities are notified of their final HIPF obligations by August 31 and payment is due by September 30. Under the ACA, the nationwide aggregate HIPF amount for all Covered Entities is as follows:

2014	\$ 8.0 billion
2015	\$ 11.3 billion
2016	\$ 11.3 billion
2017	\$ 13.9 billion
2018	\$ 14.3 billion

2019 Indexed for CY2019 and thereafter

More recent legislation has suspended collection of the HIPF for both 2017 and 2019. As a result, Covered Entities were not required to pay the fee in 2017 and will not be required to do so in 2019. However, those organizations will be required to pay the fee in 2018.

Tax Implications

The HIPF is treated by the IRS as an excise tax. As such, Covered Entities may not deduct the HIPF for federal corporate income tax purposes. As a result, when a Covered Entity is reimbursed for the HIPF, net revenues rise and federal income tax liability increases as well, generally at the 2018 marginal rate of 21%. In addition, when a Covered Entity is reimbursed through premiums for the cost of the HIPF, an additional Texas state premium tax of 1.75% is incurred. Principles of actuarial soundness generally require an actuary to include such federal and state tax implications in discerning whether the amounts paid to the MCO are actuarially sound.

The Impact of the HIPF on Texas Medicaid and CHIP Programs

As noted above, because the IRS has not exempted state Medicaid programs from its calculations of HIPF liability, premiums paid to Covered Entities under state Medicaid programs have been subject to the HIPF. In other words, for years 2014, 2015, and 2016, the portion of the HIPF assessed to each Covered Entity has been subsequently attributable to the state Medicaid programs in which they participate.

To this point, Texas has reimbursed Medicaid-participating Covered Entities for HIPF amounts paid by the organization and attributable to the Texas Medicaid program. Previously, HHSC chose to reimburse the HIPF liability because of the requirements of federal regulations. In addition, under ASOP #49, the Actuarial Standards Board further refined the definition of actuarial soundness and included a specific requirement (Section 3.2.12.d) that the actuary must include such taxes and fees in the reimbursement, removing any actuarial discretion that may have existed in this regard.

As a result of the HIPF requirements, Texas has reimbursed participating Covered Entities the following aggregate amounts by year:

2014 \$ 210.1 million
2015 \$ 274.8 million
2016 \$ 275.2 million
2017 HIPF was suspended for 2017

The 2018 HIPF amounts from IRS are not yet finalized. HHSC estimates that the 2018 HIPF reimbursements for the Texas Medicaid program will total approximately \$300 million.

Actuarial Soundness

A critical concept in Medicaid managed care rate setting is that of actuarial soundness. In determining what services or costs should be included in Medicaid premium rates or what fees are eligible for reimbursement, the actuary must make a judgement decision on whether the service or cost is reasonable and appropriate under the circumstances. The Center for Medicare and Medicaid Services (CMS) and the Actuarial Standards Board (ASB) have both provided guidance to the

actuary regarding actuarial soundness. According to CMS, “Actuarial soundness requires that capitation payments cover reasonable, appropriate and attainable costs in providing covered services to enrollees in Medicaid managed care programs.”

The ASB establishes and improves standards of actuarial practice. These Actuarial Standards of Practice (ASOPs) identify what the actuary should consider, document, and disclose when performing an actuarial assignment. The ASB’s goal is to set standards for appropriate practice for the U.S.

ASOP #49, for example, from the ASB includes the following: “Medicaid capitation rates are ‘actuarially sound’ if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, *and government-mandated assessments, fees, and taxes* [emphasis added].”

2018 HIPF

I have been asked to provide an opinion on whether Texas is required to reimburse Covered Entities participating in the Texas Medicaid program for liability resulting from the 2018 HIPF. In evaluating this issue, I considered the following questions, among other things:

- 1) Is a portion of the Covered Entity’s HIPF amount directly attributable to services rendered under the Texas Medicaid program? If so, is the amount attributable to the state determinable.
- 2) Do the participating Covered Entities have any flexibility in their requirement to pay the HIPF or in the amount of the fee?

The HIPF is a function of premiums paid to the Covered Entity. Premium amounts paid to the Covered Entity from state Medicaid programs is a component of the formula used to determine HIPF for each MCO. For purposes of determining the HIPF, IRS has given that Medicaid premium dollars receive the same treatment as all other funds used in the calculations, i.e., their impact on the HIPF amount is proportional to that for all other funds. As a result, IRS practice makes a portion of the HIPF charged to a Covered Entity that participates in the Texas Medicaid program directly attributable to services provided by the Covered Entity under the Texas Medicaid program.

The formula used by the IRS to determine a Covered Entity’s HIPF liability produces a single dollar amount. It does not produce separate amounts for each of the Covered Entity’s clients. However, as the HIPF formula treats each client’s premium dollar exactly the same, Covered Entities will allocate their HIPF liability to each of their clients in proportion to the client’s percentage of the Covered Entity’s total premium. For example, if the Texas Medicaid program comprises 10% of the Covered Entity’s total premium, then the Texas Medicaid program will also assume 10% of the MCO’s HIPF liability. As such, if the IRS assesses HIPF liability to an MCO based on premiums for Texas Medicaid, the amount attributable to the Texas Medicaid program is easily and reasonably determinable.

The requirement for Covered Entities to pay the HIPF and the method used to determine the amount of the fee for each Covered Entity is included in federal law. The aggregate total HIPF for 2018 for all Covered Entities is \$14.3 billion. The IRS will make the necessary calculations and distribute the 2018 fee amounts to each Covered Entity by August 31, 2018. Covered Entities are required to pay the fee and have no flexibility in the determination of the fee amount. In other words, actuarial soundness principles require Covered Entities to be reimbursed for the cost of the fee since it is directly attributable to services provided to HHSC and the Covered Entity has no flexibility in the determination of the amount of the fee.

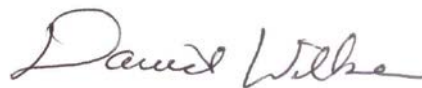
Conclusion

Based on the analysis summarized in this correspondence, in order for the Texas Medicaid program's premium rates to be deemed actuarially sound, it is my professional opinion that Texas must reimburse participating Covered Entities for the program's share of their 2018 HIPF, adjusted for any federal and state tax implications. HIPF liability has been a legitimate business expense of Texas Medicaid MCOs in the past and is directly attributable to services delivered under the Texas Medicaid program. The state's portion of the Covered Entity's HIPF is easily determinable using reasonable and appropriate methods.

ASOP #49 has been beneficial to actuaries working for state Medicaid programs because it more clearly defines actuarial soundness requirements and, specifically, the requirement to recognize government-mandated taxes and fees in the Medicaid managed care premium rates. This has made it easier for actuaries to explain to state Medicaid agencies that provision for the HIPF must be included in the rates. However, this does not mean that, absent ASOP #49, Medicaid managed care premium rates would be actuarially sound if they did not include the HIPF.

Absent ASOP #49, principles of actuarial soundness must still prevail. In that regard, it is my opinion that any liability imposed by the IRS upon MCOs for Texas Medicaid for the 2018 HIPF must be recognized in the Medicaid premium rates in order for those rates to satisfy the general actuarial soundness requirements. In other words, in order for the Texas Medicaid managed care premium rates to be actuarially sound, Texas must reimburse the Covered Entities for the state's share of the 2018 HIPF. If Texas or other states wish to avoid 2018 HIPF liability for its Medicaid programs, HIPF liability for Medicaid premiums must not be assessed upon, or paid by, Medicaid MCOs in the first instance.

Sincerely,



David G. Wilkes, F.S.A. M.A.A.A.

DGW:nlg

David G. Wilkes

- Position:** Principal and Senior Actuary
Rudd and Wisdom, Inc.
Austin, Texas
- Responsibilities:** Actuary for:
- Health and welfare actuarial services
 - Postretirement benefit liability determinations
 - Miscellaneous health-related insurance assignments
- Educational Background:**
- Bachelor of Science Degree in Mathematics, University of Texas at Austin, 1982
 - Fellow, Society of Actuaries, 1988
 - Member, American Academy of Actuaries, 1987
- Experience:**
- Actuary with Rudd and Wisdom, Inc. since 1991
 - Actuary, Blue Cross and Blue Shield of Texas, 1983-1985 and 1986-1991
 - Actuary, American Founders Life Insurance Company, 1985-1986
- Technical Capability/Expertise:**
- Health and welfare plan design and financing
 - Request for Proposal design and preparation
 - Evaluation and selection of insurance, reinsurance and managed care arrangements
 - Health and welfare plan data management and statistical reporting
 - Determination of self-funded plan premium rates and liability estimates
 - Life, disability and dental insurance pricing
 - Actuarial cost projections/statistical modeling
 - Carrier negotiation
 - Evaluation of provider networks for HMO, POS and PPO plans.
 - Evaluation of proposed legislation
- Reference Projects:**
- Actuary to Texas Medicaid Program and CHIP since 1991
 - Employees Retirement System of Texas (ERS) actuary for the Group Benefits Program (GBP) since 1991
 - Actuary to University of Texas System Employee Group Insurance program
 - Responsible for pricing and reserving assignments for trade and professional association insurance programs

RUDD AND WISDOM, INC.
Cost Proposal
Exhibit A

Position	Fiscal Year 2015-2016 Cost Per Hour	Fiscal Year 2017 Cost Per Hour	Fiscal Year 2018 Cost Per Hour	Fiscal Year 2019 Cost Per Hour
Senior Actuary	\$360.00	\$370.00	\$380.00	\$395.00
Actuary	\$320.00	\$330.00	\$340.00	\$350.00
Associate Actuary	\$270.00	\$280.00	\$285.00	\$295.00
Assistant Actuary II	\$245.00	\$250.00	\$260.00	\$270.00
Assistant Actuary I	\$220.00	\$225.00	\$235.00	\$240.00
Actuarial Assistant	\$190.00	\$195.00	\$200.00	\$210.00
Clerical	\$90.00	\$95.00	\$95.00	\$100.00
Travel (Must Itemize)				
Other Cost (Must Itemize)				

Notes:

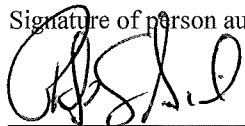
- The above billing rates are guaranteed for the five-year period as indicated.
- The proposed FY2017 billing category for those Rudd and Wisdom actuaries currently servicing the HHSC contract is as shown below.

Philip S. Dial – Senior Actuary
 David G. Wilkes – Senior Actuary
 Evan L. Dial – Actuary
 Charles V. Faerber – Associate Actuary
 Khiem D. Ngo – Assistant Actuary

Please note that the billing category for individual employees is subject to change. For example, an employee may, at some point, be promoted from Actuarial Assistant to Assistant Actuary. We will discuss these situations with appropriate HHSC staff if and when the situation arises.

- Rudd and Wisdom does not anticipate any travel-related or other expenses.

Signature of person authorized to legally bind Rudd and Wisdom, Inc.



Printed Name

Philip S. Dial

7/13/2016
 Date

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION**

TEXAS,
KANSAS,
LOUISIANA,
INDIANA,
WISCONSIN, and
NEBRASKA,

Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
ALEX AZAR, in his Official Capacity as
SECRETARY OF HEALTH AND
HUMAN SERVICES, UNITED STATES
INTERNAL REVENUE SERVICE, AND
DAVID J. KAUTTER, in his Official
Capacity as ACTING COMMISSIONER
OF INTERNAL REVENUE,

Defendants.

§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§
§

Civil Action No. 7:15-cv-00151-O

**APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY
RESTRAINING ORDER AND PRELIMINARY INJUNCTION
AND SUPPORTING BRIEF**

Exhibit L

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION

TEXAS,
KANSAS,
LOUISIANA,
INDIANA,
WISCONSIN, and
NEBRASKA,

Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, ALEX AZAR, in his
Official Capacity as SECRETARY OF
HEALTH AND HUMAN SERVICES,
UNITED STATES INTERNAL
REVENUE SERVICE, AND DAVID
J. KAUTTER, in his Official Capacity
as ACTING COMMISSIONER OF
INTERNAL REVENUE,

Defendants.

Civil Action No. 7:15-CV-00151-O

DECLARATION OF HEATHER SMITH

I, Heather Smith, hereby depose and state under oath and upon personal knowledge as follows:

1. I am over the age of eighteen, and am fully competent to make this Declaration.

2. Since January 8, 2018, I have served as the Administrator of the Division of Medicaid Services (DMS) with the Wisconsin Department of Health

Services (DHS) and also serve as the Wisconsin Medicaid Director. My current job duties include:

- a. Director of Wisconsin's BadgerCare Plus program (which includes Wisconsin's Medicaid and Children's Health Insurance (CHIP) programs), providing health and long term care services to over 1.2 million members with a biennial budget of over \$18.6 billion.
 - b. Administrator of the division responsible for delivery, administration and policy development of the Supplemental Nutritional Assistance Program (SNAP), providing assistance to over 800,000 Wisconsin residents with an annual budget of over \$1 billion.
3. As the Administrator of the Division of Medicaid Services (DMS) and Wisconsin Medicaid Director, I am familiar with the contracts that govern managed care services funded under the Medicaid and CHIP programs, including Wisconsin DHS's obligations under those contracts.
4. I am also familiar with the litigation in the Northern District of Texas regarding the imposition of the Health Insurance Provider Fee (HIPF) on the states. On March 5, 2018, the District Court for the Northern District of Texas ruled that "[i]n the ACA [(Affordable Care Act)], Congress expressly exempted states from paying the HIPF [HIPF]." *Texas et al. v. United States et al.*, No. 7:15-cv-00151, 300 F. Supp. 3d 810, 821 (N.D. Tex. 2018). Wisconsin was a plaintiff in that case, and I provided a declaration in my capacity as the Administrator of DMS.

5. I make this declaration based on my personal knowledge and review of the records in my custody.

6. For calendar year 2018, Wisconsin DHS is obligated to reimburse Wisconsin managed care organizations (MCOs) for the Medicaid- and CHIP-specific portion of the HIPF that the IRS assesses against each MCO.

7. Attached as Exhibit A is a true and correct copy of the Contract for BadgerCare Plus and/or Medicaid SSI HMO Services Between The HMO and the Wisconsin Department of Health Services, January 1, 2018 through December 31, 2019.

8. Under the contract, reimbursement of the HIPF is based on the determined capitation rates, which “shall be prospective and based on an actuarially sound methodology” as required by federal law and the Center for Medicare and Medicaid Services’ requirements. Ex. A at 9, 273. Wisconsin DHS entered into these contracts prior to the Northern District of Texas’s ruling on March 5, 2018. *Texas et al. v. United States et al.*, No. 7:15-cv-00151, 300 F. Supp. 3d 810 (N.D. Tex. 2018).

9. In June 2018, DMS reviewed the Form 8963s that the Wisconsin MCOs submitted to the IRS, as well as the Letter 5066Cs that the IRS issued to the Wisconsin MCOs. DMS confirmed that the IRS had included Medicaid and CHIP premiums in its preliminary calculation of the HIPF for Wisconsin MCOs.¹

¹ The Wisconsin MCOs have not consented to DHS’s disclosure of these IRS documents. Plaintiff State of Wisconsin will provide them to the Court upon receiving such consent, or if ordered by the Court to do so.

10. On July 13, 2018, DHS submitted a letter objecting to the IRS's inclusion of Medicaid premiums in its calculation of the HIPF for the Wisconsin MCOs. Attached as Exhibit B is a true and correct copy of my July 13, 2018 letter to Commissioner Kautter of the IRS.

11. On July 10, 2018, DHS emailed the contract administrators for the Wisconsin MCOs, asking that they timely object to the IRS including the value of Medicaid premiums in the premiums upon which the HIPF is calculated. The email informed the Wisconsin MCOs of the process and deadline for objecting to the preliminary calculation of the HIPF. Attached as Exhibit C is a true and correct copy of my July 10, 2018 email correspondence written on behalf of DHS and delivered to the Wisconsin MCOs.

12. Upon information and belief, two of the Wisconsin MCOs availed themselves of the objection process.

13. On or about August 31, 2018, the IRS was to issue final fee calculations (Letters 5067C) to the Wisconsin MCOs. Ex. A. at 277. Upon information and belief, the final fee calculations for the Wisconsin MCOs continue to include the value of Medicaid and CHIP premiums in the total premium amount from which the HIPF is calculated.

14. Under the contract described above, DHS is required to reimburse the Wisconsin MCOs for the portion of the HIPF attributable to Wisconsin Medicaid and CHIP premium amounts by approximately September 25 of each calendar year.

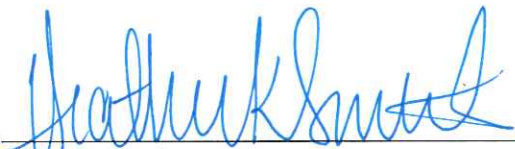
Ex. A at 277. Thus, DHS's reimbursement for the Medicaid and CHIP portion of the HIPF for calendar year 2018 is due on or about September 25, 2018.

15. Prior to that deadline, MCOs calculate and submit a request for reimbursement of the portion of their HIPF attributable to Medicaid and CHIP services, and DHS must undergo review, validation, and payment processes to ensure accurate and timely payment.

16. The specific injury to Wisconsin will be determined when DHS reviews and validates the MCO requests for HIPF reimbursement on or by September 18, but as of the current date, providers have indicated that DHS is liable for payments totaling \$30,885,180.19.

17. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the forgoing is true and correct.

Dated this 13 day of September, 2018.


HEATHER SMITH

Contract for BadgerCare Plus and/or Medicaid SSI

HMO Services

Between

The HMO

and

**The Wisconsin Department of
Health Services**

January 1, 2018 through December 31, 2019

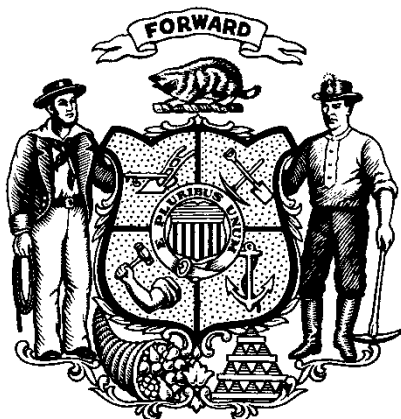


Table of Contents

ARTICLE I	8
I. DEFINITIONS.....	8
ARTICLE II.....	31
II. ENROLLMENT AND DISENROLLMENT	31
A. Enrollment.....	31
B. Disenrollment.....	35
C. Exemptions	40
ARTICLE III.....	44
III. CARE MANAGEMENT	44
A. Care Management Model for the BadgerCare Plus Childless Adults Population.....	44
B. Care Management Model for the Medicaid SSI Population	47
C. Care Coordination Requirements for all Members	63
D. Screening Requirements for non-Childless Adults BadgerCare Plus Members	64
ARTICLE IV	65
IV. SERVICES.....	65
A. BadgerCare Plus and/or Medicaid SSI Services	65
B. Mental Health and Substance Abuse Coverage Requirements/Coordination of Services with Community Agencies.....	84
C. HealthCheck.....	95
D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women	97
E. Immunization Program	110
F. Abortions, Hysterectomies and Sterilizations	111
G. HIV/AIDS Health Home.....	111
H. Provider Moral or Religious Objection.....	114
ARTICLE V.....	116
V. PROVIDER NETWORK AND ACCESS REQUIREMENTS	116
A. Use of BadgerCare Plus and/or Medicaid SSI Enrolled Providers	116
B. Protocols/Standards to Ensure Access	116
C. Written Standards for Accessibility of Care	116
D. Monitoring Compliance	118
E. Access to Selected BadgerCare Plus and/or Medicaid SSI Providers and Covered Services... 118	

F. Network Adequacy Requirements 124

G. Provider to Member Ratio Requirements 125

H. Use of Non-Medicaid Providers 126

I. Online Provider Directory..... 126

ARTICLE VI 127

VI. MARKETING AND MEMBER MATERIALS 127

A. Marketing Plans and Informing Materials 127

B. Reproduction/Distribution of Materials 131

C. HMO ID Cards..... 131

D. Member Handbook, Provider Directory, Education and Outreach for Newly Enrolled Members
131

ARTICLE VII 135

VII. MEMBER RIGHTS AND RESPONSIBILITIES 135

A. Advocate Requirements 135

B. Advance Directives 138

C. Primary Care Provider Assignment 140

D. Member Appointment Compliance..... 142

E. Choice of Network Provider 142

F. Coordination and Continuation of Care 142

G. Cultural Competency and Culturally and Linguistically Appropriate Services (CLAS) Standards
144

H. Health Education and Disease Prevention 148

I. Language Access Services 149

ARTICLE VIII 152

VIII. PROVIDER APPEALS 152

A. HMO Responsibility 152

B. Provider Responsibility..... 154

ARTICLE IX 157

IX. Member Grievances and Appeals 157

A. Procedures..... 157

B. Grievance and Appeal Process..... 160

C. Notifications to Members..... 162

D. Continuation of Benefits Requirements..... 166

E. Reporting of Grievances to the Department..... 167

ARTICLE X..... 168

X. QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)..... 168

A. QAPI Program 168

B. Monitoring and Evaluation 171

C. Health Promotion and Disease Prevention Services 173

D. Provider Selection (Credentialing) and Periodic Evaluation (Recredentialing) 173

E. Member Feedback on Quality Improvement 176

F. Medical Records 176

G. Utilization Management (UM)..... 178

H. Dental Services Quality Improvement (Applies only to an HMO Covering Dental Services). 181

I. Accreditation..... 182

J. Performance Improvement Priority Areas and Projects..... 182

K. Pregnant Women..... 187

L. Healthy Birth Outcomes..... 188

M. HMO Pay-for-Performance (P4P) program and Core Reporting: 189

N. Alternative Payment Models (APM) 191

O. Potentially Preventable Readmissions (PPR)..... 192

P. Public Reporting 194

ARTICLE XI 195

XI. HMO ADMINISTRATION..... 195

A. Statutory Requirement 195

B. Compliance with Applicable Law..... 195

C. Organizational Responsibilities and Duties 196

D. Confidentiality of Records and HIPAA Requirements 210

ARTICLE XII 218

XII. REPORTS AND DATA 218

A. Required Use of the Secure ForwardHealth Portal 218

B. Access to and/or Disclosure of Financial Records..... 218

C. Access to and Audit of Contract Records 218

D. Encounter Data and Reporting Requirements..... 219

E. Encounter Data Quality Criteria 222

F. Coordination of Benefits (COB), Encounter Record, Formal Grievances and Birth Cost Reporting Requirements 225

G. Records Retention..... 225

H. Reporting of Corporate and Other Changes..... 226

I. Provider and Facility Network Data Submission..... 226

J. Financial Report..... 226

K. Contract Specified Reports and Due Dates..... 228

L. Communicable Disease Reporting..... 230

M. Program Integrity 231

N. Non-Disclosure of Trade Secrets and Confidential Competitive Information..... 236

XIII. FUNCTIONS AND DUTIES OF THE DEPARTMENT 238

 A. Utilization Review and Control 238

 B. Department Audit Schedule..... 238

 C. HMO Review of Study or Audit Results 238

 D. Vaccines for Children (BadgerCare Plus Only)..... 238

 E. Fraud and Abuse Training..... 238

 F. Provision of Data to the HMO 239

 G. Conflict of Interest 239

ARTICLE XIV..... 240

 XIV. CONTRACTUAL RELATIONSHIP 240

 A. Delegations of Authority..... 240

 B. Subcontracts..... 240

 C. Remedies for Violation, Breach, or Non-Performance of Contract..... 247

 D. Interpretation of Contract Language 264

ARTICLE XV 265

 XV. FISCAL COMPONENTS/PROVISIONS 265

 A. Billing Members 265

 B. Physician Incentive Plans..... 266

 C. Enhanced Physician Reimbursement for Medical Home Practice Design..... 267

 D. Payment Requirements/Procedures..... 267

ARTICLE XVI..... 273

XVI. PAYMENTS TO THE HMO..... 273

 A. Actuarial Basis 273

 B. Annual Negotiation of HMO Payments..... 273

 C. Capitation Rates 273

 D. Recoupments..... 274

 E. Risk adjustment payments or recoupments..... 275

 F. Maternity Kick Payment Guide 275

 G. Health Insurance Fee Reimbursement 276

 H. Reinsurance..... 279

 I. Coordination of Benefits (COB), Third Party Liability (TPL) and Subrogation 279

 J. Ventilator Dependent Members 282

 K. Hospital Access Payment for Non-Critical Access Hospitals..... 289

 L. Critical Access Hospital (CAH) Access Payment 293

 M. Payment Method 297

ARTICLE XVII 299

 XVII. HMO SPECIFIC CONTRACT TERMS 299

 A. Documents Constituting Contract..... 299

 B. Disclosure Statement(s) of Ownership or Controlling Interest in an HMO and Business Transactions 299

 C. Miscellaneous 304

 D. HMO Specific Contract Terms 306

ADDENDUM I..... 310

 I. MEMORANDA OF UNDERSTANDING..... 310

ADDENDUM II..... 314

 II. STANDARD MEMBER HANDBOOK LANGUAGE FOR BADGERCARE PLUS AND MEDICAID SSI..... 314

ADDENDUM III 327

 III. GUIDELINES FOR THE COORDINATION OF SERVICES BETWEEN THE HMO, TARGETED CASE MANAGEMENT (TCM) AGENCIES AND CHILD WELFARE AGENCIES 327

ADDENDUM IV 329

 IV. REPORT FORMS AND WORKSHEETS 329

 A. Coordination of Benefits Quarterly Report Form and Instructions for Completing the Form..... 329

 B. Court Ordered Birth Cost Requests 332

C. HMO Newborn Report (BadgerCare Plus Only) 335

D. HealthCheck Worksheet 336

E. Member Complaint and Grievance and Appeal Reporting Form 337

F. Summary Hospital Access Payment Report to Department of Health Services 339

G. Summary Critical Access Hospital (CAH) Access Payment Report to Department of Health Services 341

H. ATTESTATION 343

ADDENDUM V 344

V. BENEFITS AND COST SHARING CHART 344

ADDENDUM VI 345

VI. CY2017 RATE EXHIBITS 345

A. SSI Medicaid Only Rate Exhibits 345

B. SSI Dual Eligible Rate Exhibits 356

C. MAPP Medicaid Only Rate Exhibits 366

D. MAPP Dual Eligible Rate Exhibits 371

E. BadgerCare Plus Standard Rate Exhibits 378

F. BadgerCare Plus Childless Adults (CLA) Rate Exhibits 397

CONTRACT FOR SERVICES

Between
The Wisconsin Department of Health Services
And
HMO

ARTICLE I

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

I. DEFINITIONS

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

Access: Per [42 CFR §438.320](#), as it pertains to external quality review, “access” means the timely use of services to achieve optimal outcomes, as evidenced by the HMO successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined in [42 CFR §438.68](#) (Network adequacy standards) and [42 CFR §438.206](#) (Availability of services).

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

Actuarially Sound Capitation Rates: Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the HMO for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with CMS requirements.

Actuary: An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board.

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

Alternative Payment Models (APMs): Payments made by Wisconsin Medicaid HMOs to their providers through quality and value-based purchasing arrangements.

The APM numerator is defined as the total dollar value of all payments made by Wisconsin Medicaid HMOs to their providers, that are directly linked to attainment of quality goals by the providers, or are “at-risk”. The numerator includes capitation payments made by HMOs to their providers for which the providers assume the full insurance risk. The numerator does not include any surplus or profit sharing by HMOs with the providers if such sharing is not directly related to attainment of quality goals.

The denominator is defined as the total payments made by Wisconsin HMOs to their providers for services rendered to BadgerCare Plus and Medicaid SSI members.

Providers include non-hospital providers (community based providers, and home health agencies, among others) and hospitals.

Appeal: A formal request for review of an action (i.e. the denial, in whole or in part of payment for a service). For provider appeals, an application or proceeding for review when a provider does not agree with the claim reconsideration decision. For example: A claim is denied by the HMO for untimely claim filing. The Provider must appeal the denial action to the HMO; an internal review by the HMO is required.

Authorized Representative: For the purposes of filing a complaint, grievance, appeal, or approving the member’s care plan, an individual appointed by the member, including a

provider or estate representative, may serve as an authorized representative with documented consent of the member.

Auxiliary Aids & Services: Includes qualified interpreters, qualified readers, note takers, telephone handset amplifiers, telecommunications devices, audio recordings, large print or Braille materials, or other effective methods of making materials available to individuals with hearing or visual impairments.

BadgerCare Plus: BadgerCare Plus is Wisconsin's health care program for low income individuals created in 2008 that merges the low-income, family portion of the current Wisconsin Medicaid population, BadgerCare, and Healthy Start to form a single program that expands coverage to Wisconsin residents. Effective April 1, 2014, all members eligible for Badger Care Plus are enrolled in the BadgerCare Plus Standard Plan. Effective April 1, 2014, the following populations are eligible for BadgerCare Plus:

- Parents and caretakers with incomes at or below 100 percent of the Federal Poverty Level (FPL).
- Pregnant women with incomes at or below 300 percent of FPL.
- Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL.
- Childless adults with incomes at or below 100 percent of the FPL.
- Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL.

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

Budget Neutral: Per [42 CFR §438.5\(a\)](#), a standard for any risk sharing mechanism that recognizes both higher and lower expected costs among contracted HMOs under a managed care program and does not create a net aggregate gain or loss across all payments under that managed care program.

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

Capitation Payment: A payment the State agency makes periodically to a contractor on behalf of each member enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State Plan. The State agency makes the payment regardless of whether the particular member receives services during the period covered by the payment.

Care Coordination: The purposeful organization by care management staff to seamlessly deliver comprehensive services in response to a member's needs and work toward achieving desired health outcomes.

Care Management Model: A health care delivery process to arrange, deliver, monitor and evaluate the member's care, including all medical and social services, with the goal of helping members achieve their self-identified goals. For SSI members, the Care Management Model includes the following processes: a screening, information gathering and assessment, needs-stratification, comprehensive care plan development, care plan review and updates, and appropriate transitional care.

Care Management Staff: Staff that assists in patient-centered, evidence-based, coordinated care and services designed to effectively manage health conditions and help members meet their self-identified goals.

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

Case Management: A collaborative process of assessing, planning, facilitating, coordinating, evaluating, and advocating for options and services to meet an individual's comprehensive health needs through communication and available resources to promote quality and cost-effective outcomes.

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

CFR: Code of Federal Regulations.

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

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

Childless Adults (CLAs): BadgerCare Plus Childless Adults members who are under 100% FPL. As of April 1, 2014, childless adults are eligible for Standard Plan benefits.

CLA Health Needs Assessment (HNA) Screening: A survey tool to collect information on members' self-reported diagnosis history, patterns of health service utilization, and social determinants of health, allowing HMOs to stratify its CLA population based on urgent care and service needs. HNA screenings are conducted by appropriately qualified staff either online, through face-to-face, telephone or mail contact with the member and/or legal guardian.

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

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

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

Communication Materials: Member communication materials are materials designed to provide members with clear and concise information about the HMO's program, the HMO's network, and the BadgerCare Plus and/or Medicaid SSI program.

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

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

Comprehensive Care Plan (for Medicaid SSI members only): Written documentation of a plan of action developed by the HMO and the member that identifies strengths, needs, goals, and necessary interventions to be addressed within a specific timeframe. The Care Plan is a living document that reflects an ongoing cycle of activity as long as care is being provided.

HealthCheck: HealthCheck is Wisconsin’s name for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children under age 21. The EPSDT benefit is defined in federal law at [§1905\(r\) of the Social Security Act](#). The benefit provides comprehensive and preventive health care services for all children under 21 years old. Federal and state regulations establish certain requirements for comprehensive HealthCheck screenings. A comprehensive HealthCheck screen includes all of the following components:

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

HealthCheck “Other Services: HealthCheck “Other Services” is Wisconsin’s term for the federal mandate (under EPSDT) that requires that states cover “other necessary health care, diagnostic services, treatment, and other measures” which a child (under age 21) may require to treat, correct or reduce illnesses and conditions regardless of whether the necessary service is covered in a state’s Medicaid plan. The needed service must be allowable under federal Medicaid law ([§1905\(a\) of the Social Security Act](#)), and coverage is determined on a case-by-case basis.

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

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

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

- Any reports that the Department may reasonably require, and
- At least the following services to eligible HealthCheck members formally enrolled with the provider as enumerated in [42 CFR §441.60\(a\)\(1\)-\(5\)](#):
 - Screening, diagnosis, treatment and referrals for follow-up services;
 - Maintenance of the members consolidated health history, including information received from other providers;
 - Physician's services as needed by the member for acute, episodic or chronic illness or conditions;
 - Provision or referral for dental services; and
 - Transportation and scheduling assistance.

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

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

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

Coordination of Benefits (COB): Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.

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

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

Culturally Competent: A set of congruent behaviors, attitudes, practices and policies that are formed within an agency, and among professionals that enable the system, agency, and professionals to work respectfully, effectively and responsibly in diverse situations. Essential elements of cultural competence include understanding diversity

issues at work, understanding the dynamic of difference, institutionalizing cultural knowledge, and adapting to and encouraging organizational diversity.

Days: Unless stated otherwise, “days” means calendar days.

Department: The Wisconsin Department of Health Services.

Department Values: The Department’s shared values include:

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

Durable Medical Equipment: Items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in absence of disability, illness, or injury, can withstand repeated use and can be reusable or removable.

Educational Materials: These are materials designed to provide members with information and resources regarding their health.

Emergency Medical Condition:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
 - Serious impairment of bodily functions, or
 - Serious dysfunction of any bodily organ or part.

- With respect to a pregnant woman who is in active labor:
 - Where there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - Where transfer may pose a threat to the health or safety of the woman or the unborn child.
- A psychiatric emergency involving a significant risk or serious harm to oneself or others.
- A substance abuse emergency exists if there is significant risk of serious harm to a member or others, or there is likelihood of return to substance abuse without immediate treatment.
- Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever or trauma. In all emergency situations, the HMO must document in the member's dental records the nature of the emergency.

Emergency Medical Transportation: Transportation by ambulance, specialized medical vehicle (SMV) or county-approved or tribe-approved common carrier as defined under Wis. Admin Code DHS 107.23(1)(d) when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient's condition. Wis. Admin Code DHS 107.23.

Emergency Room Care: Any health care service given in an emergency room and provided to evaluate and/or treat any medical condition that a prudent layperson believes requires immediate unscheduled medical care.

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act, and needed to evaluate or stabilize an emergency medical condition.

Encounter:

- A service or item provided to a patient through the health care system. Examples include but are not limited to:
 - Office visits
 - Surgical procedures
 - Radiology (including professional and/or technical components)
 - Durable medical equipment
 - Emergency transportation to a hospital

- Institutional stays (inpatient hospital, rehabilitation stays)
- HealthCheck screens

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

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

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

Encounter Priced Amount: The fee-for-service equivalent rate assigned to an encounter.

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

Enrollee, Member, Participant and Consumer: A BadgerCare Plus and/or Medicaid SSI member who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the HMO Enrollment Rosters that the Department transmits to the HMO according to an established notification schedule. These terms are used interchangeably.

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

Enrollment Specialist: An entity contracted by the Department to perform HMO choice counseling and HMO enrollment activities. Choice counseling refers to activities such as

answering questions and providing unbiased information on available managed care organization delivery system options, and advising on what factors to consider when choosing among HMOs and in selecting a primary care provider. Enrollment activities refers to distributing, collecting, and processing enrollment materials and taking enrollments by phone, by mail, or in person.

Estimated Data Completeness: A measure used by the Department to evaluate HMO compliance with encounter submission requirements.

Excluded Services: Services that Medicaid does not pay for.

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

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

External Quality Review (EQR): Per [42 CFR §438.320](#), the analysis and evaluation by an External Quality Review Organization of aggregated information on quality, timeliness, and access to the health care services that an HMO or their contractors furnish to Medicaid beneficiaries.

External Quality Review Organization (EQRO): Per [42 CFR §438.320](#), an organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR §438.358, or both.

Fiscal Agent (as cited in [42 CFR §455.101](#)): A contractor that processes or pays vendor claims on behalf of the Medicaid agency.

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

ForwardHealth interChange: ForwardHealth interChange handles claims, prior authorizations, and other services for many of the state health care programs within a single system. Throughout this contract, the system is referred to as "interChange."

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

Grievance: An expression by a member or authorized representative of dissatisfaction or a complaint about any matter other than an action. The term is also used to refer to the overall system of complaints and grievances handled by the HMO. Possible grievance subjects include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The member or authorized representative may file a grievance either orally or in writing and must follow an oral filing with a written, signed grievance (unless the member requests expedited resolution) ([42 CFR §438.402\(c\)\(1\)\(ii\)](#)).

Habilitation Services and Devices: Health care service and devices that help a person keep, learn, or improve skills and functioning for daily living

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

Health Care Services: All Medicaid services provided by an HMO under contract with the Department in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

Health Insurance: A contract with an individual that requires a health insurer to pay some or all of an individual's health care costs.

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

Highest Needs Members: Members with complex needs, multiple comorbidities, and/or a history of frequent emergency department visits or inpatient admissions during the previous 12 months as identified by the HMO's needs-stratification process.

HHS: The federal Department of Health and Human Services.

HHS Transaction Standard Regulation: 45 CFR, Parts [160](#) and [162](#).

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

High Risk Members: Beneficiaries with complex needs, multiple comorbidities, and a history of frequent emergency department visits or inpatient admissions during the previous 12 months.

HMO: The Health Maintenance Organization or its parent corporation with a Certificate of Authority to do business in Wisconsin as an HMO, that is obligated under this Contract. A separate Certificate of Authority and HMO Certification Application must be submitted for each contract the HMO intends to enter into with the Wisconsin Medicaid program (if, for example, an HMO offers multiple product lines, does business under another name, etc.).

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

Homeless: An individual who lacks a fixed and regular nighttime residence or an individual whose primary nighttime residence is:

- A supervised shelter designed to provide temporary accommodations;
- A halfway house or similar institution that provides temporary residence for individuals; or
- A place not designed for, or ordinarily used as a regular sleeping accommodation for human beings (e.g., a hallway, bus station, or a lobby).

Home Health Care: Home health skilled nursing and therapy services, including medication management, are provided to a recipient who, due to his/her medical condition, is unable to leave home to obtain necessary medical care and treatment and therefore, must receive this care at home.

Hospice Services: Services necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided to the family and other individuals caring for the terminally ill recipient. Wis. Admin Code DHS 107.31(2)

Hospitalization: An inpatient stay at a certified hospital as defined in Wis. Admin Code DHS 101.03(76).

Hospital Outpatient Care: The provision of services by an outpatient department located within an inpatient hospital licensed facility which does not include or lead to an inpatient admission to the facility.

Income Maintenance Agencies: Agencies include tribes, consortia or counties that determine BadgerCare Plus and Medicaid SSI enrollment and ongoing case management. Members can apply for benefits online, by phone, by mail or in person with their local agency.

Indian: Pursuant to [42 CFR § 438.14\(a\)](#), any individual defined at [25 U.S.C. 1603\(13\)](#), [1603\(28\)](#), or [1679\(a\)](#), or who has been determined eligible as an Indian, under [42 CFR 136.12](#). The individual:

- Is a member of a Federally recognized Indian tribe;
- Resides in an urban center and meets one or more of the four criteria:
 - Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
 - Is an Eskimo or Aleut or other Alaska Native;
 - Is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian Health Care Provider (IHCP): Pursuant to [42 CFR § 438.14\(a\)](#), a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those

terms are defined in section 4 of the Indian Health Care Improvement Act ([25 U.S.C. 1603](#)).

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

Information: Any “health information” provided and/or made available by the Department to a Trading Partner, and has the same meaning as the term “health information” as defined by [45 CFR Part 160.103](#).

Information Gathering and Assessment (for Medicaid SSI members only): A detailed evaluation where the care management staff collects all relevant information about the member’s health care, and cultural and socioeconomic needs to conduct needs-stratification and to develop the Comprehensive Care Plan.

Limited English Proficiency (LEP): Potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

Low Birth Weight: Defined as a birth weight of less than 2,500 grams.

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

Marketing: Any unsolicited contact by the HMO, its employees, affiliated providers, subcontractors, or agents to a potential member for the purpose of persuading such persons to enroll with the HMO or to disenroll from another HMO. Marketing does not include communication to a potential member from the issuer of a qualified health plan as defined in [45 CFR 155.200](#), about the qualified health plan.

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

Material Adjustment: An adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or

misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

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

Medicaid SSI (Supplemental Security Income): Wisconsin's Medicaid plans for the elderly, blind or disabled provide health care for members who are:

- Age 65 or older, blind or disabled,
- With family income at or below the monthly program limit, and
- Who are United States citizens or legal immigrants.

Plan eligibility depends on member income, assets, and the type of care needed. Individuals who receive SSI payments automatically qualify for Medicaid and are eligible for additional social services through their income maintenance agency.

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

Member: An individual who has been determined eligible for BadgerCare Plus or Medicaid.

Medically Necessary: A medical service, device or item that meets the definition of [Wis. Adm. Code DHS 101.03\(96m\)](#).

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

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

Members with Special Needs: Pursuant to 42 CFR § 438.208(c)(1), the terminology used in clinical diagnostic and functional development to describe individuals who require additional assistance for conditions that may be medical, mental, developmental, physical or psychological (this includes, but is not limited to, SSI members, members who need intensive medical or behavioral case management, members enrolled in the Obstetrical Medical Home (OBMH), or Birth to 3 members).

Needs-stratification: The assignment of individual members to specific levels of care management, based on individual member's overall medical and social needs that could affect the health care outcomes for that member. Needs-stratification helps align an individual member's overall medical and social needs with the most appropriate level of care management for that member.

Newborn: A member less than 100 days old.

Non-Participating Provider: Facility or provider that the HMO does not have a contract with to provide services to a member of the plan.

Outcomes: Per [42 CFR §438.320](#), changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

Outreach Materials: Materials used by the HMO to help bring awareness of services to members.

Participating Provider: Facility or provider the HMO has a contract with to provide covered services to a member of the plan.

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

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

Pharmacy Services Lock-in Program: A program implemented by the Department to coordinate the provision of health care services for HMO members who abuse or misuse pharmacy benefits by seeking duplicate or medically unnecessary services, for restricted medications. Members enrolled in the program will have one pharmacy provider and one primary prescriber for restricted medications.

Physician Services: Any medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative services provided in a physician's office, in a hospital, in a nursing home, in a recipient's residence or elsewhere, and performed by or under the direct, on-premises supervision of a physician within the scope of the practice of medicine and surgery as defined in Wis. Stats. 448.01 (9).

Plan: A plan is an individual or group plan that provides, or pays the cost of, medical care.

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

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

Preauthorization: The written authorization issued by the Department or the HMO to a provider prior to the provision of a service. Also known as 'prior authorization'. Wis. Admin Code DHS 101.03(134).

Pricing Percentage: Refers to percent priced for a defined time period such as a calendar or fiscal year. This measure is calculated by the HMO and is reported to the Department as a component of the Estimated Data Completeness measure.

Primary Care Provider (PCP): Primary care physician or other licensed provider who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions. Including, but not limited to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), tribal health centers, and physicians, nurse practitioners, nurse midwives, physician assistants and physician clinics with specialties in general practice, family practice, internal medicine, obstetrics, gynecology, and pediatrics. Pursuant to 42 CFR §438.208(b)(1), the primary care provider is a person formally designated as primarily responsible for coordinating the services accessed by the member.

Prospective Risk Adjustment: Per 42 CFR §438.5(a), a methodology to account for anticipated variation in risk levels with the contracted HMO that is derived from historical experience of the contracted HMO and applied to rates for the rating period for which the certification is submitted.

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

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

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

Quality: Per [42 CFR §438.320](#), as it pertains to external quality review, the degree to which a HMO increases the likelihood of desired outcomes of its enrollees through:

- Its structural and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based-knowledge.
- Interventions for performance improvement.

Rate Cell: A set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

Rating Period: A period of 12 months selected by the Department for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by [42 CFR §438.7\(a\)](#).

Readily Accessible: Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

Reconsideration of a Claim: A request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors.

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

Rehabilitation Services and Devices: Services and devices designed for recovery or improvement of function and to restore to previous level of function if possible.

Resubmission of a Claim: A claim or a portion of a claim that was denied is resubmitted through the claims process with changed or added information.

Retrospective Risk Adjustment: Per 42 CFR §438.5(a), a methodology to account for variation in risk levels with the contracted HMO that is derived from experience concurrent with the rating period of the contracted HMO subject to the adjustment and calculated at the expiration of the rating period.

Risk Adjustment (Previously known as Chronic Illness & Disability Payment System (CDPS)): Per 42 CFR §438.5(a), a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of HMOs contracted with the State.

Rural Exception: The provision under [42 CFR 438.52](#) allowing states to require members in rural areas to enroll into a single HMO.

Screening: The use of data-gathering techniques, tests, or tools to identify or quantify the health and/or cultural needs of a member. Screening methods may include telephonic contact, mailings, interactive web tools, or encounters in person with screeners or health care providers. For Medicaid SSI members, the screening must be an in-person or telephonic interview where an HMO identifies the member's medical, dental, behavioral health and social needs.

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

Serious Emotional Disturbance, Severe Emotional Disturbance, Severely Emotionally Disturbed and SED: A persistent mental or emotional disturbance listed in

the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders affecting an individual under 21 who meets specific criteria for symptoms or functional impairments, and receiving services from multiple systems.

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

Service Authorization: A member's request for the provision of a service.

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

Skilled Nursing Care: Medically necessary skilled nursing services ordered by and to be administered under the direction of a physician that may only be provided by an advanced practice nurse, a registered nurse (RN), or a licensed practical nurse (LPN) working under the supervision of an RN.

Social Determinants of Health: Social, economic, and material factors surrounding people's lives, traumatic life events, access to stable housing, education, health care, nutritional food, employment and workforce development.

Specialist: A physician whose practice is limited to a particular branch of medicine or surgery, especially one who is professionally certified by a board of physicians.

Standard Plan: Effective April 1, 2014, all members eligible for BadgerCare Plus will be enrolled in the BadgerCare Plus Standard Plan. Standard Plan is the benefit package for BadgerCare Plus and Medicaid SSI defined in the ForwardHealth online handbooks and through State Plan Authority.

State: The State of Wisconsin.

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

Substantial Failure to Perform: Includes any violation of any requirement of this Contract that is repeated or ongoing, that goes to the essentials or purpose of the Contract, or that injures, jeopardizes or threatens the health, safety, welfare, rights or other interests of members.

Third Party Liability (TPL): The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the “payer of last resort,” the identification of other payer obligations is a major requirement in the adjudication of claims (see Addendum IV, A for additional definitions pertaining to TPL).

Trade Secret: Per [Wis. Stat. 134.90\(1\)](#), trade secrets are information, including a formula, pattern, compilation, program, device, method, technique or process to which all of the following apply:

- [134.90\(1\)\(c\)1.1](#). The information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use.
- [134.90\(1\)\(c\)2.2](#). The information is the subject of efforts to maintain its secrecy that are reasonable under the circumstances.

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

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

Transitional Care: Processes to ensure continuity of care that include, but are not limited to, medication reconciliation, ensuring members have a comprehensive understanding of their treatment plan, and assisting members with scheduling follow-up appointments with their primary care provider or specialists as needed after a member is discharged from an emergency department, hospital, nursing home, or rehabilitation facility. Per [42 CFR § 438.208\(b\)\(2\)](#), processes to coordinate services the HMO furnishes to the member between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.

Trauma-informed Care: An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

Urgent care/service needs: Services provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services are often but not always those that if not fulfilled could result in an emergency room visit or inpatient admission.

Usual sources of care: Doctor, clinic, health center, or other place that an individual reports visiting when sick. Persons who report the emergency department as the place of their usual source of care are defined as having no usual source of care.

Validation: Per 42 CFR §438.320, 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.

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

Waste: The unnecessary incurrence of costs as a result of inefficient or inaccurate practices, systems or controls.

Wisconsin Interdisciplinary Care Team (WICT): A group of health care professionals, including HMO partners, and other ancillary staff representing diverse disciplines who work together to share expertise, knowledge, and skills to help members meet their self-identified goals. An effective WICT requires interdependent collaboration, open communication, and shared decision-making working toward a common goal.

Wisconsin Statewide Health Information Network (WISHIN): Wisconsin's health information network that shares electronic health information securely between participating physicians, clinics, hospitals, pharmacies, clinical laboratories, and HMOs across the state.

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

Per 42 CFR 438.10, HMOs must use the definitions for managed care terminology found above when communicating with members to ensure consistency in the information provided to members. Terms that are not defined above shall have their primary meaning identified in [Wis. Adm. Code DHS 101-108](#).

ARTICLE II

II. ENROLLMENT AND DISENROLLMENT

A. Enrollment

1. Enrollment Authority

BadgerCare Plus

Enrollment in the HMO is voluntary by the member except where limited by departmental implementation of a State Plan Amendment or a Section 1115(a) waiver. The current State Plan Amendment and 1115(a) waiver require mandatory enrollment into an HMO for those service areas in which there are two or more HMOs with sufficient slots for the HMO eligible population and in rural areas, as defined in [42 CFR 438.52](#), where there is only one HMO with an adequate provider network as determined by the Department.

Medicaid SSI

The current State Plan Amendment requires mandatory enrollment into an HMO for those service areas in which there are two or more HMOs with sufficient slots for the HMO eligible population and in rural areas, as defined in [42 CFR 438.52](#), where there is only one HMO with an adequate provider network as determined by the Department.

Medicaid SSI members who are dual eligible for Medicaid and Medicare and members who are enrolled in a Medicaid Purchase Plan (MAPP) are not subject to mandatory enrollment.

2. Enrollment Determination

The Department will identify BadgerCare Plus, Medicaid SSI and SSI-Related Medicaid members who are eligible for enrollment in the HMO as the result of eligibility under the medical eligibility status codes listed in the chart at the following link:

[Medical Status Codes Eligible for BadgerCare Plus and Medicaid SSI HMO Enrollment](#)

The Department will make all reasonable efforts to enroll pregnancy cases in HMOs as soon as possible for BadgerCare Plus.

3. Enrollment Rosters

The Department will promptly notify the HMO of all BadgerCare Plus and/or Medicaid SSI members enrolled in the HMO under this Contract. Notification will be effected through the HMO Enrollment Rosters. These rosters shall be available through electronic file transfer capability and will include medical status codes.

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

a. BadgerCare Plus and Medicaid SSI

- 1) The Initial HMO Enrollment Roster will list all of the HMO’s members and disenrollees for the enrollment month that are known on the date of roster generation. The Initial HMO Enrollment Roster will be available to the HMO on or about the twenty-first of each month. A capitation claim shall be generated for each member listed as an ADD or CONTINUE on this roster. Members who appear as PENDING on the Initial Roster and are reinstated into the HMO by the last business day of the month will appear as a CONTINUE on the Final Roster and a capitation claim will be generated at that time.
- 2) The final HMO Enrollment Roster will list all of the HMO’s members for the enrollment month, who were not included in the Initial HMO Enrollment Roster. The Final HMO Enrollment Roster will be available to the HMO by the first day of the capitation month. A capitation claim will be generated for every member listed as an ADD or CONTINUE on this roster. Members in PENDING status will not be included on the final roster.

- b. The Department will provide the HMO with effective dates for medical status code changes, county changes and other address changes in each enrollment roster to the extent that the income maintenance agency reports these to the Department.

4. Enrollment Levels

The HMO, for BadgerCare Plus or Medicaid SSI, must designate a maximum enrollment level for each service area. The Department may take up to 60 days from the date of written notification to implement maximum enrollment level changes. The HMO must accept as enrolled all persons who appear as members on the HMO Enrollment Rosters up to the HMO specified enrollment level for its service area. The number of members may exceed the maximum enrollment level by 5% on a temporary basis. The Department does not guarantee any minimum enrollment level. The maximum enrollment level for a service area may be increased or decreased during the course of the Contract period based on mutual acceptance of a different maximum enrollment level. The HMO must not obtain enrollment through the offer of any compensation, reward, or benefit to the member except for additional health-related services that have been approved by the Department.

5. Enrollment Errors

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

6. Open Enrollment

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

7. Reenrollment

A member may be automatically reenrolled into the HMO if they were disenrolled solely because she/he loses BadgerCare Plus and/or Medicaid SSI eligibility for a period of six months or less.

8. Newborn Enrollment

If the mother is enrolled in a BadgerCare Plus HMO at the time of birth, and the child is reported to the certifying agency within 100 days of birth, the newborn will be enrolled in the same HMO as the mother back to the infant's date of birth.

If the mother is not enrolled in a BadgerCare Plus HMO on the date of birth, or the child is not reported to the certifying agency within 100 days, then the newborn will be enrolled following the normal ADD methodology for HMO enrollment if applicable. The newborn will be enrolled the next available enrollment month.

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

9. Member Lock-In Period

a. BadgerCare Plus

Under the Department's State Plan Amendment, mandatory members will be locked into the HMO for 12 months. The first 90 days of the 12-month lock-in period is an open enrollment period during which the member may change HMOs without cause.

b. Mandatory SSI and SSI-Related Medicaid

For mandatory Medicaid SSI and SSI-related Medicaid the first 90 days of the 12 month lock-in period are an open enrollment period during which the member may change HMOs without cause. The member, legal guardian, or authorized representative may request a change in HMOs without cause at any time during the first 90 days of enrollment. If the HMO fails to complete the assessment and care plan during the 90 day period, the disenrollment period will be extended for 30 days following completion of the assessment and care plan.

c. Voluntary Medicaid SSI and SSI-Related Medicaid

Voluntary Medicaid SSI and SSI-related Medicaid have 90 days for an open enrollment period during which the member may request disenrollment without cause at any time. After the 90 day opt-out period, if the member does not choose to go back to FFS, they will be locked-in for nine additional months. If the HMO fails to complete the assessment and care plan during the first 90 days of enrollment, the disenrollment period will be extended for 30 days following completion of the assessment and care plan.

B. Disenrollment

Disenrollment requests will be processed as soon as possible and will generally be effective the first day of the next month of the request, unless otherwise specified. If the Department fails to make a disenrollment or exemption determination within 30 days of receipt of all necessary information, the disenrollment or exemption is considered approved. The HMO must direct all members with disenrollment requests to the Department's Enrollment Specialist.

Disenrollment requests will not be backdated, unless an exception is granted by the Department. The HMO will not be liable for services, as of the effective date of the disenrollment.

The disenrollment charts located in Subsection 6 of this article indicate whether the disenrollment is applicable to BadgerCare Plus or SSI HMO.

1. Voluntary Disenrollment

Voluntary disenrollment requests from HMO enrollment must come from the member, the member's family, or legal guardian. Below are listed the different types of voluntary disenrollments.

a. BadgerCare Plus

All BadgerCare Plus members shall have the right to disenroll from the HMO pursuant to [42 CFR 438.56](#) unless otherwise limited by a State Plan Amendment or a Section 1115(a) waiver of federal laws. A voluntary disenrollment shall be effective no later than the first day of the second month following the month in which the member requests termination. Wisconsin currently has a State Plan Amendment and an 1115(a) waiver which allows the Department to "lock-in" members to the HMO for a period of 12

months in mandatory HMO service areas, unless disenrollment is allowed for just cause. Voluntary exemptions and disenrollments from the HMO are allowed for a variety of reasons.

b. Medicaid SSI

All mandatory Medicaid SSI or SSI related Medicaid members shall have the right to disenroll from the HMO pursuant to [42 CFR 438.56](#) unless otherwise limited by a State Plan Amendment. A voluntary disenrollment shall be effective no later than the first day of the second month following the month in which the member requests termination. Wisconsin currently has a State Plan Amendment which allows the Department to “lock-in” members to the HMO for a period of 12 months in mandatory HMO service areas, unless disenrollment is allowed for just cause. Voluntary exemptions and disenrollments from the HMO are allowed for a variety of reasons.

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

- c. Members may also request disenrollment upon automatic reenrollment under [42 CFR 438.56\(c\)](#) if the temporary loss of BadgerCare Plus and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period.
- d. A member may also request disenrollment if an HMO does not, because of moral or religious objections, cover the service the member seeks. The HMO must notify the Department, at the time of certification, of any services that they would not provide due to moral or religious objections.
- e. A member may request HMO disenrollment if the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member’s primary care

provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

- f. A member may request HMO disenrollment for other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs.

2. System Based Disenrollments

System disenrollments happen automatically in the system based on changes to the member's eligibility. If those eligibility changes are not updated timely, by the enrollment system, disenrollment requests may be requested through the Department's HMO Enrollment Specialists by the HMO.

a. Loss of BadgerCare Plus and/or Medicaid SSI Eligibility

If a member loses BadgerCare Plus or Medicaid SSI eligibility or dies, the member shall be disenrolled. The date of disenrollment shall be the date of BadgerCare Plus or Medicaid SSI eligibility termination or the date after the date of death. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

b. Out-of-Service Area Disenrollment

The member moved to a location that is outside of the HMO's service area(s). The date of the disenrollment shall be the date the move occurred, even if this requires retroactive disenrollment. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

c. Medicare Beneficiaries (BadgerCare Plus Only)

Members who become eligible for Medicare will be disenrolled effective the first of the month of notification to the BadgerCare Plus program from the Social Security Administration (SSA). Even if SSA awards Medicare eligibility retroactively, the effective date

of HMO disenrollment will be the first of the month of notification.

d. Inmates of a Public Institution (All Plans)

The HMO is not liable for providing care to members who are inmates in a public institution as defined in DHS [101.03\(85\)](#) for more than a full calendar month. The HMO must provide documentation that shows the member's placement. The disenrollment will be effective the first of the month following the first full month of placement or the date of BadgerCare Plus and/or Medicaid SSI ineligibility, whichever comes first.

e. County Case Management Waiver Programs (All Plans)

The member is or will be participating in CIP, COP or Pace/Partnership, other home and community waiver programs, or other managed care programs (such as Family Care). The HMO must inform the Enrollment Specialist of the effective dates that the member is/was participating in the county waiver program or other managed care program to accommodate a timely disenrollment. Disenrollment shall be effective the first month in which the member entered the other program. Disenrollments are not backdated more than four months from the date the request is received. Any capitation payments made for months subsequent to disenrollment will be recouped.

3. Involuntary Disenrollment Requests

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

a. Just Cause

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

b. Nursing Home

BadgerCare Plus members in a nursing home for longer than 30 days will have their medical status code changed to an institutional code which will automatically disenroll them from an HMO. Automatic disenrollment does not occur for the following populations and HMOs must notify the Enrollment Specialist for disenrollment:

1) Medicaid SSI

If a member is in a nursing home 90 days or longer, the member shall be disenrolled. In the event the member transfers from the nursing home to a hospital and back to the nursing home, the applicable 90 day period shall run continuously from the first admission to the nursing home and shall include any days in the hospital.

2) CLA

If a member is in a nursing home at the time of enrollment, the member shall be removed from the HMO effective the initial date of enrollment. If a member enters a nursing home while enrolled in the HMO and is in the nursing home longer than 30 days, the member shall be disenrolled from the HMO.

C. Exemptions

Exemption requests will be processed as soon as possible and will generally be effective the first day of the next month of the request, unless otherwise specified. The HMO must direct all members with exemption requests to the Department's Enrollment Specialist.

Exemption requests will not be backdated, unless an exception is granted by the Department. The HMO will not be liable for services, as of the effective date of the exemption.

Exemption requests from HMO enrollment must come from the member, the member's family, or legal guardian. Below are listed the exemption criteria that the Department uses to grant exemptions. The exemption chart (Subsection 6 of this article) indicates whether the exemption is applicable to BadgerCare Plus or SSI HMO. Even if a member meets the exemption criteria, the Department may, in its sole discretion, deny an exemption. Members who are denied an exemption may request a State Fair Hearing to appeal the denial.

1. Commercial HMO Insurance

Members who have commercial HMO insurance may be eligible for an exemption from a BadgerCare Plus or Medicaid SSI HMO if the commercial HMO does not participate in BadgerCare Plus or Medicaid SSI. In addition, members who have commercial insurance that limits them to a restricted provider network (e.g., PPOs, PHOs, etc.) may be eligible for an exemption from enrollment in a BadgerCare Plus or Medicaid SSI HMO.

The HMO may request assistance from the Department's contracted Enrollment Specialist in situations where the member has commercial insurance that limits the members to providers outside the HMO's network.

When the Department's member eligibility file indicates commercial HMO coverage limiting a member to providers outside the BadgerCare Plus and/or Medicaid SSI HMO network and the member seeks services from the BadgerCare Plus and/or Medicaid SSI HMO network providers, the BadgerCare Plus and/or Medicaid SSI HMO network providers may

refuse to provide services to that member and refer him/her to their commercial network, except in the case of an emergency.

2. Transplant (BadgerCare Plus and SSI Medicaid Plans)

Members who have had a transplant that is considered experimental such as a liver, heart, lung, heart-lung, pancreas, pancreas-kidney or bone marrow transplant are eligible for an exemption.

- Members who have had a transplant that is considered experimental will be permanently exempted from HMO enrollment the first of the month in which surgery is performed.
- In the case of autologous bone marrow transplants, the person will be permanently exempted from HMO enrollment the date the bone marrow was extracted.
- Members who have had one or more of the transplant surgeries referenced above prior to enrollment in an HMO will be permanently exempted. The effective date will be either the first of the month not more than six months prior to the date of the request, or the first of the month of the HMO enrollment, whichever is later. Exemption requests may be made by the HMO and should be directed to the Department's fiscal agent Nurse Consultant.

3. Admission to a Birth-to-3 Exemption (BadgerCare Plus Only)

A child from birth through two years of age (including two year olds), who is severely developmentally disabled or suspected of a severe developmental delay, or who is admitted to a Birth-to-3 program is eligible for an exemption. Exemption request must be made by the case head of the member or the County Birth-to-3 programs, on behalf of a member. Exemption requests should be directed to the Department's Enrollment Specialist. Exemptions are backdated no more than two months from the date the request is received.

4. Indian (All Plans)

Members who are Indian and members of a federally recognized tribe are eligible for disenrollment.

5. Continuity of Care

Continuity of Care exemptions may be granted when a person is newly enrolled or about to be enrolled in an HMO and is receiving care from a provider that is not part of the HMO the person was assigned to or chose or is not part of any HMO’s network available to the member. Continuity of Care exemptions are generally short term, granted for 6 months or less.

6. System Based Disenrollments and Exemptions

- a. Listed below are the reasons for system based disenrollment as defined in Subsection 2:

System Disenrollment reason	BadgerCare Plus	Medicaid SSI/SSI Related
Loss of BadgerCare Plus and/or Medicaid SSI eligibility	Yes	Yes
Out-of-State or Out-of-Service Area Move	Yes	Yes
CIP, COP, or Other Home and Community Based Waivers, Family Care and Pace/Partnership	Yes	Yes
Medicare Beneficiaries	Yes	No
Med stat code changes	Yes	Yes
Living in a public institution	Yes	Yes

- b. Listed below are the exemption requests which may be requested by the member and approved by the Department:

Exemption Type	BadgerCare Plus	Medicaid SSI/SSI Related
High Risk Pregnancy	Yes	Yes
Commercial HMO	Yes	Yes
Indian	Yes	Yes
Birth-to-3	Yes	No
Continuity of Care	Yes	Yes

- c. Listed below are disenrollments requests which may be requested by the HMO and approved by the Department:

Disenrollment Reason	BadgerCare Plus	Medicaid SSI/SSI Related
Just Cause	Yes	Yes
Infants with Low Birth Weight	Yes	No
Transplants	Yes	Yes
Nursing Homes	Yes	Yes

ARTICLE III

III. CARE MANAGEMENT

A. Care Management Model for the BadgerCare Plus Childless Adults Population

The HMO will provide care coordination and case management services as defined in Article I. As part of the Care Management model, the HMO will employ care coordinators and case managers to arrange, deliver, and monitor Medicaid-covered services to meet the member needs.

The HMO shall use care management staff (i.e., care coordinators, case managers, behavioral health professionals or nurses) trained in the cultural, health and socioeconomic needs of the BadgerCare Plus and Medicaid SSI population in order to conduct care coordination activities.

The care coordinators and case managers will work together with the member and the primary care provider to provide appropriate services for HMO members.

The HMO must develop Care Management guidelines to operationalize their Care Management Model which must receive Department approval prior to its implementation; any subsequent changes to the guidelines are also subject to Department approval.

1. Care Management Elements

As part of the Care Management Model, the following must be provided for each member:

- a. Health Needs Assessment Screening (BadgerCare Plus Childless Adults only)
 - 1) HMOs shall conduct an initial Health Needs Assessment (HNA) Screening for Childless Adults (CLA) members within 60 days of enrollment in the HMO.
 - 2) The HMO must perform an initial HNA Screening for newly enrolled CLA members, and CLA members that were previously enrolled in the HMO but re-enroll in the HMO at least six months after their last disenrollment.

- 3) The initial HNA Screening shall be conducted by appropriately qualified staff via methods that may include telephonic contact, mailings, interactive web tools, or encounters in person with screeners or health care providers.
- 4) Initial HNA Screening Elements – At a minimum, the HNA screening must address the following elements:
 - i. Urgent medical and behavioral symptoms (i.e. dyspnea, rapid weight gain/loss, syncope, suicidal ideations, psychotic break);
 - ii. Members’ perception of their general well-being;
 - iii. Identify usual sources of care (e.g. primary care provider, clinic, specialist and dental provider);
 - iv. Frequency in use of emergency and inpatient services;
 - v. History of chronic physical and mental health illness (e.g. respiratory disease, heart disease, stroke, diabetes/pre-diabetes, back pain and musculoskeletal disorders, cancer, overweight/obesity, severe mental illness, substance abuse);
 - vi. Number of prescription medications used monthly;
 - vii. Socioeconomic barriers to care (e.g. stability of housing, reliable transportation, nutrition/food resources, availability of family/caregivers to provide support);
 - viii. Behavioral and medical risk factors including member’s willingness to change their behavior such as:
 1. Symptoms of depression
 2. Alcohol consumption and substance abuse
 3. Tobacco use
 - ix. Weight (e.g. using BMI or waist circumference) and blood pressure indicators.
- 5) As part of the HNA Screening process, HMOs are encouraged to assist members in identifying a primary care provider.

- 6) Based on member's responses to the HNA Screening, HMOs shall conduct additional chronic or acute illness assessments as needed and identify members that may need additional care coordination.

b. Service Delivery

The HMO must coordinate and provide Medicaid-covered, medically necessary services to members in accordance with the needs identified in the HNA Screening for the CLA population. The HMO care coordinator or other professional staff shall follow-up regularly with the member to determine if services provided best address their needs.

2. Performance Targets for Health Needs Assessment (HNA) Screening for the BadgerCare Plus – Childless Adults Population

BadgerCare Plus HMOs are required to meet the lesser of the following targets of timely HNA Screenings:

- a. Performance Level Target – 35% rate of timely HNA Screenings in calendar year (CY) 2018 and 2019 OR
- b. Reduction In Error Target– 10% improvement from baseline.
 - 1) CY2018 – 10% Reduction in Error from the EQRO review of 2016 HMO HNA performance.
 - 2) CY2019– 10% Reduction in Error from the EQRO review of 2017 HNA performance.
 - 3) Reduction In Error Example:
 - Assume an HMO has a 2018 baseline of 20%.
 - 2018 Error: $100\% - 20\% = 80\%$.
 - 2018 Reduction in Error Target:
 $100\% - [80\% * (100\% - 10\%)] = 28\%$.
 - In this example, the HMO 2018 target for timely HNA Screenings would be 28%, not 35%.

HMOs that do not meet their target will be subject to financial performance penalties. The penalty amount will be the lesser of either \$250,000 or 25% of the monthly administrative capitation rate for the proportion of the BadgerCare Plus Childless Adult (CLA) membership for whom the HMO failed to meet the HNA performance target in the calendar year. For examples of how the financial performance penalty will be applied, please refer to the 2018 Health Needs Assessment Guide.

The Department will notify HMOs of their appeal rights prior to any financial performance penalties being implemented.

3. Evaluation of Performance Targets (BadgerCare Plus – Childless Adults)

The Department and the EQRO have developed a Health Needs Assessment Guide that describes the methodology that the EQRO will use to determine compliance with the Care Management requirements defined in this article. The Department's EQRO will perform a review of the HMO's member records annually to determine compliance with the HNA performance targets and other Care Management requirements defined in this article. The Department reserves the right to request additional data and reports from HMOs as needed to monitor compliance with the Care Management requirements.

B. Care Management Model for the Medicaid SSI Population

The goal of the Department's Medicaid SSI program is to improve the health of its members and enhance quality of care while reducing health care costs. The Department's vision is to collaborate with HMOs to develop a comprehensive, integrated care model; incorporating social, behavioral health, and medical needs for members. The Department excludes those SSI Medicaid members who have Medicare coverage (dual eligible) from the SSI Care Management requirements.

The HMO is responsible for establishing a team-based care management model. The care structure and care management model must assure coordination and integration of all aspects of all SSI members' health care needs. The HMO must also promote effective communication and shared decision-making between care management team and the member regarding the member's care. Based on health conditions and social determinants of health, the HMO must stratify members into different care management needs groups which will include an Wisconsin

Interdisciplinary Care Team (WICT) structure (Article III (B)(2)(b)) for members with the highest needs.

1. Care Management Model Characteristics

The HMO will have flexibility in developing its own care model(s) but it must have the following characteristics:

a. Effective Member Outreach and Engagement

HMOs must develop effective outreach strategies to connect with and engage SSI members using a member-centric, culturally competent, collaborative approach to care. The HMO must encourage member self-determination and self-care.

b. A Coordinated, Team-based, Patient-centered Approach to Care

The HMO's care management model must take into consideration the importance of shared decision-making between the care management team and members; the need for scheduling flexibility; and the need for team-based, care coordination services.

c. Social Determinants Approach to Care

Addressing member social determinants is a critical consideration for SSI members. While the HMO is not required to provide "wrap around" social services, the HMO must establish partnerships and maintain effective working relationships with key social service and community-based agencies to ensure the social determinants of health (e.g., housing instability, low health literacy, chronic stress, traumatic life events, and other social factors) are identified and addressed.

d. Use of Information Technology Integral to Care Management Model

The HMO must use information technology to improve communication within and across health care settings and to reduce fragmentation in the delivery of services to the member.

The HMO must encourage use of the Office of the National Coordinator's (ONC) Interoperability Standards Advisory best available standards to share information electronically across the continuum of care.

e. Evidence Based Approach to Care

The HMO must provide high quality of care and will be held accountable by the standards of care defined in Article X of this contract. The HMO must monitor health care outcomes regularly and promote the use of evidence-based care. In addition, through effective member engagement and outreach strategies the HMO must assist members in navigating the health care system.

2. Care Management Infrastructure

The HMO must have an appropriate care management infrastructure to serve the SSI Managed Care population. The HMO must have a sufficient number of adequately trained care management staff to meet individual member needs. As part of the care management infrastructure, the HMO must also have a WICT that is capable of rapidly mounting an intensive intervention and share a caseload for members identified by the HMO with the highest needs and to serve as a consultative resource for other Care Management staff.

At a minimum, the care management infrastructure must include the following:

a. Care Management Staff and WICT

1) Qualifications

In order to respond to the unique needs of SSI members, the HMO must employ, or contract for the employment of, licensed healthcare professionals and other qualified care management staff with the following skills and knowledge needed to coordinate care for members (upon hiring or incorporated into their annual training plan):

- i. Motivational interviewing skills
- ii. Patient engagement strategies

- iii. Knowledge of the target population
- iv. Knowledge and experience with trauma informed care and the stages of change approach
- v. An understanding of the impact of social determinants (e.g., poverty, lack of food or social supports) on health.

2) Care Management Staff Training Plan

HMOs must submit to the Department for review and approval a Care Management Staff Training Plan. This Staff Training Plan shall be submitted to the Department as part of the certification application review process and upon the Department's request.

3) Caseloads

HMOs must allow care management staff and the WICT adequate time to effectively coordinate the delivery of integrated care. In order to do so, HMOs must have strategies in place to monitor care management team workloads and to assure that each team member is assigned a manageable caseload based on their roles and responsibilities within the team. HMOs must develop and maintain written caseload standards in consideration of the following:

- i. The complexity of the cases.
- ii. The need for licensed health care professionals and other care management staff to coordinate with other providers and community resources.
- iii. The need for face-to-face contacts with the member, providers, and others instrumental to meeting the needs of the member.
- iv. Management duties, including providing direction to care management team members and ensuring adequate documentation of care management activities.

b. Wisconsin Interdisciplinary Care Team (WICT)

In addition to the care management requirements above, the HMO Care Management Model must include a Wisconsin Interdisciplinary Care Team (WICT) which will be the vehicle for providing member-centered care management services for members with the highest needs. The WICT must engage the member, his or her caregivers/family supports and other resources instrumental to the member's care.

1) WICT Structure

The WICT will have a Core Team which must include a minimum of two licensed health care professionals with adequate expertise across medical, mental and behavioral health, and social determinants of health. The WICT Core Team must have ready access to dedicated resources such as pharmacists, physicians, psychiatrists, dieticians, rehabilitation therapists, and substance abuse specialists. These resources should be engaged as part of the WICT Core Team depending on member needs.

The WICT Core Team will also coordinate with the member's PCP, medical specialists, behavioral health specialists, dental providers, and other community resources as driven by the member's care plan.

2) WICT Functions

The WICT must work collaboratively with members, their providers, and their caregivers to accomplish shared goals across medical, mental and behavioral health, and other settings to achieve coordinated, high-quality care.

At a minimum, the WICT Core Team must meet weekly, preferably face-to-face, to discuss their entire shared case load. While the WICT Core Team must meet weekly the level of discussion on each member may vary. The WICT Core Team must have regular opportunities to staff difficult cases with a larger, multidisciplinary WICT Team.

At a minimum, a team member of the WICT Core Team must meet once a month face-to-face with the member to

discuss the member's care. The face-to-face meeting with the WICT member may be completed by a community-based case manager if the case manager has a close, collaborative relationship with the WICT Core Team that is demonstrated in the member's care plan and includes reciprocal communication between the WICT Core Team and the community-based case manager.

It is expected that members will transition from the WICT to a lower intensity of ongoing care management as they become more stable; members may need to return to the WICT in the future if their needs change.

The WICT is intended to be a short-term, intensive intervention. The Department will conduct a chart review for any member enrolled in the WICT for more than 12 months.

3. Care Management Process

The HMO Care Management Model must perform all the activities described below:

a. Screening

1) Purpose

The purpose of the screening is for the HMO to identify medical, dental, mental and behavioral health or social needs of members. The screening must be used by the HMO's care management team to:

- Conduct additional assessments (e.g. for specific conditions) as needed,
- Perform needs-stratification,
- Refer members with the highest needs to the WICT.

2) Timeframe

New Members - The screening must be completed by the HMO within 60 days of the member's HMO enrollment.

Re-Enrolled Members - Members that were previously enrolled in the HMO but had a disenrollment period of six months or more from their last disenrollment must also have a screening within 60 days of the member's re-enrollment in the HMO.

3) Modes of Contact

The screening must be conducted between the HMO and the member, face-to-face, via interactive video technology (synchronous telehealth), or over the phone depending on member preference. The screening cannot be conducted via mail or electronic questionnaire or email. The screening does not need to be conducted by a licensed healthcare professional.

4) Required Components

At a minimum, the screening must include questions that enable the HMO to identify the following:

- The member's chronic physical, mental and behavioral health illness(es) (e.g. respiratory disease, cardiac disease, stroke, diabetes/pre-diabetes, renal disease, back pain and musculoskeletal disorders, cancer, overweight/obesity, all mental health and substance abuse disorders).
- The member's perception of their strengths, their general well-being (including chronic conditions and access to prescription medications).
- If the member has a usual source of care.
- Any indirect supports the member may have (family and social supports).

- Any relationships the member may have with community resources.
- Any immediate and/or long-term concerns a member may have about their overall well-being (e.g. social determinants of health).
- If the member needs assistance to conduct activities of daily living (including but not limited to bathing, dressing and eating) as well as instrumental activities of daily living (including but not limited to medication management, money management and transportation).

b. Information Gathering and Assessment

The care management team must collect, maintain, and update all relevant information to conduct needs-stratification and to develop the Comprehensive Care Plan including:

- 1) Reviewing the results of the member's screening and conducting other assessments for specific conditions as needed.
- 2) Collecting and analyzing a comprehensive set of available data regarding the member's medical and behavioral health history including data provided by the Department.
- 3) Collecting additional information about the member's social determinants of health.

c. Needs-Stratification

Needs stratification aims to align the member's overall medical and social needs with the most appropriate level of care management for that member, including WICT for highest needs members. In order to achieve this alignment, HMOs must use individual member-level needs stratification as an input for developing individual care management plans, and for using those plans to provide care management for the members. The HMO's care management team will be responsible for conducting and

validating the needs stratification results. The HMO must have established processes, systems, tools, models, and administrative and clinical staff to conduct the following tasks related to needs stratification:

- 1) Proactively stratify individual members upon enrollment, using clinical, social, administrative and other relevant data collected during Information Gathering of the care management process.
- 2) Use the stratification information for each member to assign individual members to the most appropriate care management strata, including the WICT for the highest-needs members. Prior to assigning a member to the WICT, HMOs must confirm that the member is able to participate in the intensive short-term intervention and the HMO is able to meet the WICT functional requirements for that member.
- 3) Use stratification information as an input to develop individualized comprehensive care plans.
- 4) Use the care plans to provide the most appropriate care management for individual members based on their needs.
- 5) Periodically reassess whether the members are assigned to the most appropriate strata, based on changes in their overall medical and social needs.
- 6) Continuously monitor and enhance HMO's stratification methods for improving the health outcomes for members.
- 7) If a HMO's needs stratification process results in over 5% of its monthly SSI caseload being identified as high needs and enrolled in a WICT, the HMO must notify DHS within 15 calendar days of the next calendar month. The Department will discuss with the HMO any approved continued high-WICT enrollment or any changes the HMO makes to the needs stratification process and/or care management model.

SSI HMOs will be required to submit a Performance Improvement Project (PIP) proposal further described in Article X (J) of this contract for Calendar Year 2018. This PIP aims to support the Medicaid SSI care management initiative through a robust needs stratification process, which will be assessed by the Department and the EQRO using qualitative and quantitative approaches.

d. Comprehensive Care Plan

1) Purpose

The purpose of the Comprehensive Care Plan is to ensure that appropriate care is delivered to the member by following an evidence-based, member-centric treatment plan that addresses his or her unique needs. The Plan is developed by the care management team or the WICT and the member, incorporating the elements identified in the Screening, Information Gathering, and the Needs-stratification processes.

2) Timeframe

New and Re-enrolled Members - The Comprehensive Care Plan must be completed within 30 days of completion of the Screening or 90 days after enrollment in the HMO, whichever comes first.

Current Members – All currently enrolled members must have a Comprehensive Care Plan completed by the HMO within 30 days of completion of the Screening.

3) Modes of Contact

The care management team or the WICT must develop the Comprehensive Care Plan in coordination with the member face-to-face, via interactive video (synchronous telehealth), or over the phone.

4) Care Plan Characteristics

After completing the initial Screening and the Information Gathering processes, the care management team or the WICT must develop and implement a Comprehensive Care Plan in coordination with the member that prioritizes interventions based on the member's medical, mental, behavioral, dental health and other social needs.

The Comprehensive Care Plan must have the following characteristics:

- Be member-centric, incorporating the member's short and long-term health and well-being goals.
- Incorporate health literacy and cultural competency attributes based on the individual member needs.
- Reflect understanding between the member and the care management team or WICT.
- Identify all formal and informal supports, by name or position, that are instrumental to the member's care plan goals (e.g. family, friends, caregivers, providers, community agencies). Include their role in executing the care plan, and if/how they will receive care plan updates.
- Identify the member's current medical and non-medical needs to be addressed by the care management team or WICT including:
 - Chronic conditions and acute illnesses;
 - Mental and behavioral health conditions and history of abuse, violence, or traumatic life events;
 - Dental care needs;
 - Medications taken by the member;
 - Additional supports to conduct activities of daily living (including but not limited to bathing, dressing, and eating) and instrumental activities of daily living (including but not limited to medication

- management, money management, and transportation);
 - Social determinants of health;
 - Other factors that will impact the member's ability to achieve goals.
- Identify and address any gaps in care ensuring that the member has a primary care provider, and behavioral health specialist, dentist, or other health specialists as needed.

5) Care Plan Development

As part of the Comprehensive Care Plan development, the care management team or the WICT, in coordination with the member, must create an evidence-based plan of care that includes:

- Specific goals appropriate for the member's needs,
- The member's readiness to self-manage their care and their willingness to adopt healthy behaviors,
- A description of the interventions that will be implemented to address the member's needs and their sequence.

The care management team or the WICT must:

- Develop the Comprehensive Care Plan with the member (either face-to-face, via interactive video (synchronous telehealth) or over the phone) and obtain member's agreement prior to its implementation.
- Upon completion, share the Comprehensive Care Plan with the member, the member's primary care provider and others as identified, as appropriate, in the care plan and discussed with member.
- Document the Comprehensive Care Plan, preferably according to the specifications for Care Plans in the ONC Interoperability Standards Advisory.

e. Review and Updates to the Comprehensive Care Plan

The care management team or the WICT must monitor available sources (e.g. data received from the Department, claims data, discharge information) for changes in the member's condition. The team should contact the member and update the Comprehensive Care Plan to ensure the member is receiving the appropriate services and care.

At a minimum, all SSI Managed Care members must be contacted once per calendar year (by either the care management team or the WICT) to review the Comprehensive Care Plan, or more frequently based on the member's needs.

The Comprehensive Care Plan must be updated as necessary to reflect changes in the member's condition and new information collected during the review.

1) Review of the Comprehensive Care Plan

As part of the review of the Comprehensive Care Plan, the care management team or the WICT must:

- Have documentation of care and services provided to the member.
- Determine if the member received care and services according to the Comprehensive Care Plan and the member's preferences.
- Determine if the interventions that were conducted helped the member achieve the goals identified in the Comprehensive Care Plan.
- Reassess the member's health and psychosocial status to identify necessary care plan updates.
- Assess the member's satisfaction with the care received.
- Conduct additional screening, information gathering, and/or needs stratification as appropriate.

2) Updating the Comprehensive Care Plan

The Comprehensive Care Plan must be updated, in any of the following scenarios:

- Whenever there are significant changes to the member's medical and behavioral health conditions. For example, when a member is diagnosed with a new chronic condition or experiences severe complications from an existing condition that results in a hospitalization.
- The member is not responsive to the treatment plan outlined in the Care Plan.
- The member frequently transitions between care settings, e.g. members that have an Emergency Room visit or are admitted to the hospital and then are discharged to home, or members that are discharged from a hospital to a Skilled Nursing Home facility.
- At the member's request or whenever the care management team or the WICT identifies a problem or a gap in the member's care. This would include social determinants such as becoming homeless or experiencing food instability.

The member, or the member's authorized representative must approve all updates made to the Comprehensive Care Plan and member consent must be captured in the updated Comprehensive Care Plan.

f. Appropriate Transitional Care

The HMO is responsible for having appropriate transitional care processes and procedures in place to assist members after a discharge from emergency departments, hospitals and nursing homes or rehabilitation facilities. This includes encouraging providers to share a summary care record, as specified in the ONC Interoperability Standards Advisory. As part of appropriate transitional care processes, the care management team or the WICT must ensure the member understands his or her discharge plan and medication regimen.

At a minimum, the following must occur after every discharge from an inpatient hospitalization:

- 1) The care management team or WICT must have follow-up contact with the member and his/her family supports within five business days of discharge from an inpatient facility.
 - The follow-up contact must be done in-person, via interactive video (synchronous telehealth), or over the phone.
 - The follow-up must include reviewing the discharge information prepared by the hospital with the member, conducting medication reconciliation, and helping the member understand:
 - Their treatment plan.
 - Their medications and medication schedule.
 - How to best manage their conditions.
- 2) The care management team or the WICT must assess if the member should have a follow-up visit and assist with scheduling appointments, as necessary, with their primary care provider and/or appropriate specialists.
- 3) The care management team or the WICT must have adequate documentation in the Comprehensive Care Plan of the meeting with the member, their feedback, and any follow-up appointments the member had with their primary care provider and/or appropriate specialists.

4. Care Management Billing Rules

The Department has developed a special care management benefit for the SSI managed care population. The benefit is defined above in Article III. B., (Care Management Model for the Medicaid SSI Population). The Department will reimburse HMOs for the care management services (outlined in Article III. B.) outside of the regular capitation payment. The Department will continue to cover other care management activities as an administrative component of the capitation rate or as an integral and inseparable component of another Medicaid covered benefit, as appropriate.

The Department has identified specific procedure codes to represent the Medicaid SSI care management benefit. HMOs will be required to use these procedure codes to identify SSI care management activities provided by the WICT and / or SSI care management staff. HMOs will be required to submit member-specific claims via encounter records for the SSI care management benefit. The HMO must maintain documentation for each member that supports the claimed services in their care management system.

Non-Duplication of Care Management Services

The Department developed the care management services defined in Article III. B., as a separate and distinct benefit for the Medicaid SSI managed care population. As a distinct benefit, the care management requirements defined in Article III. B., must be reported as such using encounter records. HMOs must not report these care management activities using the financial template typically used to report the HMO's administrative activities.

HMOs must have a process to ensure that care management activities provided to the SSI managed care population are identified and accurately reported as either a benefit or as an administrative activity. A specific care management activity must never be deemed both a benefit and an administrative activity. For example, a general reminder call to SSI members about the availability of seasonal influenza vaccines cannot be reported both as an encounter and as an administrative activity. The HMO is responsible for ensuring that these activities are clearly defined and categorized. Services outside the allowed Medicaid-covered services and the billing codes, as documented in the SSI Care Management Billing Guide, are defined as an administrative service.

All care coordination activities reported as an encounter must be provided in accordance with the identified member's care plan. Care management activities that are not provided to an identified member and not provided in accordance with the requirements of Article III. B., are not covered as a separate benefit and must not be submitted as an encounter. HMOs must continue to report other care management costs under "administration" in the financial template.

The Department will provide detailed billing instructions, including procedure codes, reimbursement levels, and other claim submission requirements, in the SSI Care Management Billing Guide. HMOs must use

the billing guide in addition to the HMO Contract to ensure that care management activities that are intrinsic to the SSI Care Management benefit are properly documented, billed and reported.

5. Evaluation of Care Management Requirements (Medicaid SSI)

The Department and the EQRO will develop a methodology to review the HMO's member records to determine compliance with the performance targets and other requirements of the Care Management Model. The Department's EQRO will perform a chart review annually to determine if the HMO has met the performance targets and other Care Management requirements. In addition, the Department will analyze the encounter data with G codes submitted by the HMOs to evaluate how well the care management services delivered by the HMOs meet the program objectives. The Department reserves the right to request additional data and reports from HMOs as needed to monitor compliance with the Care Management requirements.

The MY2018 HMO Quality Guide provides additional information about the targets, measures and other operational aspects related to the evaluation of care management requirements for Medicaid SSI.

6. Submission of Care Management Information to WISHIN (Medicaid SSI)

The HMO must submit care management information for SSI members to the Wisconsin Statewide Health Information Network (WISHIN), when the capacity is available. The HMO will work with DHS and WISHIN to define the care management information that will be shared electronically and securely with WISHIN in 2018.

C. Care Coordination Requirements for all Members

Per 42 CFR § 438.208(b)(2), the HMO must coordinate the services it provides to members:

- Between settings of care, including appropriate discharge planning for hospital or institutional stays.
- With services provided by another HMO.
- With services a member receives through Medicaid Fee-for-Service.
- With services a member receives through community and social support providers.

D. Screening Requirements for non-Childless Adults BadgerCare Plus Members

Pursuant to [42 CFR § 438.208\(b\)\(3\)](#), the HMO must make a best effort to conduct an initial screening of each member's needs, within 90 days of HMO enrollment for all new members.

ARTICLE IV

IV. SERVICES

A. BadgerCare Plus and/or Medicaid SSI Services

The HMO must provide BadgerCare Plus and/or Medicaid SSI covered services to the extent outlined below, but is not restricted to only providing BadgerCare Plus and/or Medicaid SSI covered services. Sometimes the HMO may find that other treatment methods may be more appropriate than BadgerCare Plus and/or Medicaid SSI covered services, or result in better outcomes. An HMO may cover services for a member that are in addition to those services covered under the state plan per [42 CFR §438.3\(e\)](#). In lieu of services can be covered by HMOs on a voluntary basis as follows: the Department determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan; the member is not required by the HMO to use the alternative service or setting; the approved in lieu of services are identified in the HMO contract and will be provided at the option of the HMO; and the utilization and cost of in lieu of services is taken into account in developing the component of the capitation rates that represent the covered state plan services.

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

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

1. Provision of Contract Services

The HMO must promptly provide or arrange for the provision of all services required under [Wis. Stats., s. 49.46\(2\)](#), [s. 49.471\(11\)](#), [s. 49.45\(23\)](#) and [Wis. Adm. Code DHS 107](#) as applicable to the particular member and as further clarified in all Wisconsin Health Care Programs Online Handbook and HMO Contract Interpretation Bulletins, Provider Updates, through the interChange Portals, and as otherwise specified in this Contract except:

- a. Non-emergency Medical Transportation (NEMT) as listed in Article IV Section A(6).
- b. Dental, unless the HMO elects to provide dental services. BadgerCare Plus HMOs serving Milwaukee, Waukesha, Racine, Kenosha, Ozaukee and Washington counties must provide dental services. SSI HMOs serving Milwaukee, Waukesha, Racine and Kenosha counties must provide dental services.
- c. Prenatal Care Coordination (PNCC), except the HMO must sign a Memorandum of Understanding (MOU) with the PNCC.
- d. Targeted Case Management (TCM), except the HMO must work with the TCM case manager as indicated in Addendum III.
- e. School-Based Services (SBS), except the HMO must use its best efforts to sign a Memorandum of Understanding (MOU). SBS are those services identified in a student's Individualized Education Plan (IEP) and provided by a school district or CESA.
- f. Child Care Coordination.
- g. Certain Tuberculosis-related services, including directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring.
- h. Crisis Intervention Benefit.
- i. Community Support Program (CSP) services.
- j. Comprehensive Community Services (CCS).
- k. Community Recovery Services (CRS).
- l. Chiropractic services, unless the HMO elects to provide chiropractic services.
- m. Lead investigations, as defined in [s. 254.11\(8s\)](#), of persons having lead poisoning or lead exposure, as defined in [s. 254.11\(9\)](#).
- n. Medication therapy management.

- o. Prescription, over-the-counter drugs, and diabetic and other drug related supplies (as defined by the Department dispensed by a provider licensed to dispense by the Wisconsin Department of Safety and Professional Services (DSPS)).
- p. Provider administered drugs, as discussed in the following handbook topics:

Provider-Administered Drugs ([Topic #5697](#)), of the Covered and Non-covered Services chapter of the ForwardHealth Online Handbook.

- q. Behavioral Treatment Services (Autism Services) as defined in ForwardHealth Online Handbook

The HMO must provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to the member under fee for service Medicaid, as set forth in [42 CFR § 438.210\(a\)\(2\)](#), [42 CFR § 440.230](#), and [42 CFR part 441, subpart B](#).

Pursuant to [42 CFR §438.210\(a\)\(3\)](#), the HMO:

- a. Must ensure that the services furnished to the member are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
- b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

In addition, the HMO must comply with the care coordination requirements defined in Art. III, section C. Addendum V contains a link to additional summary information on BadgerCare Plus and Medicaid SSI covered services. Please refer to the ForwardHealth Provider Updates for the most current information regarding BadgerCare Plus and/or Medicaid SSI covered services.

2. Medical Necessity

The actual provision of any service is subject to the professional judgment of the HMO providers as to the medical necessity of the service, except

that the HMO must provide assessment, evaluation, and treatment services ordered by a court.

Per 42 CFR §438.210(a)(4), the HMO can make decisions to provide or deny medical services on the basis of medical necessity and appropriateness as defined in the State Plan and [DHS 101.03\(96m\)](#) or place appropriate limits on a service for the purpose of utilization control provided that:

- i. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i);
- ii. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports; and
- iii. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

The HMO must specify what constitutes "medically necessary" in a manner that:

- a. Is no more restrictive than that used in the Medicaid program as indicated in [DHS 101.03\(96m\)](#), [the State Plan, Wis. Stats., s. 49.46\(2\)](#), [s. 49.471\(11\)](#), [s. 49.45\(23\)](#) and [Wis. Adm. Code DHS 107](#), Wisconsin Health Care Programs Online Handbook and HMO Contract Interpretation Bulletins, [and the](#) ForwardHealth Provider Updates; and
- b. The HMO is responsible for covering services related to:
 - i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that result in health impairments and/or disability.
 - ii. The ability for a member to achieve age-appropriate growth and development.
 - iii. The ability for a member to attain, maintain or regain functional capacity.

Regarding physical therapy, occupational therapy, and speech and language therapy and audiology, the HMO must provide these services sufficient for a member to attain, maintain, or regain functional capacity.

Per Wis. Admin code 107.16(3)(c), 107.17(3)(d), and 107.18(3)(d), maintenance therapy services provided by a skilled therapist or audiologist are considered medically necessary and therefore must be provided by the HMO in any of the following situations:

- a. The skills and training of a therapist or audiologist are required to execute the entire preventive and maintenance program;
- b. The specialized knowledge and judgment of the therapist are required to establish and monitor the maintenance therapy program including the initial evaluation, the design of the program appropriate to the member, the instruction of nursing or other support personnel, family or member, and the re-evaluations required; or
- c. When, due to the severity or complexity of the member's condition, nursing or other support personnel cannot handle the member safely and effectively.

Furthermore, the HMO must not consider physical, occupational, and speech and language therapy services supplied in school settings automatically duplicative when it is considering the medical necessity of a requested community based therapy.

Disputes between the HMO and members about medical necessity can be appealed through the process described in Article IX. The Department will consider whether BadgerCare Plus and/or Medicaid SSI would have covered the service on a FFS basis (except for certain experimental procedures).

3. Physician and Other Health Services

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

4. Pre-existing Medical Conditions

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

5. Emergency Ambulance Services

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

- a. Pay a service fee for an ambulance response to a call in order to determine whether an emergency exists, regardless of the HMO's determination to pay for the call.
- b. Pay for emergency ambulance services based on established BadgerCare Plus and/or Medicaid SSI criteria for claims payment of these services.
- c. Either pay or deny payment of a clean claim from an ambulance service within 45 days of receipt of the clean claim.
- d. Respond to appeals from ambulance providers within the time frame described. Failure will constitute the HMO's agreement to pay the appealed claim to the extent FFS Medicaid would pay.

6. Non-Emergency Medical Transportation (NEMT) (BadgerCare Plus and Medicaid SSI)

Most non-emergency Medical Transportation (NEMT) is coordinated by the Department of Health Services' NEMT manager. The NEMT manager arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include public transportation such as a city bus, non-emergency ground ambulance, rides in specialized medical vehicles (SMV), or rides in other types of vehicles depending on a member's medical transportation needs, as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus and Medicaid SSI covered services. Non-emergency medical transportation also includes coverage of meals and lodging in accordance with the ForwardHealth policy.

Members needing non-emergency medical transportation services should be directed to the DHS NEMT manager. Members may visit the Wisconsin Medicaid and BadgerCare Plus [Non-emergency Medical Transportation webpage](#) for more information.

The HMO must promptly provide or arrange for the provision of all NEMT ambulance services not reimbursed by the DHS NEMT manager listed in the [ForwardHealth Online Handbook Topic #11898](#).

7. Transplants

Transplant coverage is as follows:

- a. Cornea and kidney transplants. These services are no longer considered experimental. Therefore, the HMO must also cover these services.
- b. The HMO is not required to cover procedures that are approved only at particular institutions, including bone marrow transplants, liver, heart, heart-lung, lung, pancreas-kidney, and pancreas transplants. There are no funds in the HMO capitation rates for these services.
- c. As a general principle, the BadgerCare Plus and/or Medicaid SSI program does not pay for transplants that it determines to be experimental in nature.

Members who have had one or more of the transplant surgeries referenced in 7b above will be permanently exempted from HMO enrollment. Refer to Article II, C for the exemption criteria.

8. Dental Services

- a. Dental services covered by HMOs who are not contracted to provide comprehensive dental services for BadgerCare Plus and Medicaid SSI Plans:

1) Emergency Dental Care

The HMO must cover emergency dental care. The only exceptions are the charges for professional services billed

using CDT codes and the charges for professional services rendered by a dentist and billed using CPT codes.

2) Dental Surgeries Performed in a Hospital

The HMO must pay all ancillary charges relating to dental surgeries when a hospital or freestanding ambulatory care setting is medically indicated. Ancillary charges include, but are not limited to physician, anesthesia, and facility charges. The only exceptions are the charge for professional services billed using CDT codes and the charges for professional services rendered by a dentist and billed using CPT codes. If the HMO is unable to arrange for the dental surgery to be performed within their own provider network then the HMO must authorize the service(s) to be performed out of plan.

3) Prescription Drugs Prescribed by a Dental Provider

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

4) Coordination with Fee-for-Service

As defined in Art. III, section C, the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Service.

b. Dental services covered by the HMO contracted to provide dental care for BadgerCare Plus and Medicaid SSI:

- 1) All BadgerCare Plus and/or Medicaid SSI covered dental services are required under [DHS 107.07](#) and Wisconsin Health Care Programs Online Handbooks and Updates.
- 2) HMOs providing dental coverage in service areas of Racine, Marathon, Brown, and Polk Counties will be required to participate in a dental pilot program authorized in the 2015-17 biennial budget.

- 3) Diagnostic, preventive, and medically necessary follow-up care to treat a dental disease, illness, injury or disability of members while they are enrolled in the HMO.
- 4) Completion of orthodontic or prosthodontic treatment begun while a member was enrolled in the HMO if the member became ineligible for BadgerCare Plus and/or Medicaid SSI or disenrolled from the HMO, no matter how long the treatment takes. The HMO will not be required to complete orthodontic or prosthodontic treatment on a member who began treatment as a FFS member and who subsequently was enrolled in the HMO.

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

c. Right to Audit

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

d. Requirements to Dental Service Providers

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

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

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

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

* Orthodontic treatment is only covered by BadgerCare Plus and/or Medicaid SSI for children under 21 as a result of a HealthCheck referral ([DHS 107.07\(3\)](#)).

9. Emergency and Post-Stabilization Services

a. 24-Hour Coverage

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

The HMO must:

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

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

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

- 3) Notify the Department and county human services department with which the HMO has a MOU or in which the HMO has enrollment of any changes to this toll-free telephone number for emergency calls within seven business days of the change.
- 4) Per Art. III, section C, the HMO must coordinate the services it provides to members between settings of care.

b. Coverage of Payment of Emergency Services

The HMO must promptly provide or pay for needed contract services for emergency medical conditions and post-stabilization services, regardless of whether the provider that furnishes the service has a contract with the entity. The HMO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or HMO of the member's screening and treatment within ten (10) days of presentation for emergency services. The HMO in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the HMO as identified in [42 CFR 438.114\(b\)](#) and [42 CFR 438.114\(d\)](#) as responsible for coverage and payment. Nothing in this requirement mandates the HMO to reimburse for non-authorized post-stabilization services.

- 1) The HMO shall provide emergency services consistent with [42 CFR 438.114](#). It is financially responsible for emergency services whether obtained within or outside the HMO's network. This includes paying for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.
- 2) The HMO may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- 3) The HMO may not deny payment for emergency services for a member with an emergency medical condition (even

if the absence of immediate medical attention would not have had the outcomes specified in paragraphs 1., 2. and 3. of part a. of the definition of Emergency Medical Condition) or for a member who had HMO approval to seek emergency services.

- 4) The member may not be held liable for payment of screening and treatment needed to diagnose the specific condition or stabilize the patient.
- 5) The treating provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the HMO.

c. Coverage and Treatment of Post-Stabilization Care Services

1) The HMO is financially responsible for:

- Emergency and post-stabilization services obtained within or outside the HMO's network that are pre-approved by the HMO. The HMO is financially responsible for post-stabilization care services consistent with the provision of [42 CFR 438.114\(C\)](#).
- Post-stabilization services obtained within or outside the HMO's network that are not pre-approved by the HMO, but administered to maintain, improve or resolve the member's stabilized condition if:
 - The HMO does not respond to a request for pre-approval of further post-stabilization care services within one (1) hour;
 - The HMO cannot be contacted; or
 - The HMO and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the HMO must give the treating

physician the opportunity to consult with the HMO care team or medical director. The treating physician may continue with care of the member until the HMO care team or medical director is reached or one of the following occurs:

- A network physician assumes responsibility for the member's care at the treating hospital or through transfer;
 - The treating physician and HMO reach agreement; or,
 - The member is discharged.
- 2) The HMO's financial responsibility for post-stabilization care services it did not pre-approve ends when a network provider assumes responsibility for care, at the treating hospital or through transfer, when the treating physician and HMO reach agreement or when the member is discharged.
- 3) The HMO must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the HMO. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

d. Additional Provisions

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

until the patient is stabilized and can be safely discharged or transferred.

- 2) When emergency services are provided by non-affiliated providers, the HMO is liable for payment only to the extent that BadgerCare Plus and/or Medicaid SSI pays, including Medicare deductibles, or would pay, FFS providers for services to BadgerCare Plus and/or Medicaid SSI populations. For more information on payment to non-affiliated providers, see Article XV, Section D, part 4. The HMO must not make any payments to providers with a financial institution outside the United States. In no case will the HMO be required to pay more than billed charges. This condition does not apply to:

- Cases where prior payment arrangements were established; and
- Specific subcontract agreements.

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

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

10. Family Planning Services and Confidentiality of Family Planning Information

BadgerCare Plus and Medicaid SSI Plan members:

- a. The HMO must give members the opportunity to have a different primary physician for the provision of family planning services. This physician does not replace the primary care provider chosen by or assigned to the member.
- b. The member may choose to receive family planning services at any Medicaid-enrolled family planning clinic. Family planning services provided at non-network Medicaid-enrolled family planning clinics are paid FFS for HMO members including pharmacy items ordered by the family planning provider.
- c. All information and medical records relating to family planning shall be kept confidential including those of a minor.

11. Pharmacy Coverage

a. Pharmacy Coverage

Prescription, over-the-counter, diabetic and other drug related supplies (as defined by the Department), medication therapy management and provider administered drugs under Article IV, A.1.o, is carved out of the capitation rate for all BadgerCare Plus and/or Medicaid SSI members and will be paid on a fee-for-service basis.

Per Article III, section C, the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Service.

b. Pharmacy Services Lock-In Program

DMS will manage a Pharmacy Services Lock-In Program to coordinate the provision of health care services for HMO members who abuse or misuse pharmacy benefits by seeking duplicate or medically unnecessary services, for restricted medications.

Abuse or misuse is defined under Recipient Duties in [DHS 104.02, Wisconsin Administrative Code](#). Restricted medications are most controlled substances and tramadol.

HMO members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one primary prescriber who will prescribe restricted medications.

HMO members will remain enrolled in the Pharmacy Services Lock-In Program for two years. At the end of the two-year enrollment period, DMS or the HMO will assess if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Policy on the Pharmacy Services Lock-In Program can be found in the BadgerCare Plus and Medicaid Pharmacy Provider Handbook.

1) DHS Responsibilities:

- The DMS or its designated representative shall manage the Pharmacy Services Lock-In Program and communicate directly with the HMOs regarding their members.
- The DMS or its designated representative will monitor prescription drug usage for members enrolled in the Pharmacy Services Lock-In Program.
- The DMS or its designated representative will accept select review requests from the HMO for potential Pharmacy Services Lock-In Program members. Not all select reviews may result in intervention letters or lock-in for the member.
- The DMS or its designated representative will accept referrals from the HMO for the Pharmacy Services Lock-In Program. DMS or its designated representative will proceed with Pharmacy Services lock-in for referred members.
- The DMS or its designated representative may request additional information from the HMO for referrals. The HMO must provide requested

information to DMS or its designated representative.

- The DMS or its designated representative will identify the lock-in pharmacy and the HMO will identify the lock-in primary prescriber for each member. In addition, the HMO will identify any alternate prescribers for restricted medications, as appropriate.
- The DMS or its designated representative will send letters of notification to the lock-in member and HMO for the lock-in pharmacy.
- The DMS or its designated representative will provide an electronic monthly report to the HMO that identifies any members in the Pharmacy Services Lock-In Program for the specific HMO.
- The DMS or its designated representative will coordinate with the HMO for the Pharmacy Services Lock-In Program policies and procedures.

2) HMO Responsibilities:

- HMOs may request select reviews based on prescription drug utilization for potential Pharmacy Services Lock-In Program members. Not all select review requests may result in intervention letters or lock-in for the member.
- HMOs may provide Pharmacy Services Lock-In Program referrals to the DMS or its designated representative. The DMS or its designated representative will proceed with Pharmacy Services lock-in for all HMO-referred members.
- The HMO should evaluate referred Pharmacy Services Lock-In Program members at the end of the two-year enrollment period, to determine if the

member should continue enrollment in the Pharmacy Services Lock-In Program and notify the DMS or its designated representative.

- The HMO will be responsible for preparing all documentation and acting as the DMS representative for member appeals to the Division of Hearings and Appeals related to the Pharmacy Services Lock-In Program referrals.
- The DMS may request additional information from the HMO for referrals. The HMO must provide requested information to the DMS or its designated representative.
- HMOs lock-in primary prescribers may designate alternate prescribers for restricted medications, as appropriate.
- HMOs will send letters of notification to the lock-in member and the DMS or its designated representative. HMOs are required to notify primary prescribing provider and alternate prescribers when assigned for a lock-in member.
- HMOs must communicate with the DMS or its designated representative.
- The DMS or its designated representative will identify the lock-in pharmacy and the HMO will identify the lock-in primary prescriber for each member. In addition, the HMO will identify any alternate prescribers for restricted medications, as appropriate.
- HMOs may refer members to the DMS or its designated representative for the Pharmacy Services Lock-In Program if any of the following are documented by the HMO:

- Evidence of a member intentionally providing incorrect information such as ForwardHealth eligibility status or medical history to a provider to obtain restricted medications.
- Evidence of a member being convicted within one year of a crime related to restricted medications. Crimes include: forgery, theft, distribution, etc.
- Two or more occurrences of violating a pain management contract within six months from the same or different prescribers. A prescriber must agree to continue managing the member after the Lock-In Program has been initiated.
- Any combination of four or more medical appointments/urgent care visits/emergency department visits within a 14 day time period at which the member is seeking a restricted medication as the primary reason for the visits.
- A member required an ER visit or hospitalization due to suicide attempt, poisoning, or overdose from the use of restricted medication(s) in the last ninety days.

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

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

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

a. On the effective date of this Contract, the HMO must be certified to provide or have contracted with facilities and/or providers enrolled to provide the mental health and substance abuse treatment services identified in [Wis. Admin. Code DHS 107.13\(1\)-\(4\), 107.22\(4\), and certain sections of the ForwardHealth Online Handbook](#):

- 1) DHS 107.13(1) – Inpatient care in a hospital IMD (Online Handbook – Hospital, Inpatient)
- 2) [DHS 107.13\(2\)](#) – Outpatient Psychotherapy Services (Online Handbook – Outpatient Mental Health, Outpatient Mental Health in the Home and Community for Adults)
- 3) [DHS 107.13\(3\)](#) – Alcohol and Other Drug Abuse Outpatient Treatment Services (Online Handbook – Outpatient Substance Abuse)
- 4) [DHS 107.13\(3m\)](#) – Alcohol and Other Drug Abuse Day Treatment Services (Online Handbook – Substance Abuse Day Treatment)
- 5) [DHS 107.13\(4\)](#) – Mental Health Day Treatment or Day Hospital Services (Online Handbook – Adult Mental Health Day Treatment)
- 6) Narcotic Treatment Services (Online Handbook – Narcotic Treatment)
- 7) DHS 107.22(4) HealthCheck “Other Services” (Online Handbook – Child/Adolescent Day Treatment, In-Home Mental Health/Substance Abuse Treatment Services for Children)

Certification requirements for mental health and substance abuse treatment providers eligible to provide the above services are found in [Wis. Adm. Code DHS 105.21 – 105.25](#).

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

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

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

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

2. Mental Health Parity Compliance (BadgerCare Plus and Medicaid SSI)

The BadgerCare Plus and Medicaid SSI HMO must comply with the Mental Health Parity Rule requirements of [42 CFR 438.930](#). The Mental Health Parity Rule, in 42 CFR 438.910(b)(2), requires the HMO to provide mental health or substance abuse benefits to members in every classification in which medical benefits are provided (e.g., inpatient, outpatient, emergency care, prescription drugs).

The HMO must not establish any of the following when it has been determined that mental health or substance abuse treatment is medically necessary for the member:

- Any aggregate lifetime or annual dollar limits on mental health or substance abuse benefits;
- Any financial requirement or treatment limitation to mental health or substance abuse benefits;
- Any limit on the number of hours of outpatient treatment that the HMO must provide or reimburse, and
- Any monetary limit or limit on the number of days of inpatient hospital treatment.

The HMO prior authorization requirements must comply with the requirements for parity in mental health and substance abuse benefits in 42 CFR 438.910 (d). The same section of the Mental Health Parity Rule also specifies that the HMO may not impose non-quantitative treatment limits (NQTL) for mental health or substance abuse benefits in any classification unless, the HMO has processes, strategies evidentiary standards, or other factors used in applying the NQTL to mental health or substance abuse benefits that are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical benefits.

Pursuant to 42 CFR 438, subpart K, the HMO will be required to submit to the Department its Mental Health Parity Rule compliance plan as part of the HMO certification application process and upon request.

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

3. Mental Health/Substance Abuse Assessment Requirements (BadgerCare Plus and Medicaid SSI):

The HMO must adjudicate mental health or substance abuse treatment service determinations following member requests or referrals from a primary care provider or physician in the HMO's network. Any denials of service or selection of particular treatment modalities must be governed by an assessment conducted by qualified staff in a certified program who are experienced in mental health/substance abuse treatment, a review of the effectiveness of the treatment for the condition (including best practice, evidence based practice), and the medical necessity of treatment. A member's motivation to participate in treatment shall not be considered a factor in determining medical necessity and may not be used as a rationale for withholding or limiting treatment of a client/member. The HMO will use the Wisconsin Uniform Placement Criteria (WI-UPC), or the placement criteria developed by the American Society of Addiction Medicine (ASAM) as mandated for substance abuse care providers in [DHS 75](#). The requirement in no way obligates the HMO to provide care options included in the placement criteria that are not covered services under FFS.

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

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

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

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

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

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

The HMO is liable for the cost of providing assessments under the Children's Code, [Wis. Stats. s. 48.295](#), and is responsible for reimbursing for the provision of medically necessary treatment if unable to itself provide for such treatment ordered by a juvenile court. The medical necessity of court-ordered evaluation and treatment is assumed to be established and the HMO is allowed to provide the care through its

network, if at all possible. The HMO may not withhold or limit services unless or until the court has agreed.

6. Court-Related Substance Abuse Services (BadgerCare Plus and Medicaid SSI)

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

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

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

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

- a. Care provided in the first three business days (72 hours), plus any intervening weekend days and/or holidays, is deemed medically necessary and the HMO is responsible for payment.
- b. The HMO is responsible for payment for additional care beyond the time period in paragraph a. above only if notified of the emergency treatment within 72 hours, excluding weekends and holidays, and if given the opportunity to provide such care within its own provider network. The opportunity for the HMO to provide care to a member admitted to a non-HMO facility is accomplished if the county or treating facility notifies and advises the HMO of the admission within 72 hours, excluding weekends and/or holidays. The HMO may provide an alternative treatment plan for the county to submit at the probable cause hearing. The HMO must submit the name of an in-plan facility willing to treat the member if the court rejects the alternative treatment plan and the court orders the member to receive an inpatient evaluation.
- c. If the county attempts to notify the person identified as the primary contact by the HMO to receive authorization for care, and does not succeed in reaching the HMO within 72 hours of admission excluding weekends and holidays, the HMO is responsible for court-ordered care beyond the initial 72 hours. The county must document the attempts to notify with dates, times, names and numbers attempted to contact, and outcomes. The care provided to the HMO member by the non-HMO provider is deemed medically necessary, and coverage by the HMO is retroactive to the date of admission.
- d. The HMO is financially liable for the member's court ordered evaluation and/or treatment when the HMO member is defending him/herself against a mental illness or substance abuse commitment:
 - 1) If services are provided in the HMO facility; or
 - 2) If the HMO approves provision in a non-contracted facility;
or
 - 3) If the HMO was given the opportunity but failed to provide the county with the name of an inpatient facility and, as a

result, the member is sent for court ordered evaluation to an out-of-plan provider; or

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

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

8. Institutionalized Individuals (BadgerCare Plus and Medicaid SSI)

a. Institutionalized Children

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

b. Institutionalized Adults

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

9. Transportation Following Emergency Detention (BadgerCare Plus and Medicaid SSI)

The HMO shall be liable for the provision of medical transportation to the HMO-affiliated provider when the member is under emergency detention or commitment and the HMO requires the member to be moved to a

participating provider, provided the transfer can be made safely. If a transfer requires a secured environment by local law enforcement officials, (i.e., Sheriff Department, Police Department, etc.), the HMO shall not be liable for the cost of the transfer. The county agency or law enforcement agency makes the decision whether the transfer requires a secured environment. The HMO is not prohibited from entering into an MOU or agreement with local law enforcement agencies or with county agencies for such transfer.

10. Out-of-Network Benefit Coordination (BadgerCare Plus and Medicaid SSI)

Per Article III, section C, the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Services or through community and social support providers. The HMO must assign a representative to coordinate services with public health agencies or treatment programs within the HMO's service area that are not included in the HMO's network. These might include but are not limited to county health agencies, crisis intervention agencies, community support programs, comprehensive community service programs, or inpatient programs. The HMO must work with the agency/program to coordinate a member's transition to or from covered mental health and substance abuse care within the HMO's network. Any member transitioning from crisis intervention services must be able to access an appropriate level of ongoing care within 30 days of the crisis. The HMO is not required to pay for ongoing services outside the HMO network, unless the HMO has authorized those services.

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

Per Art. III, section C, the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Services or through community and social support providers. The HMO shall develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services to members. The HMO must work cooperatively with other community agencies, to treat mental health and/or substance abuse conditions as legitimate health care problems.

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

MOUs must be signed every two years as part of certification. If no changes have occurred, then both the county and the HMO must sign off that no changes have occurred and documentation to this effect must be submitted to the Bureau of Benefits Management upon request. HMOs must conduct outreach to agencies that do not have a MOU with the health plan, at a minimum, every two years. The HMO must submit evidence that it attempted to obtain a MOU or contract in good faith.

12. Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services (Medicaid SSI Only)

a. Services

This benefit will be limited to behavioral health: short term residential (non-hospital residential treatment program) per diem (over midnight census) using code: H0018 under the CBRF provider ID. Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization.

This benefit will be reimbursed at \$450 per diem.

Included in this per diem cost are services such as:

- Comprehensive interdisciplinary biopsychosocial mental health assessment;
- Crisis assessment, intervention and stabilization;
- Psychiatrist and Advanced Practice Nurse Prescriber to include medication assessment, review, consultation and prescribing;
- Psychosocial group education;
- Individual counseling;
- Peer support;

- Family consultation, as needed;
- Individualized community linkage to ongoing services and supports within the community.

Post-discharge services will be provided on an individual outpatient basis in cooperation and consent with the members' HMO. These outpatient mental health services will be included as part of the HMO capitation.

b. Provider Qualifications

- 1) The provider must be a licensed Community Based Residential Facility (CBRF).
- 2) The provider must be experienced with at least 5 years as a community based provider of non-institutional sub-acute psychiatric services.
- 3) DQA certification as an Outpatient Mental Health clinic is required.
- 4) The staffing plan shall include the following positions:
 - Director
 - Clinical Coordinator
 - Community Recovery Specialist
 - Peer Recovery Specialist
 - Mental Health Professional
 - Registered Nurse
 - Advanced Practice Nurse Prescriber
 - Medical Director
 - Other professional and/or para-professional staff as required to meet the needs of the members.

13. Certified Peer Specialist Services

The HMO may elect to provide an enhanced behavioral health benefit to eligible members through the use of Certified Peer Specialist providers. This benefit is available for BadgerCare Plus and/or Medicaid SSI HMO enrolled adults (18 years and older) with a mental health and/or substance abuse diagnosis, especially members with a co-morbid diagnosis, who are at risk of hospitalization or who may have been hospitalized.

Peer Specialists will be supervised by the HMO rendering provider, who must be a qualified mental health professional. Peer Specialists will be certified and trained by the Department's Division of Mental Health & Substance Abuse (DMHSAS). DMHSAS maintains oversight of the training, certification and supervision requirements for peer specialist providers eligible for providing this benefit to HMO members.

Peer specialist services will be billed under their supervising clinician's NPI, using HCPCS code H0038 – Self-help/peer services. Up to 16 units may be billed per week. A unit is 15 minutes.

Travel time to and from the member visits may not be billed separately, this time considered covered within the direct time reimbursement.

14. Narcotic Treatment Services

Within a reasonable distance from a member's residence, the HMO must provide access to narcotic treatment services (NTS) or medication-assisted treatment (MAT) for opioid dependence via eligible facilities and/or providers. HMOs must regularly monitor their NTS and MAT provider networks to ensure that members have access to these services. Narcotic treatment services include member assessment, screening for drugs of abuse, screening for certain infectious diseases, prescription and administration of narcotic medication, and substance abuse counseling. The ForwardHealth Online Handbook section for 'Narcotic Treatment' outlines policy for services provided by narcotic treatment programs certified under Wis. Adm. Code DHS 75.15. For members who require narcotic treatment, HMOs must ensure access to providers authorized to prescribe opioid dependency agents. Authorized providers include Wis. Adm. Code DHS 75.15 facilities or physicians who have obtained a Drug Addiction Treatment Act (DATA) 2000 waiver allowing him or her to prescribe buprenorphine-based agents. The requirement to provide narcotic treatment services does not include coverage of opioid dependency agents themselves, which are covered by ForwardHealth. HMO providers must adhere to all policy and prior authorization requirements for coverage of opioid dependency agents.

C. HealthCheck

The section below describes the HealthCheck requirements and responsibilities for MY2018. For MY2019 and beyond, the DHS will explore

replacing the current HealthCheck guidelines with the uniform recommendations of the American Academy of Pediatrics, published under the Bright Futures™ health supervision guidelines. Operational details for this modification will be discussed in the MY2018 HMO P4P Guide.

1. HMO Responsibilities for MY2018

- a. Provide comprehensive HealthCheck services as a continuing care provider and according to policies and procedures in [Wisconsin Health Care Programs Online Handbook](#) related to covered services.
- b. Provide comprehensive HealthCheck screens upon request. The HMO must provide a HealthCheck screen within 60 days (if a screen is due according to the periodicity schedule) for members over one year of age for which a parent or guardian of a member requests a comprehensive HealthCheck screen. If the screen is not due within 30 days, then the HMO must schedule the appointment in accordance with the periodicity schedule.

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

Comprehensive HealthCheck screens for children through two years of age generally include both blood lead toxicity testing and age appropriate immunizations.

- c. Provide comprehensive HealthCheck screens at a rate equal to or greater than 80% of the expected number of screens.
- d. Provide treatment referrals result from the HealthCheck physical exam when findings indicate the need for further evaluation, diagnosis, and treatment. All appointments for further diagnosis or treatment as a result of the screening should be scheduled within 60 days of the date of the HealthCheck screening. All BadgerCare

plus and Medicaid services on a HealthCheck referral should be provided within six months of the screening date.

- e. Provide other necessary health care services, as medically-necessary, even if those services are not otherwise covered or, exceed coverage limitations (i.e., HealthCheck “Other Services”). The HMO is responsible for all HealthCheck “Other Services” with the exception of services specified in Article IV(A)(1) in the Contract. Refer to Topic #2391 In the ForwardHealth Online Handbook for examples of HealthCheck “Other Services.”

2. Department Responsibilities

- a. MY2018 calculations for each HMO’s performance on the HealthCheck measure will be made using the methodology described in the MY2018 HMO Quality Guide. There will be a flat assessment of \$10,000 for any HMO missing the 80% target, regardless if the HMO serves BadgerCare Plus members, SSI members, or both populations. This penalty is not part of the other HMO P4P measures and withhold. Operational details for this modification, including opportunities for HMOs to provide additional information, will be discussed in the MY2018 HMO Quality Guide.

For MY2018 and beyond, the DHS will explore replacing the current HealthCheck measure with Bright Futures™ health supervision guidelines. Operational details for this modification will be discussed in the HMO Quality Guide for MY2018 and beyond.

D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women

The OB Medical Home for high-risk pregnant women is a care delivery model that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The care team is responsible for meeting the patient’s physical, behavioral health and psychosocial needs. A key component of the OBMH is enhanced care coordination provided early in the prenatal period through the postpartum period (60 days after delivery). Care coordination is defined as the deliberate

organization of patient activities between two or more individuals involved with the patient's care to facilitate the delivery of appropriate services.

The HMO, in partnership with the medical home sites, shall be guided by four core principles:

- Having a designated obstetric (OB) care provider who serves as the team leader and a point of entry for new problems. The OB care provider is defined as a physician, nurse midwife, nurse practitioner or physician assistant with specialty in obstetrics, who provides prenatal care and performs deliveries;
- Providing ongoing care over the duration of the pregnancy and postpartum period;
- Providing comprehensive care (e.g., care that meets the member's range of health and psychosocial needs); and
- Coordination of care across a person's conditions, providers and settings.

Additional information regarding the OB Medical Home Initiative may be found on the ForwardHealth Portal (click the link to be directed to the website):

[OB Medical Home Initiative](#)

Requirements

1. Target Population

The target population for the OB Medical Home Initiative is pregnant BadgerCare Plus and Medicaid SSI members who are at high-risk for a poor birth outcome. A poor birth outcome is defined as:

- Preterm birth – gestational age less than 37 weeks
- Low birth weight – birth weight less than 2,500 grams (5 lbs. 8 oz.)
- Neonatal/early neonatal death – death of a live-born infant within the first 28 days of life
- Stillbirth – a fetal demise after 20 weeks gestation

2. Members eligible to participate in the OBMH Initiative

Documentation must confirm that the member is within the first 16 weeks of pregnancy to be enrolled in the medical home and must meet one or more of the following criteria:

- Listed on the Department's Birth Outcome Registry Network (BORN) of high-risk women
- Less than 18 years of age
- African American
- Homeless
- Have a chronic medical or behavioral health condition which the obstetric care provider determines would negatively impact the outcome of the pregnancy

3. Payment Structure

Enhanced payments are available for clinics for pregnant women that meet the defined eligibility criteria above and the criteria for delivery of services articulated below. The Department issues payments to the HMOs and the HMOs subsequently issue the enhanced payment on to the OB medical home site.

Medical record reviews by the Department's External Quality Review Organization (EQRO) will be used to verify eligibility. If the EQRO is unable to verify any of the criteria as required by the OB Medical Home Initiative, the clinic is ineligible for the enhanced payment for those women. To receive the initial \$1,000, at minimum, the clinic must clearly document that all the following criteria are met. The member:

- Has had a pregnancy-related appointment with a health care provider within the first 16 weeks of her pregnancy. She must be enrolled in the OB Medical Home within 20 weeks of her pregnancy (the clinic is responsible for obtaining all medical records for documentation),
- Has attended a minimum of 10 medical prenatal care appointments with the OB care provider,
- Has a member centric, comprehensive care plan that has been reviewed by the member and, at minimum, the OB provider,

- Has been continuously enrolled in the OB medical home and receiving services during her pregnancy, and
- Has continued enrollment through 60 days postpartum, including the date of the scheduled 60 day medical postpartum visit, and any documentation of no shows or appointment refusals.

The Department will issue an additional \$1,000 (for a total of \$2,000) if the mother has a healthy birth outcome as defined by the Department.

Pregnancy loss prior to 20 weeks will not be eligible for the OBMH incentive, as limited care coordination and delivery of other services has occurred. Providers will still receive payment for the medical prenatal care through the usual claim submission process.

4. External Quality Review

The Department has established a process for verifying that members enrolled in the OB Medical Home Initiative meet the requirements.

The Department's EQRO will conduct chart reviews that:

- Verify enrolled members meet the defined contract requirements;
- Collect data to support potential future program refinements; and
- Collect data to support program evaluation.

The HMO is responsible for working with the medical home sites, external PNCC providers, hospitals and any other care provider that may or should have documentation of OB medical home services to ensure required documentation is submitted to the Department's EQRO in a timely manner. For medical home sites that provide remote access to records, the EQRO will access records that have been specified as OBMH participants. If the patient is not on the record review list, the EQRO will not access those records.

The Department does not provide additional reimbursement to HMOs or clinics for submission of medical records. HMOs are encouraged to define responsibilities of each party, which may include reimbursement policies and reporting requirements, in their subcontracts or agreements with medical home providers.

5. HMO Responsibilities

a. HMO representative

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

b. HMO Outreach and Member Engagement

HMOs must actively seek to identify and engage eligible members for participation in the OBMH. At a minimum, this should include a variety of strategies, e.g., working with existing organizations having similar goals, increasing public awareness about the OB Medical Home Initiative and its services, screening new members for eligibility, reviewing the BORN report periodically and working with colleagues to develop and implement creative strategies such as health fairs or street teams.

c. OB Medical Home Sites

HMOs must distribute communications from DHS to its participating clinics and are accountable for ensuring contracted OB medical home sites meet the requirements below.

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

- Include an OB care provider that serves as the care team leader and a point of entry for new problems during the member's pregnancy. The OB care provider, the care coordinator, and the member's primary care physician (who may or may not be the OB care provider) will work together to identify the prenatal and psychosocial needs of the member to ensure that she will have a healthy birth outcome.

- Adopt written standards for patient access and communication to the member as determined by the HMO and approved by the Department. These written standards must, at a minimum, meet appointment and wait times according to Art. V of the contract. In addition, treatment and/or medical advice must be available 24 hours a day, seven days a week.
- Use an electronic health record system to manage patient data to:
 - Document medical home enrollment date,
 - Organize clinical information,
 - Identify diagnoses and conditions among the provider's patients that have a chronic condition that will impact the pregnancy,
 - Track patient test results,
 - Identify abnormal patient test results,
 - Systematically track referrals and follow up, and
 - Document birth outcomes.
- Provide appropriate best practice medical care for high-risk pregnant women, which may include:
 - Consultation from a maternal fetal specialist and close monitoring and surveillance;
 - To the extent it is covered by ForwardHealth (such as through in person consultation per ForwardHealth Topic 510), HMOs may encourage OBMH providers to use telehealth services to identify problems early in the pregnancy and provide treatment to avoid further complications and preterm labor. HMOs have the flexibility to use administrative funding to support more enhanced telehealth services like store and forward (asynchronous) and remote patient monitoring;
 - Progesterone therapy, as appropriate;

- Plan for interconception care, including educating members on options for long-acting reversible contraception post-delivery as part of "LARC First practice." This is the practice of a prescriber who promotes awareness and use of long-acting reversible contraception as the first-line contraceptive option for women, including teens.
- Adopt and implement evidence-based guidelines that are based on, but not limited to, screening, treatment and management of the following chronic medical conditions:
 - Asthma
 - HIV/AIDS
 - Cardiac disease
 - Diabetes mellitus
 - Hypertension
 - Pulmonary disease
 - Behavioral health, including
 - Depression
 - Smoking
 - Substance Abuse
 - Morbid Obesity

The HMO and medical home sites must have clear procedures for addressing the complex needs of women with these conditions, including, but not limited to, referrals to appropriate specialists and community resources.

- Develop guidelines to ensure that screening for social factors (that could have a negative impact on pregnancy outcome and newborn health) is a routine part of care to the pregnant and postpartum member. The guidelines should address the following:
 - Integrating initial and periodic screening into information gathering
 - Incorporating identified social needs (and strengths) into the comprehensive care plan

o Effective strategies for addressing social factors, including the following,

- Identifying pertinent community resources, including personal supports;
- Referral to community health worker services;
- Developing effective working/referral relationships with these resources;
- Communication and information sharing (e.g., obtaining written authorization from the member where necessary);
- Obtaining periodic feedback from members and community resources to ensure identified resources continue to be relevant and appropriate.

o Systematic electronic tracking and follow-up on community and social determinants of health referrals to ensure referral completion.

- Actively support and promote patient self-management.
- Demonstrate cultural competency among provider and office staff.

d. Documentation Requirements

The medical home should retain electronic documentation to support the provision of the medical home services outlined in this section of the contract.

6. Care Coordination – General Requirements

A key component of the OB Medical Home Initiative is the coordination of care for the member. Each medical home site must have a designated care coordinator on-site (located where the member's OB care provider is located) to do the following:

- Establish a relationship with the member and maintain regular face-to-face contact throughout the pregnancy;
- Communicate with the member and other care providers to identify needs and assist in developing a member-centric care plan and keeping the plan up-to-date;
- Make referrals to appropriate services (e.g., physical, dental, behavioral health and psychosocial) and provide follow up.

The care coordinator may be an employee of the medical home site or of the HMO, under contract, or under a Memorandum of Understanding/Agreement. All care coordinators must be easily accessible on a regularly established schedule for members participating in the OB medical home.

To ensure continuity of care, the care coordinator shall work with the member to obtain the appropriate release forms, and contact the office(s) of any PCP, with whom the participating member had/has an ongoing relationship, to gather information about the member's medical history, current health conditions and any concerns that the PCP may have regarding the member.

HMOs and medical home sites must use the OB Medical Home Registry, provided by the Department and hosted by the Department's External Quality Review Organization, to track enrollment in the OB Medical Home.

a. Information Gathering and Comprehensive Assessment of Need

Prior to the development of a comprehensive care management plan, the OB care provider must communicate with pertinent health care providers, the member and others as appropriate, to identify the member's strengths and care coordination needs. Information gathering activities include:

- Obtaining pertinent information from the initial prenatal clinic visit, the OB care provider, the member's PCP, HMO or other source;

- Taking the member's history to identify social factors that could have a negative impact on the health and well-being of the mother and baby;
- Identifying the member's strengths and social support.

b. Comprehensive Care Plan

The care coordinator must ensure that each medical home member has a comprehensive care plan. The OB care provider must be central to the development of the care plan. To the maximum extent possible, the member and the member's PCP (if different from the OB care provider) must also be included in the development of the care plan.

The care plan must address the medical and non-medical needs identified during the information gathering process and must include:

- A listing of key health and community resources specific to the member's needs;
- A prioritized plan of action that reflects the member's preferences and goals;
- Timeframes for addressing (and following-up on) each identified need;
- Strategies to encourage patient self-care and adherence to treatment recommendations (e.g., assisting the member in identifying self-management goals and in communicating with her obstetric care provider, offering home visits, checking in with the member between visits, referring members to group classes, and sharing culturally sensitive and appropriate materials).

The care coordinator should offer home visits. Best practice suggests that the home visit occur within 30 days of enrollment in the medical home. Members, who decline the initial offer, should be asked again throughout the pregnancy. The offer attempts and refusals must be documented in the medical record.

The care coordinator must establish regular communication with the member, OB care provider and PCP, if any, and any home visiting agency/provider the member may be working with, to track progress on the care plan and ensure coordinated care.

The care plan must be developed by the OB care provider, the care coordinator, and the member. The provider must attest to the agreement and understanding of the care plan by the respective parties and document, including the date, within the EHR. The plan must be reviewed and updated as the member's health and circumstances change.

c. Ongoing Monitoring and Follow-up

Ongoing monitoring and follow-up include activities and contacts that are necessary to implement and maintain the care plan. These activities include:

- Ensuring services are being furnished in accordance with the member's care plan;
- Making referrals, which includes related activities such as assisting with scheduling follow-up appointments;
- Tracking and following up on all referrals, including referrals to community resources;
- Flagging critical referrals to ensure immediate follow-up on overdue reports (e.g., following up on laboratory and imaging results to determine the need for additional services).
 - Referrals are not complete without timely follow up with the member and/or with the service provider to track the results of the referral.
- Communicating with the member, the OB care provider and other individuals instrumental to the member's care and support, to assess the usefulness of key community

resources and to ensure the care plan is meeting the member's needs.

- Reviewing and updating the care plan, as necessary, following each health care encounter or home visit.
- Assisting in removing barriers to care, e.g., offering flexible scheduling and assessing and addressing communication gap between the health care provider and the member.

d. Transition Plan (Transfer of Care)

All members shall remain enrolled and receiving services as needed within the OB medical home for 60 days postpartum. Regardless of birth outcome, the medical home provider should do the following to minimize disruption during the transfer of care:

- Engage the member in the transfer of care, to the maximum extent possible.
- Collaborate with the HMO to ensure continuity of care for the mother and newborn following medical home discharge. For example, the medical home could summarize and share issues related to the need for ongoing support, outstanding test results, community referrals, upcoming appointments, and any unmet needs or concerns from the member's care plan.
- Ensure that each member has a transition plan, as described below.

- Healthy Birth Outcome

If the member has a healthy birth outcome, the following activities shall take place within the member's 60 day postpartum period:

- The member shall have at least one postpartum follow-up appointment with the OB care provider that meets all American

Congress of Obstetricians and Gynecologists (ACOG) or other applicable postpartum guidelines.

- Ensure that the member is connected to a PCP and has an appointment as appropriate with a PCP.
 - Ensure that the member has identified a PCP for the newborn and has made an initial appointment.
 - The care coordinator shall contact the member's PCP to inform her/him of the birth outcome and any concerns that the OB care provider has regarding the member's and/or child's health postpartum.
 - The care coordinator shall educate the member on interconception care specific to her needs.
- Poor Birth Outcome

In addition to items listed under healthy birth outcome above, for members who have a poor birth outcome, as defined by the Department, the HMO is responsible for the following:

- Working with the OB medical home site to develop a care plan for the infant and the mother that incorporates input from the mother, the OB care provider, and the PCP and/or pediatrician. The plan shall include the coordination of care with other providers (which may be within the medical home) who are appropriate to provide ongoing services for the mother's and infant's specific needs.

- Conduct follow up with the mother to ensure that the initial referral appointments with other providers are kept.
- To the extent feasible, maintain ongoing contact with the mother following the birth to ensure the mother and child are receiving appropriate care. HMO responsibility for follow up ends when the member is no longer enrolled in the HMO.

7. Reporting

The HMO must submit a report (using the template provided) to the Department annually evaluating its OB Medical Home initiative. The report is due the first business Monday of June (reporting from April of the previous year through March of the current year).

Additional reporting of program compliance by the HMO and/or medical home sites may be requested by the Department outside of the annual report, as needed.

8. Learning Collaborative

In addition to providing comprehensive, quality care, a second goal of the OB Medical Home Initiative is to provide care that meets the unique needs of each member. Prior experience in implementing the Initiative demonstrates the efficacy of OB medical home sites learning from each other. To facilitate this process, the HMOs and clinic sites must identify and/or develop and participate in at least one collaborative learning opportunity per year. Such opportunities must address identified needs of the clinics serving as OB medical homes and the members they serve.

These forums shall be described and reported in the required HMO annual report.

E. Immunization Program

As a condition of certification as a BadgerCare Plus and/or Medicaid SSI provider, the HMO must share member immunization status with the local health departments and other non-profit HealthCheck providers upon their request

without the necessity of member authorization. The Department also requires that the local health departments and other non-profit HealthCheck providers share the same information with the HMO upon request. This provision ensures proper coordination of immunization services and prevents duplication of services.

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

F. Abortions, Hysterectomies and Sterilizations

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

1. Abortions must comply with the requirements of [Wis. Stats., s. 20.927](#), [Wis. Stats., s. 253.107](#) and with [42 CFR 441 Subpart E](#)-Abortions.
2. Hysterectomies and sterilizations must comply with [42 CFR 441 Subpart F](#)—Sterilizations.

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

The HMO must abide by [Wis. Stats., s. 609.30](#).

G. HIV/AIDS Health Home

1. Health Home Services for HMO members who are diagnosed with HIV or AIDS

All members diagnosed with HIV or AIDS must have access to appropriate specialists and Medicaid-covered services through the HMO. This includes those members not enrolled in the below HIV/AIDS health home.

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid benefit that allows states to establish health homes to coordinate care for people who have chronic conditions. The goals of health homes are to improve health outcomes while lowering Medicaid costs, and to reduce preventable hospitalizations, emergency room visits, and unnecessary care for Medicaid members.

2. Program Evaluation and Ongoing Monitoring, Review, and Audit

The Affordable Care Act includes a national evaluation requirement. In response, CMS has identified a core set of quality measures to inform the evaluation and to assess the impact of health home services on health outcomes. The Department will be responsible for obtaining data and reporting on these quality measures.

The Department will conduct ongoing health home site visits for the purposes of program monitoring, review, and audit. The Department may use information obtained from site visits, encounter and paid claims data to respond to federal reporting and evaluation requirements. Health home providers are required to respond to data requests as a condition of continued health home participation.

3. Health Home Services

Health home providers coordinate care across all settings, including medical, behavioral, dental, pharmaceutical, institutional, and community care settings.

Covered HIV/AIDS health home activities include the following:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Patient and family support, including authorized representatives
- Referral to community and social support services

Health home providers must be required to provide patient-centered health home services in accordance with the requirements detailed in the [ForwardHealth online handbook](#).

When arranging direct care services, the health home provider must follow the HMO's requirements regarding prior authorization for HMO-covered services, referrals to in-network providers, and claim submission.

Health homes are strongly encouraged to use health information technology to link services and to facilitate communication.

4. Target Population

Members must have a diagnosis of HIV and at least one other chronic condition, or be at risk of developing another chronic condition. The risk factors include diabetes, hypertension and high cholesterol, among others. Member participation in the health home is voluntary. The ForwardHealth

online handbook includes detailed policies related to member eligibility for health home services.

5. Designated Health Home Provider

Wisconsin used the flexibility allowed by federal law to designate AIDS Service Organizations (funded by the DHS under s. 252.12(2)(a)8, Wis. Stats., for purposes of providing life care services to members diagnosed with HIV infection) as health home providers. The AIDS Resource Center of Wisconsin (ARCW) is the only organization that meets this requirement. The designated health home provider has clinic locations in Dane, Kenosha, Brown, and Milwaukee counties.

6. Requirements

HMOs serving members with HIV/AIDS must provide access to ARCW health home services. Health home services include coordination beyond the health care community. A significant component is focused around the engagement of community partners to ensure successful linkages to community and social supports.

Eligible members may be identified by the HMO or its providers and informed of the option to receive services through the ARCW health home (or assisted with access to HIV/AIDS specialists outside the health home areas). Members may also be identified by the ARCW health home, who must then inform the HMO to ensure care is coordinated. Members may not be obligated to receive health home services and must consent in writing to health home enrollment.

Non-Duplication of Services

To avoid duplication of care coordination activities, HMOs are encouraged to work with the health home to develop a MOU or contract that clearly delineates the respective roles. At a minimum, the HMO should address the following with the health home provider:

a. Communication

- Single points of contact within the health home and the HMO
- Response to critical events (emergency room visit, hospitalization, detox/mental health crisis)
- Expanded access to health care, where appropriate
- HMO notification and engagement if member opts out of health home
- Mode
- Frequency

- b. Member engagement (in accordance with state and federal confidentiality requirements)
 - Identification
 - Outreach
 - Obtaining member consent (to participate and for information sharing)
 - Re-engagement if lost to follow-up (for example, member identified in an emergency room)
- c. HMO engagement in the member development and implementation of the member's care plan, especially in the following areas,
 - Identification and engagement of member's PCP and other health care providers
 - Access to needed health care
 - Identifying gaps in care, needed referrals, and referral follow-up
 - Addressing missed appointments
 - HMO resources
- d. Reporting and data sharing. The HMO and health home should determine the level of reporting and data sharing necessary to ensure that the goals of health home services are accomplished. Examples of these activities include,
 - Health home utilization (for example, member count, average number of contacts per month)
 - ER use
 - Hospitalization
 - Referrals
 - Adherence to prescribed therapy
 - Results of member satisfaction surveys (conducted by the health home)
- e. Use of Information Technology where feasible (for example, sharing clinical and care plan information, communication and referrals and follow-up)

H. Provider Moral or Religious Objection

The HMO is not required to provide counseling or referral service if the HMO objects to the service on moral or religious grounds. If the HMO elects not to provide, reimburse for, or provide coverage of, counseling or referral service

because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

- To the Department and Enrollment Specialist so the Department can notify members of the HMO's non-coverage of service;
- With the HMO's certification application for a BadgerCare Plus and/or Medicaid SSI contract;
- Whenever the HMO adopts the policy during the term of the contract;
- It must be consistent with the provisions of [42 CFR 438.10](#);
- It must be provided to potential members before and during enrollment;
- It must be provided to members within ninety (90) days after adopting the policy with respect to any particular service; and
- In written and prominent manner, the HMO shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI but which are not available through the HMO because of an objection on moral or religious grounds.

ARTICLE V

V. PROVIDER NETWORK AND ACCESS REQUIREMENTS

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

A. Use of BadgerCare Plus and/or Medicaid SSI Enrolled Providers

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

B. Protocols/Standards to Ensure Access

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

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

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

C. Written Standards for Accessibility of Care

1. The HMO must have written standards for the accessibility of care and services. These standards must be communicated to providers and monitored by the HMO. The standards must include the following:
 - Waiting times for care at facilities;
 - Waiting times for appointments;
 - Statement that providers' hours of operation do not discriminate against BadgerCare Plus and/or Medicaid SSI members; and
 - Whether or not provider(s) speak the member's language.

2. The HMO's standards for waiting times for appointments must be as follows for the indicated provider types:
 - To be no longer than 30 days for an appointment with a PCP;
 - To be no longer than 30 days for an appointment with a Mental Health provider for follow-up after an inpatient mental health stay.
 - To be no longer than 90 days for an appointment with a dental provider for a routine dental appointment in regions 5 and 6.

3. The HMO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:
 - The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - Any information the enrollee needs in order to decide among all relevant treatment options.
 - The risks, benefits, and consequences of treatment or non-treatment.
 - The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

These minimum requirements shall not release the HMO from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members.

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

D. Monitoring Compliance

The HMO must develop policies and procedures regarding wait times for appointments and care. The HMO shall conduct surveys and site visits to monitor compliance with these standards and shall make them available to DHS upon request. If issues are identified, either by the HMO or by the Department, the HMO must take corrective action so that providers meet the HMO's standards and improve access for members. The Department will investigate complaints received of HMOs that exceed standards for waiting times for care and waiting time for appointments.

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

1. Dental Providers

- For the HMO that covers dental services in regions 1-4, a dental provider must be available within a 35 mile distance from any member residing in the HMO service area.
- Dental service coverage is required in regions 5 and 6 for HMOs serving BadgerCare Plus members. Dental service coverage is required in Milwaukee, Waukesha, Racine, and Kenosha counties for HMOs serving SSI members. The HMO must have a dental provider within a 25 mile distance from any member residing in the HMO service area. The HMO must maintain a Provider-to-Member Ratio of no greater than 1:1,600 for dental providers.
 - For the purpose of provider network review, the Department analyses the following dental provider specialties codes:
 - 271 – General Dentistry Practitioner
 - 274 – Pediatric Dentist
 - 289 – Dental Hygienist

If there is no enrolled provider within the specified distance, the travel distance shall be no more than for a non-enrolled member. The HMO must also consider whether the dentist accepts new patients, and whether full or part-time coverage is available.

2. Mental Health or Substance Abuse Providers

For the purpose of provider network review, the Department analyses the following mental health or substance abuse provider specialties codes:

- 112 – Licensed Psychologist (PhD)
- 117 – Psychiatric Nurse
- 120 – Licensed Psychotherapist
- 122 – Alcohol and Other Drug Abuse Counselor
- 123 – Certified Psychotherapist with SAC
- 124 – Certified Psychotherapist
- 126 – Qualified Treatment Trainee
- 339 - Psychiatry
- 532 – Registered Alcohol and Drug Counselor (RADC)/NTS
- 740 – Mental Health

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

For HMOs serving Regions 5 and 6, the HMO must maintain a Provider-to-Member Ratio of no greater than 1:900 for Psychiatry (provider specialty code 339) and 1:900 for Psychology (provider specialty code 112).

3. High Risk Prenatal Care Services

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

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

The HMO must provide adequate and timely coverage of services provided out-of-network, when the required medical service is not available within the HMO network. The HMO must coordinate with out-of-network providers with respect to payment and ensure that cost to the member is no greater than it would be if the services were furnished within the network [[42 CFR 438.206\(b\)\(v\)\(5\)](#) and [S.S.A 1932\(b\)\(2\)\(D\)](#)].

The HMO must use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance abuse disorder benefits that are comparable to, and applied no more stringently than, the process, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical benefits in the same classification.

Emergency services provided out-of-network must also not have a cost to the member greater than if the emergency services were provided in-network. The HMO must reimburse for emergency services provided to members in Canada or Mexico; however, payment for such services must be made to a financial institution or entity located within the United States. No claims to any person or entity outside of the U.S. (including, but not limited to, a network provider, out-of-network provider, subcontractor or financial institution) U.S. will be considered in the development of actuarially sound capitation rates. Non-emergency services in Canada or Mexico may be covered by the HMO per the HMO's prior authorization policies, provided the financial institution receiving payment is located within the United States.

5. Primary Care Providers

For the purpose of provider network review, the Department analyses the following primary care provider specialty codes:

- 090 – Certified Pediatric Nurse Practitioners
- 092 – Certified Family Nurse Practitioners
- 093 – Other Nurse Practitioners
- 095 – Nurse Practitioner/Nurse Midwife
- 100 - Physician Assistants
- 160 – Registered Nurse
- 212 - Nurse Midwives
- 316 - Family Practice

- 318 - General Practice
- 322 – Internal Medicine
- 328 - OB/Gynecologists
- 345 - Pediatricians
- 350 - Licensed Midwives

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

The HMO must have an enrolled primary care provider (which includes access to licensed midwives) within a 20-mile distance (or within 10-mile distance for the cities of Milwaukee, Kenosha, Racine and Madison) from any member residing in the HMO service area, unless there is no Medicaid-enrolled provider within the specified distance. In that case, the travel distance shall be no more than for a non-enrolled member.

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

6. Second Medical Opinions

The HMO must have written policies for procedures guaranteeing each member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand for providing members the opportunity to have a second opinion from a qualified network provider subject to referral procedures approved by the Department. If an appropriately qualified provider is not available within the network, the HMO must authorize and reimburse for a second opinion outside the network at no charge to the member, excluding allowable copayments.

7. Women's Health Specialists

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

8. Urgent Care Centers or Walk-in Clinics

The HMO must have policies and procedures to provide members access to urgent care centers or walk-in clinics. Such access may help to reduce emergency department utilization by providing ambulatory care for members with a sudden illness or an injury that needs medical care right away. The HMO must include in its network urgent care centers, walk-in clinics, or other medical facilities that are available to members for after-hours care from 5 p.m. to 7 p.m. during weekdays and open to members during weekends. A hospital emergency department may not serve to meet this requirement.

All urgent care centers, walk-in clinics, and physician office open extended hours must accept and advertise that walk-in appointments are accepted. HMOs are encouraged to contract with urgent care providers that meet these criteria:

- X-ray on site.
- Phlebotomy services on site.
- Appropriately licensed providers on site with the resources to obtain and read an EKG and X-ray on site; administer PC, IM and IV medication/fluids on site; and perform minor procedures (ex. sutures, splinting) on site.
- Have the following equipment and staff trained in its use:
 - Automated external defibrillator (AED)
 - Oxygen, ambu-bag/oral airway
- At least two exam rooms.

The HMO must have a process to communicate urgent care access information to members via the Provider Directory (either mailed or online) and submit the urgent care and walk-in clinics list to the Department in the provider and facility files.

In addition, BadgerCare Plus and Medicaid SSI HMOs serving Brown, Dane, Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties must have centers or clinics within a 20 mile distance

from any member residing in the HMO service area, unless there is no such clinic within the specified distance. In that case, the travel distance shall be no more than for a non-enrolled member. All urgent care centers and walk-in clinics do not have to be open for extended hours or weekends, but there shall be at least one such clinic that is open within 20 miles from each member for the specified amount of time each day.

9. Hospitals

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

- Within 20 mile distance from any member residing in the HMO service area in Brown, Dane, Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties.
- Within a 35 mile distance from any member residing in the HMO service area in any county not mention above.

If there is no hospital within the specified distances, the travel distance shall be no more than for a non-enrolled member.

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

10. Access to Indian Health Providers

For Indian members enrolled in the HMO, the HMO must ensure access to an Indian Health Care Provider (IHCP), when available. Pursuant to 42 CFR § 438.14(b)(1), the HMO must have sufficient IHCPs participating in its provider network to ensure timely access to services available under the contract from such providers for Indians members.

Indian members of the HMO are allowed to receive primary care services from an IHCP provider, as long as such provider agrees to serve in the HMO network as a PCP and has capacity for additional patients. If no such provider is contracted, the HMO must allow the member to see the IHCP out-of-network as defined in 42 CFR §438.14(b)(4). If an Indian

member receives services through an out-of-network IHCP, the HMO must allow the out-of-network IHCP to refer the Indian member to a provider within the HMO network for additional care.

If timely access to an IHCP cannot be ensured, the HMO may allow Indian members to access out-of-state IHCPs or the member may choose to disenroll from the HMO per the process outlined in Art. III, section C.

The HMO must pay all IHCPs, whether participating in the network or not, at a minimum, the full Medicaid fee-for-service payment rate for provision of services or items to Indian members. The HMO must make payments to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.

Indian members are exempt from payment of fees, co-payments, or premiums for services provided by an IHCP.

Indian members can be identified through the following:

- ForwardHealth medical status code
- Letter from Indian Health Services identifying the individual as a tribal member
- Tribal enrollment/membership card
- Written verification or a document issued by the Tribe indicating tribal affiliation
- Certificate of degree of Indian blood issued by the Bureau of Indian Affairs
- A Tribal census document
- A medical record card or similar documentation that is issued by an Indian health care provider that specifies an individual is an Indian, or
- A statement of Tribal Affiliation ([F-00685](#)).

F. Network Adequacy Requirements

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

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

2. The expected utilization of services, considering member characteristics and 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 members, distance, travel time, normal means of transportation used by members and whether provider locations are accessible to members with disabilities.

The HMO must provide documentation and assurance of the above network adequacy criteria as required by the Department for pre-contract certification or upon request of the Department.

The HMO must submit its provider network and facility file electronically to the State's FTP monthly and when there are significant service area changes. The file must be submitted in the format designated by the Department in the [HMO Provider Network File Submission Specification Guide](#). The HMO must also notify the appropriate Managed Care Analyst of changes related to network adequacy. Changes that could affect network adequacy have been defined by the Department as changes in the HMO's operations that would affect adequate capacity and services, including modifications to HMO benefits, geographic service areas, provider networks, payments, or enrollment of a new population into the HMO. ([42 CFR 438.207\(c\)\(2\)\(i-ii\)](#))

The HMO must notify the Department of any geographical service area reductions 120 days before the intended decertification date unless DHS agrees to a shorter time period based on extraordinary circumstances beyond the control of the HMO. The HMO must submit a member communication/transition plan for all service area reductions.

G. Provider to Member Ratio Requirements

1. BadgerCare Plus and Medicaid SSI HMOs serving Regions 1-4

HMOs are not required to maintain specific provider to member ratios, however if a HMO chooses to implement a provider ratio, the HMO should report these standards to DHS as part of the certification

application. This should include how the HMO plans to monitor access to care.

2. BadgerCare Plus and Medicaid SSI HMOs serving Regions 5 & 6

The HMO must maintain a provider network so that the ratio of provider to member years (member months/12) does not exceed the ratios for the corresponding provider types in the table following. For this purpose, primary care provider is defined per Art. V, E.5. If a HMO does not recognize one of the provider types as a primary care provider, providers affiliated with that type will be excluded from the HMO’s primary care provider to member ratio calculation.

Provider Type	Provider to Member Ratio
Primary Care Provider	1:100
Dentist	1:1,600
Psychiatry	1:900
Psychologist	1:900

H. Use of Non-Medicaid Providers

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

I. Online Provider Directory

The HMO must post a provider directory on their website for members, network providers, and the Department to access. The file must include the following information:

- Provider full name and phone number
- Clinic address
- Specialty
- Languages spoken, and
- If they are accepting new patients.

ARTICLE VI

VI. MARKETING AND MEMBER MATERIALS

A. Marketing Plans and Informing Materials

1. Approval of Member Communication Plans and Outreach Plans

The HMO is required to submit a member communication and outreach plan to the Department annually. The HMO shall submit an initial description of its (or its subcontractors) member communication and outreach plan to the Department for review on the second Friday of January of each calendar year. The Department will review/approve the plans within 30 days. The HMO may make changes to its member communication and outreach plan throughout the year. Any significant changes to previously approved member communication or outreach plans must be submitted to the Department for review. A sample template can be found in the 2018 Member Outreach Communication and Marketing Guide.

The member communication and outreach plan must describe the HMO's timeline and process for distributing outreach and member communication materials, including materials posted to the HMO's website or distributed electronically. The HMO must also specify the format of its member communication and outreach materials (mailings, radio, TV, billboards, etc.) and its target population or intended audience. All member communication and outreach plans, including press releases, must be approved by the Department prior to distribution.

2. Review of Member Communication, Education, Outreach, and Service Expansion Materials

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

- a. The Department will review and either approve, approve with modifications, or disapprove all member communication materials and outreach materials within ten business days, except Member

Handbooks, which will be reviewed within 30 days. If the HMO does not receive a response from the Department within the prescribed time frame, the HMO should contact the Managed Care Section Chief in the Bureau of Benefits Management. A response will be prepared within two business days of this contact.

- b. Time-sensitive member communication and outreach materials must be clearly marked time-sensitive by the HMO and will be approved, approved with modifications, or disapproved by the Department within three business days. The Department reserves the right to determine whether the materials are indeed time-sensitive. If the HMO does not receive a response from the Department within three business days, the HMO must contact the Managed Care Section Chief in the Bureau of Benefits Management. A response will be prepared within one business day of this contact.
- c. The Department will not approve any materials that are confusing, fraudulent or misleading, or that do not accurately reflect the scope, philosophy, or covered benefits of the BadgerCare Plus and/or Medicaid SSI programs.
- d. The HMO must correct any problems and errors the Department identifies. The HMO agrees to comply with Ins. [6.07](#) and [3.27](#), Wis. Adm. Code, and practices consistent with the Balanced Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [42 U.S.C. 1396v(d)(2)].

3. Allowable Member Communication and Outreach Practices

HMOs are required to distribute member communication materials to BadgerCare Plus and/or Medicaid SSI managed care members. Member communication requirements are detailed below.

Member communication materials should be designed to provide the members with clear and concise information about the HMO's program, the HMO's network, and the BadgerCare Plus and/or Medicaid SSI program. All member communication materials must be written at a sixth-grade comprehension level. Written member communication materials critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and

termination notices must be made available in at least the top three non-English languages spoken by members and potential members by HMO Rate Region. An HMO serving members in at least one county in an HMO Rate Region must make its written materials critical to obtaining services available in at least the top three non-English languages for that HMO Rate Region. The Department will determine on an annual basis the non-English languages spoken by members and potential members by HMO Rate Region. . All communication materials must contain taglines in at least the top three non-English languages spoken by members and potential members in the applicable HMO Rate Region, as well as large print, explaining that written translation or oral interpretation of the document is available to the member free of charge. All written communication materials must also include a large print tagline with information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. The HMO must also arrange for translation into any other language and/or dialect appropriate for its members.

The top three non-English languages for each HMO Rate Region are:

HMO Rate Region	Non-English Language		
Rate Region 1	Spanish	Hmong	Chinese
Rate Region 2	Spanish	Hmong	Somali
Rate Region 3	Spanish	Hmong	Lao
Rate Region 4	Spanish	Hmong	Chinese
Rate Region 5	Spanish	Chinese	Russian
Rate Region 6	Spanish	Burmese	Hmong

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

Detailed information regarding allowed and prohibited practices can be found in the 2018-2019 HMO Communication and Outreach Guide.

4. Prohibited Activities

HMOs are prohibited from marketing to potential BadgerCare Plus and/or Medicaid SSI managed care members and BadgerCare Plus and/or Medicaid SSI members who are not the HMO’s members. The Department defines “marketing” as any unsolicited contact by the HMO, its employees, affiliated providers, subcontractors, or agents with a potential member, other than as permitted in 3., above, for the purpose of

persuading such persons to enroll with the health plan or to disenroll from another health plan.

HMOs are prohibited from:

- a. Direct and indirect cold calls, either door-to-door or via telephone with potential members.
 - b. Practices that seek to influence enrollment in conjunction with the sale of any other insurance product.
 - c. Offer of material or financial gain to potential members as an inducement to enroll.
 - d. Materials which contain the assertion that the client must enroll in the HMO in order to obtain benefits or avoid losing benefits.
 - e. Practices that are discriminatory.
 - f. Activities that could mislead, confuse, or defraud members or potential members or otherwise misrepresent the HMO, its marketing representatives, the Department, or CMS.
 - g. Materials that contain false information.
 - h. Practices that are reasonably expected to have the effect of denying or discouraging enrollment.
5. The HMO Agreement to Abide by Member Communication/Informing Criteria

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

adequately monitor ongoing future member communication or marketing activities of the subcontractors.

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

- a. Immediate retraction of materials
- b. Sanctions detailed in Article XIV, Section C

B. Reproduction/Distribution of Materials

HMOs may reproduce and distribute (at their own expense) information or documents sent to the HMO from the Department that contains information the HMO-affiliated providers must have in order to fully implement this Contract.

C. HMO ID Cards

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

D. Member Handbook, Provider Directory, Education and Outreach for Newly Enrolled Members

1. The member handbook shall be written at a sixth-grade reading comprehension level and at a minimum will include 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 HMO.
 - c. Location of facilities.
 - d. Hours of service.
 - e. Informal and formal grievance procedures, including notification of the member's right to a fair hearing.
 - f. Grievance and appeal procedures.
 - g. HealthCheck.
 - h. Family planning policies.
 - i. Policies on the use of emergency and urgent care facilities.

- j. Contracted providers' telephone numbers and whether the provider is accepting new "members." Additionally, include languages spoken by the provider.
 - k. Changing HMOs.
 - l. SSI Comprehensive assessments (for Medicaid SSI members only).
 - m. Counseling and referral services that are not covered under the contract because of moral or religious objections.
2. Within 10 days of final enrollment notification to the HMO, as outlined in Article II, HMOs shall provide a hardcopy member handbook (see Addendum II) to new members according to the specification outlined in Article VI, D. HMOs may provide the member handbook and provider directory in an electronic format if all of the following are met:
 - a. The format is readily accessible;
 - b. The information is placed in a location on the HMOs web site that is prominent and readily accessible;
 - c. The information is provided in an electronic form which can be electronically retained and printed;
 - d. The information is consistent with language and content requirements of this contract; and
 - e. The member is informed that the information is available in paper form without charge upon request and the HMO provides it upon request within five (5) business days.
3. HMOs must post their current BadgerCare Plus and/or Medicaid SSI member handbook and provider directory on their website. Annually, HMOs must notify all members that these materials are available online and can be mailed hard copy upon request.
4. With Department approval, HMOs may send member handbooks, provider directories, newsletters, and other new member information (which does not contain PHI) electronically to members that provide an e-mail address to the HMO, provided the HMO meets the timeframes above regarding distribution of member handbooks. HMOs may also choose to send the annual materials electronically to members that have provided an e-mail address. HMOs must document these plans in the Member Outreach and Communication Plan submitted to the Department for approval.
- 5.

6. Notification about the availability of the member handbook and provider directory must be mailed to each case head, but HMOs may choose to mail to each individual member.
 - a. As needed, the HMO must provide periodic updates to the handbook and notify members of changes to the information listed above. The HMO must provide members at least a 30 day notice, in writing, of any significant changes to the handbook before the intended effective date of the change. Such changes must be approved by the Department prior to printing. The HMO must work with the Department to review these changes in accordance with the timeline established in Article VI, A.2.
 - b. When the HMO reprints their member handbooks, they must include all of the changes to the standard language as specified in this Contract.
 - c. The member handbook (or other substitute member information approved by the Department that explains the HMO's services and how to use the HMO) must be made available upon request within a reasonable timeframe in the three prevalent languages for each rate region. The handbook must tell members how to obtain a copy of the handbook in those languages. The Department will translate the standard handbook language into the three prevalent languages for each rate region. The HMO may use the translated standard handbook language as appropriate in its service area. However, the HMO must have local resources review the final handbook language to ensure that the appropriate dialect(s) is/are used in the standard translation. The HMO must also arrange for translation into any other dialects appropriate for its members. The HMO also must arrange for the member handbook to be provided in Braille, larger fonts or be orally translated for its visually limited members.
 - d. The HMO may create member handbook language that is simpler than the standard language, but the language must be approved by the Department. The HMO must also independently arrange for the translation of any non-standard language.

- e. The HMO must submit their member handbook for review and approval no more than 60 days after the effective date of the 2018-2019 BadgerCare Plus and Medicaid SSI HMO Contract.
- f. Any exceptions to the standard language must be approved in advance by the Department, and will be approved only for exceptional reasons. If the standard language changes during the course of the Contract period, due to changes in federal or state laws, rules or regulations, the HMO must insert the new language into the member handbooks as of the effective date of any such change and notify members of the changes.
- g. In addition to the above requirements for the member handbook, the HMO must perform other education and outreach activities for newly enrolled members. The HMO must submit to the Department for prior written approval an education and outreach plan targeted towards newly enrolled members as described in Article VI, Section A. The outreach plan will be examined by the Department during pre-contract review. Newly enrolled members are listed as “ADD-New” on the enrollment reports. The plan must identify at least two educational/outreach activities the HMO will undertake to tell new members how to access services within the HMO network. The plan must include the frequency (i.e., weekly, monthly, etc.) of the activities, the person within the HMO responsible for the activities, and how the activities will be documented and evaluated for effectiveness.

ARTICLE VII

VII. MEMBER RIGHTS AND RESPONSIBILITIES

The HMO must have written policies guaranteeing each member's rights, and share those written policies with staff and affiliated providers to be considered when providing services to members. The HMO must comply with any applicable Federal and State laws, including those identified in [42 CFR 438.100](#), that pertain to member rights. The HMO must have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. As cited in [42 CFR 438.100](#), enrollees of HMOs have the following rights:

- Receive information in accordance with [42 CFR §438.10](#).
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- If the privacy rule, as set forth in 45 CFR parts [160](#) and [164](#) subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR [164.524](#) and [164.526](#).
- Be furnished health care services in accordance with 42 CFR §438.206 through §438.210.
- Be free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the HMO and its network providers treat the enrollee.

A. Advocate Requirements

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

1. Functions of the BadgerCare Plus and/or Medicaid SSI HMO Advocate(s)
 - a. Investigate and resolve access and cultural sensitivity issues identified by HMO staff, State staff, providers, advocate organizations, and members.
 - b. Monitor formal and informal grievances with the grievance personnel for purposes of identification of trends or specific problem areas of access and care delivery. The monitoring function includes ongoing participation in the HMO grievance committee.
 - c. Recommend policy and procedural changes to HMO management including those needed to ensure and/or improve member access to and quality of care. The recommended changes can be for both internal administrative policies and subcontracted providers.
 - d. Act as the primary contact for member advocacy groups. Work with member advocacy groups on an ongoing basis to identify and correct member access barriers.
 - e. Act as the primary contact for local community based organizations (local governmental units, non-profit agencies, etc.). Work with local community based organizations on an ongoing basis to acquire knowledge and insight regarding the special health care needs of members.
 - f. Participate in working with DMS Managed Care staff assigned to the HMO on issues of access to medical care, quality of medical care, and working with the enrollment specialist, ombudsmen, and the Department's approved external advocate on issues of access to medical care, quality of medical care, and enrollment and disenrollment.
 - g. Analyze on an ongoing basis internal HMO system functions that affect member access to medical care and quality of medical care.
 - h. Attend, organize and provide ongoing training and educational materials for the HMO staff and providers to enhance their understanding of the values and practices of all cultures with which the HMO interacts.

- i. Provide ongoing input to HMO management on how changes in the HMO provider network will affect member access to medical care and member quality and continuity of care. Initiate and participate in the development and coordination of plans to minimize any potential problems that could be caused by provider network changes.
- j. Review and approve the HMO's informing materials to be distributed to members to assess clarity and accuracy.
- k. Assist members and their authorized representatives for the purpose of obtaining their medical records.
- l. The lead advocate position is responsible for overall evaluation of the HMO's internal advocacy plan and is required to monitor any contracts the HMO may enter into for external advocacy with culturally diverse associations or agencies. The lead advocate is responsible for training the associations or agencies and ensuring their input into the HMO's advocacy plan.
- m. Be willing to travel, as needed, to be accessible to meet the needs of members in different areas of the state.

Upon request from the Department, the HMO must provide evidence of compliance with the job duties mentioned above, such as proof of complaint investigations and participation in cultural competency training.

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

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

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

an HMO acting as an Administrative Service Organization (ASO) for another HMO will have at least one advocate or FTE position for each ASO contract as well as maintain their own internal advocate(s). The HMO must consider and monitor current enrollment levels when evaluating the number of advocates necessary to meet the needs of members. The HMO may employ less than the required FTE advocate position(s), but must justify to the satisfaction of the Department why less than one FTE position(s) will suffice for the HMO's member population. The HMO must also regularly evaluate the advocate position(s), work plan(s), and job duties and allocate an additional FTE advocate position or positions to meet the duties listed in Subsection A, 1, a-m above if there is significant increase in the HMO's member population or in the HMO service area. The Department reserves the right to require the HMO to employ an FTE advocate position if the HMO does not demonstrate the adequacy of a part-time advocate position.

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

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

B. Advance Directives

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

1. Provide written information at the time of HMO enrollment to all adults receiving medical care through the HMO. Per 42 CFR 438.3(j), if a

member is incapacitated at the time of initial enrollment and is unable to receive information or articulate whether or not he or she has executed an advance directive, the HMO may give advance directive information to the member's family or authorized representative. The written information should be regarding:

- a. The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and
 - b. The individual's right to file a grievance with the Department of Health Services, Division of Quality Assurance, regarding noncompliance with advance directive requirements. If requested, assist the member in filing a grievance with the Division of Quality Assurance regarding noncompliance with advance directive requirements, and
 - c. The HMO's written policies respecting the implementation of such rights.
2. Per 42 CFR 438.3(j), maintain written policies and procedures concerning advance directives which must, at a minimum, do the following:
- a. Clarify any differences between any HMO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives.
 - b. Describe the range of medical conditions or procedures affected by the conscience objection.
 - c. Document in the individual's medical record whether or not the individual has executed an advance directive.
 - d. Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

- e. Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.
- f. Provide education for staff and the community on issues concerning advance directives.
- g. Providing staff training about HMO specific policies and procedures related to advance directives.

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

C. Primary Care Provider Assignment

Per 42 CFR § 438.208(b)(1), the HMO must ensure that every member has a primary care provider or a primary care clinic responsible for coordinating the services accessed by the member. The HMO must have a process in place to link each BadgerCare Plus and Medicaid SSI member with a primary care provider, a primary care clinic, or a specialist when appropriate based on the preferences and health care needs of the member. The process shall include a defined method to notify the member of their primary care provider and how to contact the provider. The HMO shall allow members an initial choice of primary care provider or primary care clinic prior to assignment.

1. HMO primary care provider or primary care clinic assignment strategy

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

- Diabetes

- Asthma
- COPD
- Congestive heart failure
- Behavioral health
- Prenatal and post-partum care

HMOs must ensure members are linked to a primary care provider or primary care clinic that provides culturally appropriate care. Specifically, the provider must be able to relate to the member and provide care with sensitivity, understanding, and respect for the member's culture.

As part of the primary care provider or primary care clinic assignment strategy, HMOs must include the following:

- a. A process for linking all members to an appropriate primary care provider or primary care clinic (or specialist for members identified with chronic conditions), including a step in which members are given the opportunity to choose their PCP. HMOs shall ensure care is coordinated between the primary care provider, primary care clinic and/or specialists, which includes the development of a patient-centered and comprehensive treatment plan.
 - b. Communication methods that notify members of their primary care provider, primary care clinic or specialist to ensure the member utilizes primary care and encourages members to keep their scheduled appointments.
 - c. The HMO will evaluate the effectiveness of their primary care provider assignment strategy to ensure quality of care.
2. Changing and lock-in PCP assignments

The HMO must permit members to change primary providers at least twice in any year, and to change primary care providers more often than that for just cause, just cause being defined as lack of access to quality, culturally appropriate, health care. Such just cause will be handled as a formal grievance.

3. Data sharing with PCP

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

D. Member Appointment Compliance

The HMO must have a strategy in place to reduce the number of members who do not show up for scheduled appointments. This strategy must include outreach and education components for both members and providers. DHS may request additional information from HMOs on member appointment compliance during the contract period.

E. Choice of Network Provider

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

F. Coordination and Continuation of Care

The HMO must have a system in place to ensure well-managed patient care, including at a minimum:

1. Management and integration of health care through primary provider/gatekeeper/other means.
2. Systems to ensure referrals for medically necessary, specialty, secondary and tertiary care.

3. Systems to ensure provision of care in emergency situations, including an education process to ensure that members know where and how to obtain medically necessary care in emergency situations.
4. Systems that clearly specify referral requirements to providers and subcontractors. The HMO must keep copies of referrals (approved and denied) in a central file or the patient's medical records.
5. Systems to ensure the provision of a clinical determination of the medical necessity and appropriateness of the member to continue with mental health and substance abuse providers who are not subcontracted with the HMO. The determination must be made within 10 business days of the member's request. If the HMO determines that the member does not need to continue with the non-contracted provider, it must ensure an orderly transition of care.
6. Per Art. III, C, coordinate the services the HMO provides to the member with:
 - a. The services the member receives from any other provider of health care or insurance plan.
 - b. The services the member receives through Medicaid Fee-for-Service.
 - c. The services a member receives through community and social support providers.
7. Share with other HMOs (which may include Medicare or commercial plans, or members transitioning to a new BadgerCare Plus or Medicaid HMO) serving the member the results of its identification and assessment of any member with special health care needs (see Art. I for definition of special health care needs) so that those activities need not be duplicated as described in 42 CFR § 438.208(b)(4).
8. Specific Requirements for Medicaid SSI Only

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

- a. Authorize coverage of services with the member's current providers for the first 90 days of enrollment or until the first of the

month following completion of the initial assessment and care plan, whichever is later.

- b. Honor FFS authorizations for therapies and personal care at the level authorized by FFS for 90 days or until the first of the month following completion of the initial assessment and care plan, whichever is later. Exceptions to the 90 day requirement will be allowed in situations where the member agrees to change providers, the member agrees to a lower level of care, or if the HMO can document that continuing the care would result in abuse, safety or quality concerns. This does not extend authorizations beyond the time or visits approved under FFS.
- c. The HMO must have a detailed automated system for collecting all information on member contacts by care coordinators, case managers and any other staff that has a direct impact on the member's access to services.
- d. The HMO shall assist members who wish to receive care through another HMO or return to the FFS system by making appropriate referrals and by assisting in the transfer of medical records to new providers.

G. Cultural Competency and Culturally and Linguistically Appropriate Services (CLAS) Standards

1. Mission, vision, and goals

It is DHS' vision that all consumers who receive health care in Wisconsin will routinely and systematically receive respectful, culturally competent and confidential services. Such services will be those that are known to be effective in promoting health equity and reducing health disparities as advocated for in the Institute of Medicine Report (2002) and enhanced in the Affordable Care Act (2010). The Division of Medicaid Services is working to include cultural competence strategies and goals in major projects and in the daily activities of the Division.

2. ¹National Culturally and Linguistically Appropriate Services (CLAS) Standards

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to implement culturally and linguistically appropriate services. The National CLAS Standards include:

- a. Principal Standard
 - Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- b. Governance, Leadership and Workforce
 - Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
 - Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
 - Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- c. Communication and Language Assistance
 - Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
 - Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

¹ National CLAS Standards - <https://www.thinkculturalhealth.hhs.gov/clas/standards>

- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
 - Provide easy-to-understand print and multimedia and signage in the languages commonly used by the populations in the service area.
- d. Engagement, Continuous Improvement, and Accountability
- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
 - Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
 - Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
 - Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
 - Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
 - Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
 - Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
3. In support of DMS's efforts to promote the delivery of services in a culturally competent manner to all members, the HMO must incorporate

the National CLAS standards into organizational practices and the delivery of services with a particular focus on care management services for BadgerCare Plus and Medicaid SSI members. As part of HMO certification and recertification, the HMO must:

- a. Develop and submit policies and procedures demonstrating how all National CLAS standards have been incorporated into organizational practices and delivery of services as part of certification.
 - b. Complete and submit the CLAS pledge.
 - c. Complete and submit a CLAS self-assessment by the end of 2018. The Department will provide guidance on completing the assessment in early 2018.
 - d. HMO staff working with the BadgerCare Plus and/or Medicaid SSI members must complete two cultural competence trainings per year (chosen by the HMO). The HMO shall provide detail about trainings completed in the certification application.
4. The HMO must address the special health needs of members who are low income or members of population groups needing specific culturally competent services. The HMO must incorporate in its policies, administration and service practice elements such as:
- a. Recognizing members' beliefs,
 - b. Addressing cultural differences in a competent manner, and
 - c. Fostering in its staff and providers behaviors that effectively address interpersonal communication styles that respect members' cultural backgrounds.
 - d. Permitting members to change provider's based on the provider's ability to provide culturally competent services.
 - e. Culturally competent grievance protocols.

The HMO must have specific policy statements on these topics and communicate them to subcontractors as well as provide a strategic plan upon request by the Department.

The HMO must encourage and foster cultural competency among providers. When appropriate the HMO must permit members to choose

providers from among the HMO's network based on linguistic/cultural needs. The HMO must permit members to change primary care providers based on the provider's ability to provide services in a culturally competent manner. Members may submit grievances to the HMO and/or the Department regarding their inability to obtain culturally appropriate care, and the Department may, pursuant to such a grievance, permit a member to disenroll from that HMO and enroll into another HMO, or into FFS in a county where HMOs do not enroll all BadgerCare Plus or Medicaid SSI eligible members.

H. Health Education and Disease Prevention

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

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

1. An individual responsible for the coordination and delivery of services.
2. Information on how to obtain these services (locations, hours, telephone numbers, etc.)
3. Health-related education materials in the form of printed, audiovisual and/or personal communication.

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

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

5. Health education and disease prevention programs, including injury control, family planning, teen pregnancy, sexually transmitted disease prevention, prenatal care, nutrition, childhood immunization, substance abuse prevention, child abuse prevention, parenting skills, stress control, postpartum depression, exercise, smoking cessation, weight gain and healthy birth, postpartum weight loss, and breast feeding promotion and support. (Note: Any education and prevention programs for family planning and substance abuse would supplement the required family planning and substance abuse health care services covered by BadgerCare Plus and/or Medicaid SSI.)
6. The HMO should offer a discrete substance abuse screening and prevention program for members at risk of substance abuse disorder. Wisconsin Medicaid and BadgerCare Plus covers a screening, brief intervention, and referral to treatment benefit (SBIRT) for all members (see ForwardHealth online handbook, Topic #8297) and a similar benefit for pregnant women (see Topic #4442).
7. Promotion of the health education and disease prevention programs, including use of languages understood by the population served, and use of facilities accessible to the population served.
8. Information on and promotion of other available prevention services offered outside of the HMO, including child nutrition programs, parenting classes, programs offered by local health departments and other programs.
9. Systematic referrals of potentially eligible women, infants, and children to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and relevant medical information to the WIC program. More information about the WIC program as well as list of the local WIC agencies can be found on the WIC website (<http://www.dhs.wi.gov/wic/>).

I. Language Access Services

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

1. Offer language access services in all crucial situations requiring language assistance as soon as it is determined that the member is of limited English proficiency or has communication impairment.
2. Provide 24 hours a day, seven days a week access to interpreter and sign language services in languages spoken by those individuals eligible to receive the services provided by the HMO or its providers.
3. Provide timely language access services to assist adequately with all necessary care, including urgent and emergency care, upon member or provider request in a specific situation where care is needed. The HMO must clearly document all such actions and results. This documentation must be available to the Department upon request.
4. Use professional language access staff (including interpreters, auxiliary aids and services), 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.
5. 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.
6. Designate a staff person to be responsible for the administration of language access services.
7. Receive Department approval of written policies and procedures for the provision of language access services.

As part of the certification application, the HMO must submit the policies and procedures for language access services (including auxiliary aids and services). For interpreters, a list of interpreters the HMO uses, and the language spoken by each interpreter. The HMO must also submit, as part of certification, its policy on provision of auxiliary aids to hearing-impaired members. The policy must include a description of the HMO’s process for assessing the preferred method of communication of each hearing-impaired member. The HMO must offer each hearing-impaired member the type of auxiliary aid(s) s/he prefers in order to access program services and benefits. Once the hearing-impaired member

identifies the type of auxiliary aid(s) s/he prefers, a less effective form of communication may not be used. For example, a person who can most effectively communicate in sign language may not be required to communicate using hand written notes. For members with visual impairment, the HMO must include its policy on providing materials in Braille, larger fonts, or other alternatives.

ARTICLE VIII

VIII. PROVIDER APPEALS

Providers, who have attempted unsuccessfully to resolve payment disputes directly with the HMO through the HMO's established appeal process, may choose to pursue resolution directly with the Department through the provider appeal process. The provider has 60 days from the HMO's final appeal decision to submit all relevant information pertaining to the case(s) in question. If, based on the preliminary information provided by the provider, the Department determines that there is insufficient evidence to overturn the original denial, the Department will not pursue additional contact with the HMO and uphold the denial. If, however, the Department determines that the provider's appeal necessitates further review, it will seek rebuttal from the HMO.

The Department may send an official Request for Additional Information notice, as appropriate, either via US mail or secure email to the HMO or the provider. The Additional Information notice and requested documents must be returned to the Department, within 14 calendar days, via US mail, fax or electronically if sent over a secure network. If the HMO fails to submit the requested information by the date required by the Department, the Department will overturn the original denial and compel the HMO to pay the claim. The Department will uphold the original denial if the provider fails to provide the requested information.

The Department has 45 days from the date of receipt of all written comments to inform the provider and the HMO of the final decision. If the Department's decision is in favor of the provider, the HMO will pay provider(s) within 45 days of receipt of the Department's final determination. The HMO and the provider must accept the Department's final decision regarding appeals of disputed claims. A reconsideration of a final decision will only be made if an error has been made or there was a misrepresentation of facts.

The following items outline the various responsibilities of the HMO and the provider when an appeal is made to the Department:

A. HMO Responsibility

1. The HMO must have adequate staff available to train and support providers on resources available in order to prevent claim processing issues and denials. Refer to Article XI, B.7. The HMO must perform ongoing monitoring of provider appeal numbers and perform provider outreach and education/training on trends to prevent future denials/partial payments, thus reducing future provider appeals to the HMO and to the Department.

2. The HMO must inform providers and subcontractors, in writing at the time they enter into a contract, of the toll-free number for members to file appeals as well as the provider's and subcontractor's right to appeal a denied/reduced payment or payment recoupment after audit or Utilization Management review.
3. HMOs must provide a clear process for claim dispute escalation which must include the below elements in their contract or MOU with providers, in their provider manual, or through written notification for non-contracted providers. Written (or HIPAA 835 transaction) notification of payment or denial must occur on the date of action when the action is denial of payment.
4. Language distinguishing "resubmission of a claim" or, "reconsideration of a claim" and "appeal of a claim" as defined in Article I with a clear indication of level of action being taken.
5. The payment remittance document must include the date the denial action was taken and specific explanation of the payment amount or a specific reason for nonpayment.
6. A statement regarding the provider's rights to appeal to the HMO, including the timeline.
7. The name of the person and/or function at the HMO to whom provider appeal should be submitted.
8. The appeal response must clearly state why the claim will not be paid, and include all contract language that supports the denial/recoupment of payment.
9. The HMO must adhere to the following timelines
 - The HMO must accept written appeals from providers submitted within 60 days of the HMO's initial payment and/or nonpayment notice, or notice of audit/recoupment. In exceptional cases, the Department may override the HMO's time limit for submission of claims and appeals. The Department will not exercise its authority in this regard unreasonably.

- The HMO must respond in writing within 45 days from the date on the appeal letter. If the HMO fails to respond within 45 days, or if the provider is not satisfied with the HMO's response, the provider may seek a final determination from the Department.
10. The HMO must provide an explanation of the process the provider should follow to appeal the HMO's decision to the HMO once all claim reconsideration action has been exhausted, which includes the following steps:
 11. Submit a completed HMO designated Appeal form or a separate letter clearly marked "appeal".
 12. Include the provider's name, date of service, date of billing, date of payment and/or nonpayment, member's name and BadgerCare Plus and/or Medicaid SSI ID number.
 13. Clearly state the reason(s) the claim is being appealed, including all documentation necessary to support the reason.
 14. If the provider's complaint is medical (emergency, medical necessity and/or prior authorization), the HMO must indicate if medical records are required and need to be submitted with the appeal.
 15. Address the letter or form to the person and/or function at the HMO that handles provider appeals.
 16. Send the appeal to the HMO within 60 days of the initial denial or payment notice.
 17. The HMO must provide a statement advising the provider of their right to appeal to the Department if all appeals actions have been exhausted with the HMO, the HMO fails to respond to the appeal within 45 days from the date on the appeal letter or if the provider is not satisfied with the HMO's response to the appeal.

B. Provider Responsibility

1. All BadgerCare Plus and Medicaid SSI providers must exhaust all appeal rights with the HMO before filing an appeal to the Department if they disagree with the HMO's appeal response. Failure to exhaust all reasonable methods of dispute resolution with the HMO will result in the appeal being returned unprocessed.
2. Appeals to the Department must be submitted in writing within 60 days of the date on the HMO's final decision notice or, in the case of no response, within 60 days from the 45 day timeline allotted the HMO to respond.
3. A decision to uphold the HMO's original payment denial or to overturn the denial will be made based on the documentation submitted for review. Failure to submit the required documentation or submitting incomplete/insufficient documentation may lead to an upholding of the original denial. The decision to overturn an HMO's denial must be clearly supported by the documentation.
4. Providers may use the Department's form when submitting an appeal for State review. All elements of the form must be completed or listed in the letter if the form is not used. The form with instructions is available at the following website: <https://www.dhs.wisconsin.gov/library/F-12022.htm>
5. Providers are required to submit legible copies of all of the following documentation, regardless of whether the Managed Care Program Provider Appeal form or their own appeal letter is used. Incomplete appeals will not receive Departmental review and will be returned and the denial upheld. The appeal packet must contain:
 - A copy of the original claim submitted to the HMO. If applicable, include a copy of all corrected claims submitted to the HMO.
 - A copy of all of the HMO's payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial.
 - A copy of the provider's written appeal to the HMO.
 - A copy of the HMO response to the appeal.

- A copy of the medical record for appeals regarding coding issues, medical necessity, or emergency determination. Providers should only send relevant medical documentation that supports the appeal. Large records submitted with no indication will not be reviewed. Large documents should be submitted on a CD.
- A copy of any contract language that supports your appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial. Contract language submitted with no indication will not be reviewed.
- Any other documentation that supports the appeal (e.g., commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort).

Appeals to the Department must be sent to:

BadgerCare Plus and Medicaid SSI
Managed Care Unit – Provider Appeal
P.O. Box 6470
Madison, WI 53716-0470
Fax Number: 608-224-6318

6. Providers should notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which they have submitted an appeal. Notification should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record.

ARTICLE IX

IX. Member Grievances and Appeals

The member grievance process refers to the overall system that includes complaints, grievances and appeals or expedited appeals as defined in Article I. BadgerCare Plus and/or Medicaid SSI members and/or their authorized representative may grieve any aspect of service delivery provided or arranged by the HMO, to the HMO and to the Department. The member may appeal an action to the HMO, the Department and/or to the Division of Hearings and Appeals.

A. Procedures

The HMO must:

1. Have written policies and procedures that detail what the grievance and appeal system is and how it operates.
2. Identify a contact person in the HMO to receive grievances and appeals and be responsible for routing and processing.
3. Operate a complaint process that members can use to get problems resolved without going through the formal, written grievance process. However, the HMO must treat any verbal requests seeking to appeal an action as an appeal and confirm those in writing, unless the member or authorized representative requests expedited resolution.
4. Operate a grievance process that members can use to grieve in writing or orally.
5. Inform members about the existence of the complaint and grievance processes and how to use them.
6. Attempt to resolve complaints, grievances and appeals informally.
7. Respond to grievances and appeals in writing within 10 business days of receipt, except in emergency or urgent (expedited grievance) situations. This represents the first response. The HMO must resolve the grievance or appeal within two business days of receipt of a verbal or written expedited grievance, or sooner if

possible. If the HMO denies a request for expedited resolution of an appeal, it must:

- Transfer the appeal to the timeframe for standard resolution; and
 - Make reasonable efforts to give the member prompt oral notice of the delay; and
 - Within 2 calendar days, give the member written notice of the reason for the decision to extend or deny the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.
8. Operate a grievance process within the HMO that member can use to grieve or appeal any negative response to the Board of Directors of the HMO. The HMO Board of Directors may delegate the authority to review grievances and appeals to the HMO grievance appeal committee, but the delegation must be in writing. If a grievance appeal committee is established, the BadgerCare Plus and/or Medicaid SSI HMO Advocate must be a member of the committee. The decision makers responsible for reviewing a member's grievance or appeal must not have participated in prior decision making. Health care professionals with appropriate clinical experience must participate in the HMO grievance appeal committee if the decision involves:
- An appeal of a denial based on lack of medical necessity;
 - A grievance regarding denial of expedited resolution of an appeal; or
 - Any grievance or appeal involving clinical issues.
9. Provide the member and his or her representative an opportunity, before and during the appeals process, to examine member's case file, including medical records, and any other documents and records considered during the appeals process.
10. Grant the member the right to appear in person before the grievance appeal committee to present written and oral information. The member may bring a representative to the meeting. The HMO must inform the member in writing of the time and place of the meeting at least seven days before the meeting or

in expedited grievances or appeals, the HMO must also notify the member orally of the limited time to present additional information.

11. Maintain records of complaints and grievances that includes a short, dated summary of each problem, the response, and the resolution. The log must distinguish between BadgerCare Plus and Medicaid SSI members, if the HMO serves both populations. If the HMO does not have a separate log for BadgerCare Plus and/or Medicaid SSI and their commercial members, the log must distinguish between the programs. The HMO must submit quarterly reports to the Department of all complaints, grievances and appeals (Addendum IV, H). The analysis of the log will include the number of complaints, grievances and appeals divided into two categories, program administration and benefit denials. HMOs should report [in Addendum IV, F, 1 (a-c)] those members that grieved or appealed to the HMO's grievance appeal committee.
12. Maintain a record keeping system for grievances and appeals that includes a copy of the original grievance or appeal, the response, and the resolution. The system must distinguish BadgerCare Plus or Medicaid SSI from commercial members.
13. At the time of the HMO's initial grievance denial of an action decision, the HMO must notify the member that the grievance denial decision may be appealed to the Department and/or to the Division of Hearings and Appeals. The member or his/her authorized representative may appeal orally, but must follow up with a signed written appeal.
14. Ensure that individuals with the authority to require corrective actions are involved in the grievance process.
15. Distribute to its gatekeepers, providers, subcontractors, and Independent Practice Associations (IPAs) the informational flyer on member grievance and appeal rights (the Ombuds Brochure), at the time the contract is entered. When a new brochure is available, the HMO must distribute copies to its gatekeepers, providers, subcontractors, and IPAs within three weeks of receipt of the new brochure.

16. Ensure that its gatekeepers, providers, subcontractors, and IPAs have written procedures for describing how members are informed of denied services. The HMO will make copies of the gatekeepers', providers', subcontractors', and IPAs' grievance procedures available for review upon request by the Department.
17. Inform members about the availability of interpreter services and provide interpreter services for non-English speaking and hearing impaired members throughout the HMO's grievance process.

B. Grievance and Appeal Process

The member may choose to use the HMO's grievance and appeal process or may appeal to the Department instead of using the HMO's grievance and appeal process. If the member chooses to use the HMO's process, the HMO must provide an initial response within 10 business days and a final response within 30 days of receiving the grievance or appeal. If the HMO is unable to resolve the grievance or appeal within 30 days, the time period may be extended another 14 days from receipt if the HMO notifies the member in writing that the HMO has not resolved the grievance or appeal, when the resolution may be expected, and why the additional time is needed. The total timeline for the HMO to finalize a formal grievance or appeal may not exceed 45 days from the date of the receipt. The HMO must include the resolution and date of the appeal resolution in the written notification of the member or their authorized representative. HMOs must give notice on the date of action when the action is a denial of payment.

Any grievance or appeal decision by the HMO may be appealed by the member and/or their authorized representative to the Department. The Department shall review such appeals and may affirm, modify, or reject any formal decision of the HMO at any time after the member files the formal appeal. The Department will request the name and credentials of the person making the denial decision as part of the grievance process. The Department will give a final response within 30 days from the date the Department has all information needed for a decision. Also, a member can submit a grievance or appeal directly to the Department at any time during the grievance process. Any decision made by the Department under this section is subject to member appeal rights to the extent provided by state and federal laws and rules. The Department will receive input from the member and the HMO in considering grievances and appeals.

For an expedited grievance or appeal, the HMO must resolve all issues within two business days of receiving the verbal or written request for an expedited grievance. The HMO must make reasonable effort to provide oral notice, and issue a written disposition of an expedited hearing decision within 72 hours.

The HMO and its' contracted providers must ensure that punitive action is not taken against anyone who either requests an expedited resolution or supports a member's grievance.

The HMO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal is pending and the decision to deny, limit or delay services is reversed.

A member may request a State Fair Hearing for appeal of an action. The parties to the State Fair Hearing will include DHS, the HMO as well as the member and his or her representative or the representative of a deceased member's estate.

The HMOs must reply to DHS or the state's fiscal agent within 5 business days, or sooner if possible, for the Division of Hearings and Appeals' (DHA) fair hearing appeals/requests; based on a request for a review of a denied service/authorization. This includes: the HMO denial letter, all pertinent medical or dental records, and any other pertinent documentation, including photos for plastic/cosmetic procedures, including bariatric surgery, and dental x-rays and/or models.

Decisions will be reached within the specified timeframes:

1. Standard Resolution

Within 90 days of the date the member filed the appeal with the HMO if the member filed initially with the HMO (excluding the days the member took to subsequently file for a State Fair Hearing) or the date the member filed for direct access to a State Fair Hearing.

2. Expedited Resolution (if the appeal was heard first through the HMO appeal process)

Within three (3) working days from Department receipt of a hearing request for a denial of a service that:

- Meets the criteria for an expedited appeal process but was not resolved using the HMOs appeal timeframes, or
 - Was resolved wholly or partially adversely to the member using the HMO's expedited appeal timeframes.
3. Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the HMO appeal process)

Within three (3) working days from agency receipt of a hearing request for a denial of service that meets the criteria for an expedited appeal process.

C. Notifications to Members

When the HMO, its gatekeepers, providers, subcontractors, or its IPAs discontinue, terminate, suspend, limit, or reduce a service (including services authorized by the HMO the member was previously enrolled in or services received by the member on a FFS basis), the HMO must notify the affected member(s), and his/her provider when appropriate, in writing at least 10 days before the date of action. When the HMO, its gatekeepers, providers, subcontractors, or its IPAs deny coverage of a new service, the HMO must notify the member of the denial in writing.

Notices for both ongoing services and new benefits must include all of the following:

1. The nature of the intended action.
2. The reasons for the intended action. The reason must be clearly stated in sufficient detail to ensure that the member understands the action being taken by the HMO.
3. The fact that the member and/or his/her authorized representative has the right to appeal within 45 days of the date of the notice.

4. The member has the right to examine the documentation the HMO used to make its determination prior to the HMO grievance committee hearing or the DHA.
5. The fact that interpreter services are available free of charge during the grievance and appeal process and how the member can access those services.
6. A sentence in various languages that explains who to call for interpreter services or a copy of the letter in the appropriate language.
7. The right of the member to have a representative assist him/her at any point in the appeal process including reviews or hearings.
8. The right of the member to present “new” information before or during the grievance and appeal process including reviews or hearings.
9. The fact that punitive action will not be taken against a member who appeals the HMO’s decision.
10. That the process for requesting an oral or written expedited grievance or appeal requires a medical provider to verify that delay can be a health risk. If the HMO determines the grievance or appeal does not meet expedited requirements, the HMO will review the grievance within the standard timeframes.
11. An explanation of the member’s right to appeal the HMO’s decision to the Department at any point in the process.
12. The fact that the member, if appealing the HMO action, may file a request for a hearing with the Division of Hearing and Appeals (DHA) at any point in the process.
13. The fact that the member can receive help filing a grievance or appeal by calling the HMO Advocate, the Ombuds, or the SSI External Advocate at a toll free number.

14. The address and telephone number of the HMO Advocate, the Ombuds and the External Advocate. (The External Advocate is for Medicaid SSI only.)
15. Notifications to members of termination, suspension, or reduction of an ongoing benefit (including services authorized by the HMO the member was previously enrolled in or services received by the member on a FFS basis), must in addition to items a. through n. above, also include the following:
 - The fact that a benefit will continue during the appeal or DHA fair hearing process if the member requests that it continue within 10 days of notification or before the effective date of the action, whichever is later.
 - The circumstances under which a benefit will continue during the grievance and appeal process.
 - The fact that if the member continues to receive the disputed service, the member may be liable for the cost of care if the decision is adverse to the member.

This notice requirement does not apply when the HMO, its gatekeeper, provider, subcontractor, or its IPA triages a member to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary.

The Department must review and approve all notice language prior to its use by the HMO. Department review and approval will occur during the BadgerCare Plus and/or Medicaid SSI certification process of the HMO and prior to any change of the notice language by the HMO.

16. For a rural area resident with only one HMO, the HMO must notify the member of the member's ability to obtain services outside the network.
 - From any other provider (in terms of training, experience and specialization) not available within the network.

- From a provider not part of the network who is the main source of a service to the member – provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.

The member may also receive services outside of the network for the following reasons:

- Because the only plan or provider available does not provide the service because of moral or religious objections.
- Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network.
- The State determines the other circumstances warrant out-of-network treatment.

17. The period of advanced notice is shortened to 5 days if probable member fraud has been verified or by the date of the action for the following:

- In the death of a member (when the HMO is made aware of the death);
- A signed written member statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);
- The member's admission to an institution where he/she is ineligible for further services;

- The member's address is unknown and mail directed to him/her has no forwarding address;
- The member has been accepted for Medicaid services by another local jurisdiction;
- The member's physician prescribes the change in the level of medical care;
- An adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or
- The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for NF transfers).

D. Continuation of Benefits Requirements

If the member files a request for a hearing with the DHA on or before the later of the effective date or within 10 days of the HMO mailing the notice of action to reduce, limit, terminate or suspend benefits, upon notification by the DHA the HMO will notify the member they are eligible to continue receiving care but may be liable for care if DHA upholds the HMO's decision. If the member requests that the services in question be continued pending the outcome of the fair hearing, the following conditions apply:

- If the DHA reverses the HMO's decision the HMO is responsible to cover services provided to the member during the administrative hearing process.
- If the DHA upholds the HMO's decision, the HMO may pursue reimbursement from the member for all services provided to the member, to the extent that the services were covered solely because of this requirement.

Benefits must be continued until one of the following occurs:

- The member withdraws the appeal.
- A state fair hearing decision adverse to the member is made.
- The authorization expires or the authorization service is met.

E. Reporting of Grievances to the Department

The HMO must forward both the complaint and grievance reports to the Department within 30 days of the end of a quarter in the format specified. Failure on the part of the HMO to submit the quarterly complaint and grievance reports in the required format within five days of the due date may result in any or all sanctions available under this Contract.

ARTICLE X

X. QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The HMO Quality Assessment Performance Improvement (QAPI) program must conform to the requirements of 42 CFR Part 438, Medicaid Managed Care Requirements, Subpart E, Quality Measurement and Improvement. At a minimum, the program must comply with [42 CFR 438.330 \(b\)](#) which states that the HMO must:

- Conduct performance improvement projects designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time in clinical care areas.
- Collect and submit performance measurement data.
- Have in effect mechanisms to detect both underutilization and overutilization of services.
- Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

A. QAPI Program

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

1. The HMO must evaluate the overall effectiveness of its QAPI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its BadgerCare Plus and Medicaid SSI population.
2. The HMO must document all aspects of the QAPI program and make it available to the Department for review upon request. The Department may perform off-site and on-site QAPI audits to ensure that the HMO is in compliance with contract requirements. The review and audit may include:
 - On-site visits;
 - Staff and member interviews;
 - Medical record reviews;
 - Review of all QAPI procedures, reports, committee activities, including credentialing and re-credentialing activities;
 - Corrective actions and follow-up plans;

- Peer review process;
 - Review of the results of the member satisfactions surveys; and
 - Review of staff and provider qualifications.
3. The HMO must have a written QAPI work plan that is ratified by the board of directors and outlines the scope of activity and the goals, objectives, and time lines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies and results from member satisfaction surveys and performance measures.
4. The HMO governing body is ultimately accountable to the Department for the quality of care provided to HMO members. Oversight responsibilities of the governing body include, at a minimum:
- Approval of the overall QAPI program;
 - An annual QAPI plan, designating an accountable entity or entities within the organization to provide oversight of QAPI;
 - Review of written reports from the designated entity on a periodic basis, which include a description of QAPI activities;
 - Progress on objectives, and improvements made;
 - Formal review on an annual basis of a written report on the QAPI program; and
 - Directing modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the HMO.
5. The QAPI committee must be in an organizational location within the HMO such that it can be responsible for all aspects of the QAPI program. The committee membership must be interdisciplinary and be made up of both providers and administrative staff of the HMO, including:
- A variety of health professions (e.g., physical therapy, nursing, etc.)
 - Qualified professionals specializing in mental health or substance abuse and dental care on a consulting basis when an issue related to these areas arises.
 - A variety of medical disciplines (e.g., medicine, surgery, radiology, etc.)

- A psychiatrist and an individual with specialized knowledge and experience with persons with disabilities.
 - HMO management or governing body.
6. Members of the HMO must be able to contribute input to the QAPI Committee. The HMO must have a system to receive member input on quality improvement, document the input received, document the HMO's response to the input, including a description of any changes or studies it implemented as the result of the input and document feedback to members in response to input received. The HMO response must be timely.
 7. The committee must meet on a regular basis, but not less frequently than quarterly. The activities of the QAPI Committee must be documented in the form of minutes and reports. The QAPI Committee must be accountable to the governing body. Documentation of Committee minutes and activities must be available to the Department upon request.
 8. QAPI activities of the HMO's providers and subcontractors, if separate from HMO QAPI activities, must be integrated into the overall HMO/QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter data, are incorporated into all provider and subcontractor contracts and employment agreements. The HMO QAPI program shall provide feedback to the providers and subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QAPI efforts. Other management activities (utilization management, risk management, customer service, complaints and grievances, etc.) must be integrated with QAPI program. Physicians and other health care practitioners and institutional providers must actively cooperate and participate in the HMO's quality activities.

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

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

10. The HMO must designate a senior executive to be responsible for the operation and success of the QAPI program. If this individual is not the HMO Medical Director, the Medical Director must have substantial involvement in the QAPI program. The designated individual shall be accountable for the QAPI activities of the HMO's own providers, as well as the HMO's subcontracted providers.
11. The qualifications, staffing level and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of important aspects of care and services, facilitating appropriate use of preventive services, monitoring provider performance, provider credentialing, involving members in QAPI initiatives and conducting performance improvement projects.

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

B. Monitoring and Evaluation

1. The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Important aspects of care (i.e., acute, chronic conditions, high volume, high-risk preventive care and services) must be studied and prioritized for performance improvement and updating guidelines. Standardized quality indicators must be used to assess improvement, ensure achievement of minimum performance levels, monitor adherence to guidelines, and identify patterns of over and underutilization. The Department will use HEDIS 2019 and 2020 specifications for results for measurement year (MY) 2018 and MY 2019 HMO pay-for-performance, including HMO-audited HEDIS results. For clinical areas where no HEDIS measure exists, the Department will use audited HEDIS-Like results for MY 2018 and MY 2019.
2. The HMO must use appropriate clinicians to evaluate clinical data and serve on multi-disciplinary teams tasked with analyzing and addressing data issues.

3. HMOs must mandate provider identification of provider preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR s. 434.6(a)(12) and 42 CFR s. 447.26. HMOs must report all identified provider-preventable conditions through its encounter data.

Health care acquired conditions for non-payment include hospital-acquired conditions as identified by Medicaid other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) with total knee replacement surgery in pediatric and obstetric patients.

Other provider-preventable conditions for non-payment are identified as:

- Wrong surgical or other invasive procedure performed on a patient;
 - Surgical or other invasive procedure performed on the wrong body part;
 - Surgical or other invasive procedure performed on the wrong patient.
4. The HMO must also monitor and evaluate care and services in certain priority clinical and non-clinical areas.
 5. The HMO must make documentation available to the Department upon request regarding quality improvement and assessment studies on plan performance, which relate to the enrolled population. See reporting requirements in “Performance Improvement Priority Areas and Projects.”
 6. The HMO must develop or adopt best practice guidelines in accordance with [42 CFR 438.236](#) (b) and meet the following requirements:
 - a) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
 - b) Consider the needs of the HMO members.
 - c) Are adopted in consultation with contracting health care professionals.
 - d) Are reviewed and updated periodically as appropriate.

The HMO must disseminate the guidelines to all providers and, upon request, to members and potential members.

Decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply must be consistent with the guidelines.

7. The State will arrange for an independent, external review of the quality of services delivered under each HMO's contract with the State. The review will be conducted for each HMO contractor on an annual basis in accordance with Federal requirements described in [42 CFR 438, Subpart D, Quality Measurement and Improvement; External Quality Review](#). The entity which will provide the annual external quality reviews shall not be a part of the State government, HMOs, or an association of any HMOs.

C. Health Promotion and Disease Prevention Services

1. The HMO must identify at-risk populations for preventive services and develop strategies for reaching BadgerCare Plus and/or Medicaid SSI members included in this population. Public health resources can be used to enhance the HMO's health promotion and preventive care programs.
2. The HMO must have mechanisms for facilitating appropriate use of preventive services and educating members on health promotion. At a minimum, an effective health promotion and prevention program includes HMO outreach to and education of its members, tracking preventive services, practice guidelines for preventive services, yearly measurement of performance in the delivery of such services, and communication of this information to providers and members.
3. The Department encourages the HMO to develop and implement disease management programs and systems to enhance quality of care for individuals identified as having chronic or special health care needs known to be responsive to application of clinical practice guidelines and other techniques.
4. The HMO agrees to implement systems to independently identify members with special health care needs to utilize data generated by the systems or data that may be provided by the Department to facilitate outreach, assessment and care for individuals with special health care needs.

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

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

HMOs shall not credential or recredential individual providers employed by a Narcotic Treatment Service (NTS) certified under DHS 75.15. These providers must be enrolled in the Wisconsin Medicaid Program in order to be reimbursed for services provided to Wisconsin Medicaid members per DHS 105. HMOs can rely upon NTS providers' status as Medicaid-enrolled in lieu of credentialing at the provider level. HMOs may have credentialing and recredentialing policies for facilities certified under DHS 75.15.

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

2. The HMO must periodically monitor (no less than every three years) the provider's documented qualifications to ensure that the provider still meets the HMO's specific professional requirements.
3. The HMO must also have a mechanism for considering the provider's performance. The recredentialing method must include updating all the information (except medical education) utilized in the initial credentialing process. Performance evaluation must include information from the QAPI system, reviewing member complaints, and the utilization management system.
4. The selection process must not discriminate against providers such as those serving high-risk populations, or specialize in conditions that require costly treatment. The HMO must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners in the HMO's network.

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

5. If the HMO delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.
6. The HMO must have a formal process of peer review of care delivered by providers and active participation of the HMO's contracted providers in the peer review process. This process may include internal medical audits, medical evaluation studies, peer review committees, evaluation of outcomes of care, and systems for correcting deficiencies. The HMO must supply documentation of its peer review process upon request.
7. The HMO must have written policies that allow it to suspend or terminate any provider for quality deficiencies. There must also be an appeals process available to the provider that conforms to the requirements of the HealthCare Quality Improvement Act of 1986 (42 USC 11101 etc. Seq.).
8. The names of individual practitioners and institutional providers who have been terminated from the HMO provider network as a result of quality issues must be immediately forwarded to the Department and reported to other entities as required by law (42 USC 11101 et. Seq.).
9. The HMO must determine and verify at specified intervals that:
 - a. Each provider, other than an individual practitioner is licensed to operate in the state, if licensure is required, and in compliance with any other applicable state or federal requirements; and
 - b. The HMO verifies if the provider claims accreditation, or is determined by the HMO to meet standards established by the HMO itself.
10. These standards do not apply to:
 - a. Providers who practice only under the direct supervision of a physician or other provider, and

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

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

E. Member Feedback on Quality Improvement

1. The HMO must have a process to maintain a relationship with its members that promotes two way communications and contributes to quality of care and service. The HMO must treat members with respect and dignity.
2. The HMO is encouraged to find additional ways to involve members in quality improvement initiatives and in soliciting member feedback in quality of care and services the HMO provides. Other ways to bring members into the HMO's efforts to improve the health care delivery system include but are not limited to focus groups, consumer advisory councils, member participation on the governing board, the QAPI committees or other committees, or task forces related to evaluating services. All efforts to solicit feedback from members must be approved by the Department.

F. Medical Records

1. Per 42 CFR § 438.208(b)(5), the HMO must have written policies and procedures for participating provider health records content and documentation that have been communicated to providers and a process for evaluating its providers' medical records based on the HMO's policies. The HMO should encourage use of Certified Electronic Health Record Technology (CEHRT) by clinicians for documenting and sharing clinical information as well as use of the Office of National Coordinator's (ONC) Interoperability Standards Advisory best available standards to share information electronically across the continuum of care. These policies must also address patient confidentiality, data organization and completeness, tracking, and important aspects of documentation such as accuracy, legibility, and safeguards against loss, destruction, or unauthorized use. The HMO must also have confidentiality policies and procedures that are applicable to administrative functions that are concerned with confidential patient information. Those policies must

include information with respect to disclosure of member-identifiable medical record and/or enrollment information and specifically provide:

- a. That members may review and obtain copies of medical records information that pertains to them.
 - b. That members have the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected.
 - c. That policies above must be made available to members upon request.
2. Patient medical records must be maintained in an organized manner (by the HMO, and/or by the HMO's subcontractors) that permits effective patient care, reflect all aspects of patient care and be readily available for patient encounters, administrative purposes, and Department review.
 3. Because the HMO is considered a contractor of the state and therefore (only for the limited purpose of obtaining medical records of its members) entitled to obtain medical records according to [Wis. Adm. Code, DHS 104.01\(3\)](#), the Department requires BadgerCare Plus and/or Medicaid SSI enrolled providers to release relevant records to the HMO to assist in compliance with this section. The HMO that has not specifically addressed photocopying expenses in their provider contracts or other arrangements, are liable for charges for copying records only to the extent that the Department would reimburse on a FFS basis.
 4. The HMO must have written confidentiality policies and procedures in regard to individually-identifiable patient information. Policies and procedures must be communicated to HMO staff, members, and providers. The transfer of medical records to out-of-plan providers or other agencies not affiliated with the HMO(except for the Department) are contingent upon the receipt by the HMO of written authorization to release such records signed by the member or, in the case of a minor, by the member's parent, guardian or authorized representative.
 5. The HMO must have written quality standards and performance goals for participating provider medical record documentation and be able to demonstrate, upon request of the Department, that the standards and goals have been communicated to providers. The HMO must actively monitor

compliance with established standards and provide documentation of monitoring for compliance with the standards and goals upon request of the Department.

6. Health records must be readily available for HMO-wide Quality Assessment/Performance Improvement (QAPI) and Utilization Management (UM) activities.
7. The HMO must have adequate policies in regard to transfer of medical records to ensure continuity of care when members are treated by more than one provider. This may include transfer to local health departments subject to the receipt of a signed authorization form as specified in Subsection 4 (with the exception of immunization status information which does not require member authorization.
8. Requests for completion of residual functional capacity evaluation forms and other impairment assessments, such as queries as to the presence of a listed impairment, must be provided within 10 business days of the request (at the discretion of the individual provider and subject to the provider's medical opinion of its appropriateness) and according to the other requirements listed above.
9. Minimum medical record documentation per chart entry or encounter must conform to the [Wis. Adm. Code, Chapter DHS 106.02\(9\)\(b\)](#) medical record content.

G. Utilization Management (UM)

1. The HMO and its subcontractors must have documented policies and procedures for all UM activities that involve determining medical necessity and processing requests for initial and continuing authorization of services (42 CFR 438.210(b)(1)).

The HMO must communicate to providers the criteria used to determine medical necessity and appropriateness. The criteria for determining medical necessity may not be more stringent than what is used in the State Medicaid program, as set forth in [Wis. Adm. Code DHS 101.03\(96m\)](#), [including any quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other published State policy and procedures](#). Documentation of denial of services must be available to the Department upon request.

Pursuant to 42 CFR § 438.210(b)(2), the HMO must:

- a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
- b. Consult with the requesting provider for medical services when appropriate.

When reviewing requests for authorization of services, qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s). The HMO may not deny coverage, penalize providers, or give incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or results in the under-utilization of services.

2. If the HMO delegates any part of the UM program to a third party, the delegation must meet the requirements in this Contract.
3. If the HMO utilizes telephone triage, nurse lines or other demand management systems, the HMO must document review and approval of qualification criteria of staff and of clinical protocols or guidelines used in the system. The system's performance will be evaluated annually in terms of clinical appropriateness.
4. The HMO's policies must specify time frames for responding to requests for initial and continued service authorizations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. In addition, the HMO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (interrater reliability).
 - a. Within the time frames specified, the HMO must give the member and the requesting provider written notice of:
 - The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision.

- The member's right to file a grievance or request a state fair hearing.
- b. Authorization decisions must be made within the following time frames and in all cases as expeditiously as the member's condition requires:
- Within 14 days of the receipt of the request, or
 - Within three business days if the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.

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

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

5. Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence, current standards of medical practice, or a consensus of relevant health care professionals, and are regularly updated.
6. The HMO oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.
7. Postpartum discharge policy for mothers and infants must be based on medical necessity determinations. This policy must include all follow-up tests and treatments consistent with currently accepted medical practice and applicable federal law. The policy must allow at least a 48-hour hospital stay for normal spontaneous vaginal delivery, and 96 hours for a cesarean section delivery, unless a shorter stay is agreed to by both the physician and the member. The HMO may not deny coverage, penalize providers, or give incentives or payments to providers or members. Post hospitalization follow-up care must be based on the medical needs and circumstances of the mother and infant. The Department may request documentation demonstrating compliance with this requirement.

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

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

1. The HMO or HMO affiliated dental provider must advise the member within 30 days of effective enrollment of the name of the dental provider and the address of the dental provider's site. The HMO or HMO affiliated dental provider must also inform the member in writing how to contact his/her dentist (or dental office), what dental services are covered, when the coverage is effective, and how to appeal denied services.
2. The HMO or HMO affiliated dental provider who assigns all or some BadgerCare Plus and/or Medicaid SSI HMO members to specific participating dentists must give members at least 30 days after assignment to choose another dentist. Thereafter, the HMO and/or affiliated provider must permit members to change dentists at least twice in any calendar year and more often than that for just cause.
3. HMO-affiliated dentists must provide a routine dental appointment to an assigned member within 90 days after the request. Member requests for emergency treatment must be addressed within 24 hours after the request is received.
4. Dental providers must maintain adequate records of services provided. Records must fully disclose the nature and extent of each procedure performed and should be maintained in a manner consistent with standard dental practice.
5. The HMO affirms by execution of this Contract that the HMO's peer review systems are consistently applied to all dental subcontractors and providers.
6. The HMO must document, evaluate, resolve, and follow up on all verbal and written complaints they receive from BadgerCare Plus and/or Medicaid SSI members related to dental services.

The HMO must submit annual progress reports due July 1 documenting the outcomes or current status of activities intended to increase utilization among

members and recruit and retain providers (including pediatric dental providers, orthodontists, and oral surgeons), specifically commenting on the requirements listed above. The HMO must also report on the activities it is undertaking to reach the dental utilization P4P benchmarks. These reports must include an assessment of the effectiveness of previous activities and any corrective action taken based on the assessment.

I. Accreditation

Per 42 CFR 438.332, the HMO must report to the Department if it is accredited by a private independent accrediting agency. CMS has recognized the following entities as private independent accrediting agencies: The National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care (AAAH). HMOs that have received accreditation by a private independent accrediting agency must provide the state with a copy of its most recent accreditation review, as part of the HMO certification application process. This copy must contain:

1. HMO accreditation status;
2. Name of the CMS-recognized accreditation entity;
3. The effective start and end dates of accreditation;
4. The lines of business / specific member population for which the accreditation was achieved (e.g., commercial and/or Medicaid, etc.);
5. The specific accreditation status of the HMO, including survey type and level (as applicable); and
6. Accreditation results from the accreditation entity, including recommended actions or improvements, correction action plans and summaries of findings.

The Department will post the accreditation status of all HMOs on its website including the accreditation entity, accreditation program, and the accreditation level. The Department will update this accreditation status annually

J. Performance Improvement Priority Areas and Projects

Per [42 CFR §. 438.330](#), the HMO must have an ongoing program of performance improvement projects (PIPs) to address the specific needs of the HMO's enrolled

population served under this Contract. The PIPs may include clinical and non-clinical performance areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

The Department will permit the development of collaborative relationships among the HMOs, local health departments, community-based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services in priority areas. The Department and the HMO will collaborate to develop and share “best practices” on the Performance Improvement Projects.

1. All HMOs are required to submit two PIPs each year.
 - HMOs that serve only the BC+ population are required to submit 2 PIP proposals on two different topics.
 - HMOs that serve only the SSI population are required to submit one PIP proposal for 2018 on SSI Care Management (Needs Stratification) and one PIP on another topic. The specific requirements of the SSI Care Management (Needs Stratification) PIP are described in the HMO Quality Guide for MY2018.
 - HMOs that serve both BC+ and SSI populations are required to submit (a) one PIP proposal for 2018 on SSI Care Management (Needs Stratification) and (b) another PIP proposal that targets both BC+ and SSI populations. The specific requirements of the SSI Care Management (Needs Stratification) PIP are described in the HMO Quality Guide for MY2018
2. The State has the authority to select a particular topic for the PIPs. Additionally, CMS, in consultation with the State and stakeholders, may specify performance measures and topics for performance improvement projects. HMOs that fail to meet their Pay-for-Performance (P4P) goals are encouraged to select those areas as PIP topics, in consultation with DHS.
3. If an HMO met all the pay-for-performance goals in the prior calendar year, it can choose other study topics from the P4P program and/or Core Reporting, as described in the MY2018 HMO Quality Guide. The HMO may propose alternative performance improvement topics during the preliminary topic selection summary process; approval is at the Department’s discretion. The Department’s priority areas are:

- a. Clinical

- Adolescent immunizations
- Antidepressant medication management
- Asthma management
- Blood lead testing
- Breast cancer screening
- Cardiovascular care
- Care coordination
- Childhood immunizations
- Childhood obesity interventions
- Dental care
- Diabetes management
- Emergency Department utilization
- HealthCheck
- Healthy birth outcomes
- Health disparities
- Medication reconciliation upon discharge
- Mental Health and Substance Abuse screenings and management
- Tobacco Cessation
- Hypertension management
- Preventable hospital readmissions
- SSI Care Management

b. Non-clinical

- Access and availability of services
 - Member satisfaction
 - Social Determinants of Health
 - Cultural Competence (CLAS Standards)
4. Health plans should submit PIPs which use objective quality indicators to measure the effectiveness of the interventions. Per 438.330(d)(2), HMOs should submit PIPs which include the planning and initiation of activities for sustaining or continuing PIP improvement over time. Plans should not submit baseline studies which are designed to evaluate whether a problem exists.

5. The HMO must submit a preliminary PIP proposal summary that meets the PIP guidelines issued by the EQRO as described in the HMO Quality Guide for MY2018, and state the proposed topic, the study question/project aims with a measurable goal, study indicators, study population, sampling methods if applicable, data collection procedures, improvement strategies, sustained improvement plan, and the prospective data analysis plan. The preliminary PIP proposal must be submitted to the Department or the EQRO as directed by the Department by December 1st of each calendar year.

The Department and the EQRO will review the preliminary PIP proposals and meet with the HMO in the month of December to give feedback to the HMO on the PIP proposal. The Department will determine if the PIP proposals are approved. Suggestions arising from the EQRO and HMO dialogue should be given consideration as the HMO proceeds with the PIP implementation.

If the proposal is rejected by the Department, the HMO must re-submit a new or revised PIP proposal within the timeframe specified by the Department that will be reviewed again by the Department and the EQRO.

6. After receiving the State's approval, the HMO may communicate with the EQRO throughout the implementation of the project if questions arise.
7. The HMO should perform ongoing monitoring of the project throughout the year to evaluate the effectiveness of its interventions.
8. After implementing the PIP over one calendar year, the HMO must submit to their Managed Care Contract Monitor, or the EQRO as directed by the Department, their completed PIP reports utilizing the format recommended by the Department by the first business day of July of the following year.
9. The EQRO will schedule a conference call with the HMO to review the EQRO feedback on the final PIP report.
10. Per 438.330(e)(1), if an HMO submits a multi-year PIP, then the EQRO will review and report on results trended over multiple years.

11. The EQRO may recommend an HMO's PIP for inclusion in Wisconsin's Best Practices Seminars in which all the HMOs will participate.
12. The Department will consider that the plan failed to comply with PIP requirements if:
 - a. The plan submits a final PIP on a topic that was not approved by the Department and the EQRO.
 - b. The EQRO finds that the PIP does not meet federal requirements:
 - The PIP does not define a measurable goal using clear and objective quality indicators.
 - The PIP does not include the implementation of systemic interventions to improve quality of care.
 - The PIP does not evaluate systematically the effectiveness of the interventions.
 - The PIP does not reflect the adoption of continuous cycles of improvement through which the HMO can sustain quality improvement.
 - c. The HMO does not submit the final PIP by its due date of the first business day of July of the year in which it's due. The Department may grant extensions of this deadline, if requested prior to the due date.

Failure to comply with PIP requirements may result in the application of sanctions described in Article XIV, Section C.

13. Ten Steps to A Successful PIP

Step 1: Describe the project/study topic.

Step 2: Describe the study questions/project measurable goals.

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

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

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

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

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

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

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

Step 10: Identify lessons learned and assess the sustainability of its documented improvement.

K. Pregnant Women

Tobacco Cessation

The HMO shall encourage providers to screen every pregnant woman for tobacco use during their initial prenatal visit, regardless of when this visit occurs. This information should be documented in the medical record, the member should be advised to quit and a referral made to a smoking cessation program, e.g., First Breath, Wisconsin Quit Line or other appropriate cessation assistance program. The member's cessation efforts should be assessed at every prenatal visit and at the post-partum visit.

Mental Health and Substance Abuse Screening

Wisconsin Medicaid and BadgerCare Plus covers a separate mental health and substance abuse screening benefit for all pregnant women (see ForwardHealth online handbook Topic #4442). The purpose of this benefit is to identify and assist pregnant women at risk for mental health or substance abuse problems during pregnancy. The benefit has two components:

- Screening for mental health (e.g., depression and/or trauma) and/or substance abuse problems.

- Brief preventive mental health counseling and/or substance abuse intervention for pregnant women identified as being at risk for experiencing mental health or substance abuse disorders.

Vaccines for Pregnant and Postpartum Women

The HMO shall encourage providers to screen every pregnant and postpartum woman to determine whether she needs an influenza or Tdap vaccine and to strongly recommend all vaccines needed.

L. Healthy Birth Outcomes

HMOs must meet the following requirements with regard to women at high risk of a poor birth outcome. For this purpose, these women include:

- Women with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death)
 - Women with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension)
 - Women under 18 years of age
1. The BadgerCare Plus HMO must implement the Medical Home initiative as detailed in the OB Medical Home initiative section of this contract, in the following counties: Dane, Rock, Milwaukee, Kenosha, Racine, Ozaukee, Washington, Waukesha. Medicaid SSI HMOs may choose to enroll Medicaid SSI pregnant women in participating clinics in these counties.
 2. The HMO's Medical Director, or Department-approved representative, must participate in DHS' sponsored quality efforts during the period of the contract (e.g., best practices seminars).
 3. The HMO must have a plan in place to identify women at high risk of a poor birth outcome. The plan must specifically address options for identifying high-risk women previously unknown to the BadgerCare Plus and Medicaid SSI program, (e.g., use of pregnancy notification form). The HMO may use the Department's Birth Outcome Registry Network (BORN) to identify women who had a poor birth outcome while receiving BadgerCare Plus or Medicaid SSI.

4. The HMO must ensure that these members receive early and continuous care throughout the pregnancy and post-partum period. The HMO must ensure that appropriate referrals and timely follow-up are made for all identified needs (e.g. nutrition counseling, smoking cessation, or behavioral health).
5. The HMO must have strategies in place for post-partum care, including depression screening and family planning services. Contraception options should be explored and the initial appointment for post-partum care should be made prior to discharge.
6. The HMO must have a plan in place for interconception care to ensure that the member is healthy prior to a subsequent pregnancy. At a minimum, the plan must address the needs of high-risk women with chronic conditions such as diabetes and hypertension.

M. HMO Pay-for-Performance (P4P) program and Core Reporting:

1. Goal

The HMO P4P program and Core Reporting aim to improve the quality of care received by BadgerCare Plus and Medicaid SSI members, related to preventive, chronic, mental health and substance abuse, birth-related and other healthcare services.

2. Geographic Coverage

The HMO P4P program and Core Reporting are applicable across the State of Wisconsin, i.e., all Medicaid HMO rate regions.

3. Timeframe

The 2018 Measurement Year (MY2018) will begin on January 1, 2018 and end on December 31, 2018.

4. Benefit Plans in Scope

The scope includes BadgerCare Plus (this includes the Childless Adult population) and Medicaid SSI Plan, as described in the "MY2018 HMO Quality Guide" (the Guide). The Department will publish the first version of this Guide by mid-January 2018, and will update it during MY2018, as appropriate. The Department will share all updates electronically and in a timely manner with all HMOs.

5. HMO P4P Withhold

The Department will withhold 2.5 percent of each HMO's monthly capitation payments (including administrative payments) for the P4P program. HMOs will be able to earn this withhold back by meeting quality performance targets for a specific set of measures, as described in the Guide. Depending on the relative performance of each HMO, highest-performing HMOs may be eligible for a bonus of up to 2.5 percent of their capitation payments in addition to earning back their withhold. Please see the Guide for details.

6. HMO P4P Measures and Targets

The program will include a combination of HEDIS and other measures, as finalized by the Department and as described in the Guide. Unless otherwise specified, performance targets for each measure will be of two types – Level and Degree of Improvement. Level targets are designed to recognize and give credit to HMOs with already high performance. Degree of Improvement targets are designed to recognize HMOs that are substantially below the Level targets but are making significant improvements in their performance. NCQA's Quality Compass results will be used to set the Level targets for HEDIS measures, and other statewide results will be used for non-HEDIS measures. The Degree of Improvement targets will be set using the past performance of each HMO (i.e., baselines, when available), or statewide averages. Further details of the methodology for setting targets, including definitions, are specified in the Guide.

7. Core Reporting

Core Reporting focuses on providing the Department healthcare quality data for a broad set of conditions and related measures. It does not include a withhold, though requires HMOs to report data on specific quality measures listed in the Guide. If HMOs do not report this data to the Department, they could be subject to a \$10,000 penalty per measure not reported.

8. P4P and Core Reporting Data Submission

HMOs will be asked to submit their HEDIS data and results, after authentication by their HEDIS auditor and NCQA's IDSS, to the Department by dates listed in the Guide. The Department and its fiscal agent will calculate results for non-HEDIS measures.

9. P4P Performance Measurement Methodology

Detailed methodology used to measure the performance of each HMO is described in the Guide.

N. Alternative Payment Models (APM)

1. Goal

The Department's APM program goals are aligned with Learning Action Network (LAN)'s goals to move "payments away from fee for service (FFS) and into APMs that reduce the total cost of care (TCOC) and improve the quality of care."²

2. Definition of APM

The Department defines APMs as payments made by Wisconsin Medicaid HMOs to their providers through quality and value-based purchasing arrangements.

The APM numerator is defined as the total dollar value of all payments could potentially be made by Wisconsin Medicaid HMOs to their providers for services rendered to BadgerCare Plus and Medicaid SSI members, that are directly linked to attainment of quality goals by the providers, or are "at-risk" for quality achievements. The numerator includes capitation payments made by HMOs to their providers for which the providers assume the full insurance risk. The numerator does not include any surplus or profit sharing by HMOs with the providers if such sharing is not directly related to attainment of quality goals by the providers.

The denominator is defined as the total payments made by Wisconsin HMOs to their providers for services rendered to BadgerCare Plus and Medicaid SSI members. The denominator includes any APM-related payments.

Providers include non-hospital providers (community based providers, and home health agencies, among others) and hospitals.

Additional details will be provided in the "MY2018 HMO Quality Guide" (the Guide).

3. Geographic Coverage

APMs are applicable across the State of Wisconsin, i.e., all six Medicaid HMO rate regions.

² <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

4. Timeframe

The 2018 Measurement Year (MY2018) will begin on January 1, 2018 and end on December 31, 2018.

5. Benefit Plans in Scope

The scope includes BadgerCare Plus (this includes the Childless Adult population) and Medicaid SSI Plan.

6. HMO Withhold

There are no withholds, incentives or penalties applicable to HMOs for APMs in MY2018. HMOs are required to report the potential dollars for the APM-related numerator and denominator, and the percentage of their total potential payments to providers based on quality and value-based payments. HMOs will be asked to attest to the accuracy of their report.

7. APM Threshold Target

The Department will set a threshold target percentage for combined BadgerCare Plus and Medicaid SSI dollars, and list the target in the Guide. HMOs are expected to meet that threshold in their APM payments to providers.

8. APM Data Submission

HMOs will be asked to submit their APM data annually. The submission process is described in the Guide.

O. Potentially Preventable Readmissions (PPR)

1. Goal

The Department's PPR program aims to improve the health outcomes for all Wisconsin Medicaid HMO members and reduce unnecessary care, through reduction in PPRs. Specifically for the Medicaid SSI population, it also supports the SSI Care Management initiative.

2. Definition of PPR

When an HMO member is discharged from inpatient care, and is readmitted within 30 days of discharge, the readmission could be classified as a Potentially Preventable Readmission (PPR), based on 3M's PPR software logic and exclusions.

PPR rates will be calculated for each HMO using only the HMO data and not Fee-for-Service data, by aggregating results for all members of an HMO who received inpatient care.

Additional information re: the calculation of PPRs is provided in the “MY2018 HMO Quality Guide” (the Guide).

3. Geographic Coverage

PPRs are applicable across the State of Wisconsin, i.e., all Medicaid HMO rate regions.

4. Timeframe

The 2018 Measurement Year (MY2018) will begin on January 1, 2018 and end on December 31, 2018.

5. Benefit Plans in Scope

For MY2018, the scope of PPRs for HMOs includes only BadgerCare Plus (this includes the Childless Adult population).

For MY2018, PPRs for the Medicaid SSI population will be addressed through the SSI Care Management Needs Stratification PIP requirement.

6. Incentives

HMOs are expected to work very closely with their hospital and non-hospital providers (e.g., community based providers, home health providers, among others) to reduce their PPR rates. In MY2018, the Department will set aside money as value-based payments with an “up-side” only incentive for HMOs that meet their PPR targets. There will be no penalties for not meeting the targets during MY2018. In future years, the initiative may include an up-side (bonus) and a down-side (penalties) arrangements, in alignment with the Fee-for-Service PPR initiative for hospitals.

HMOs may keep a maximum of 15% of incentive earned for administrative expenses; the rest are expected to be shared with their hospital and non-hospital providers.

7. PPR Target

The Department will calculate the baselines PPR rates for each HMO and set PPR target rates applicable to each HMO, as specified in the Guide.

8. PPR calculations

The Department will calculate and share PPR results and associated information with HMOs, as specified in the Guide.

9. Alignment with APMs

The PPR incentive dollars that shared by HMOs with their providers can be counted by the HMOs towards their numerator for the APM targets.

P. Public Reporting

The Department will publicly report various quality and other performance metrics for HMOs via a website and other media, per 42 CFR s. 438.608 Requirement 42 CFR 438.340.

ARTICLE XI

XI. HMO ADMINISTRATION

A. Statutory Requirement

In consideration of the functions and duties of the Department contained in this Contract the HMO shall retain at all times during the period of this Contract a valid Certificate of Authority issued by the State of Wisconsin Office of the Commissioner of Insurance. A separate Certificate of Authority must be submitted for each contract the HMO intends to enter into with the Medicaid program (if, for example, an HMO offers multiple product lines, does business under another name, etc.).

B. Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and rules and regulations that are in effect when the Contract is signed, or that come into effect during the term of the Contract. This includes, but is not limited to [Title XIX of the Social Security Act](#), [Title XXI](#), SCHIP, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, The Rehabilitation Act of 1973, The American with Disabilities Act, and Title 42 of the CFR.

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

The Department may incorporate into the Contract any change in covered services mandated by federal or state law effective the date the law goes into effect, if it adjusts the capitation rate accordingly. The Department will give the HMO at least 30 days' notice before the intended effective date of any such change that reflects service increases, and the HMO may elect to accept or reject the service increases for the remainder of that contract year. The Department will give the HMO 60 days' notice of any such change that reflects service decreases, with a right of the HMO to dispute the amount of the decrease within 60 days. The HMO has the right to accept or reject service decreases for the remainder of the Contract year. The date of implementation of the change in coverage will coincide with the

effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in the state budget.

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

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

C. Organizational Responsibilities and Duties

1. Ineligible Organizations

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

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

- 1) Been convicted of the following crimes:

- Program related crimes (i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid). (Section 1128(a)(1) of the Act.)
- Patient abuse (i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care). (Section 1128(a)(2) of the Act.)

- Fraud (i.e., a state or federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government). (Section 1128(b)(1) of the Act.)
 - Obstruction of an investigation (i.e., conviction under state or federal law of interference or obstruction of any investigation into any criminal offense described in Subsections a), b), or c). (Section 1128(b)(2) of the Act.)
 - Offenses relating to controlled substances (i.e., conviction of a state or federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance. (Section 1128(b)(3) of the Act.)
- 2) Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person described in C, 1, a, above from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.
- 3) Been assessed a civil monetary penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (Section 1128(b)(8)(B)(ii) of the Act.)
- b. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in Subsection 1. A substantial contractual relationship is defined as any contractual

relationship which provides for one or more of the following services:

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

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

2. Contract Representative

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

3. Attestation

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

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

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

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

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

a. Affirmative Action Plan

- 1) For agreements where the HMO has 50 employees or more and will receive \$50,000 or more, the HMO shall complete the AA plan. The HMO with an annual work force of less than 50 employees or less than \$50,000 may be exempt from submitting the AA plan.

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

<http://vendornet.state.wi.us/vendornet/contract/contcom.asp>

- 2) The HMO must file its AA plan every 3 years and includes all programs. The plan must be submitted to:

Bureau of Strategic Sourcing/Contracting Section
Department of Health Services
Division of Enterprise Services
1 West Wilson Street, Room 655
P.O. Box 7850
Madison, WI 53707

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

b. Civil Rights Compliance (CRC) Plan

- 1) The HMO receiving federal and/or state funding to administer programs, services and activities through DHS must file a Civil Rights Compliance Letter of Assurance (CRC LOA) for the compliance period of 2014-2017. All HMOs with fifty (50) or more employees AND who receive over \$50,000 in funding must complete a Civil Rights Compliance Plan (CRC Plan). The CRC Plan is to be kept on file and made available upon request to any representative of the Department of Health Services. The instructions and template to complete the requirements for the CRC Plan are found at <http://dhs.wisconsin.gov/civilrights/Index.HTM>.

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

The Department of Health Services
1 W. Wilson Street, Room 656
P.O. Box 7850
Madison, WI 53707-7850
(608) 266-9372 (voice)
(888) 701-1251 (TTY)
(608) 266-0583 (Fax)

- 2) HMOs subcontracting federal or state funding to other entities must obtain a CRC LOA from their subcontractors. The CRC LOA must be kept on file and produced upon

request or at the time that an on-site monitoring visit is conducted. Subcontractors with fifty (50) or more employees AND who receive over \$50,000 in funding must complete a CRC Plan. The CRC Plan is to be kept on file and produced upon request by the DHS AA/CRC Office, a representative of the DHS or at the time the HMO conducts an on-site monitoring visit.

- 3) The HMO agrees to not discriminate in the provision of services or benefits on the basis of age, color, disability, national origin, race, religion or sex/gender. This policy covers enrollment, access to services, facilities, and treatment for all programs and activities. All employees of the HMO are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.
- 4) The HMO agrees not to exclude qualified persons from employment otherwise. The HMO agrees to not discriminate on the basis of the conscience rights of health care providers as established and protected following Federal Health Care Provider Conscience Protection Laws: the Church Amendments; the Public Health Service Act Section 245; the Weldon Amendment; and the Affordable Care Act.
- 5) The HMO agrees to comply with all of the requirements contained in the Department CRC Plan and to ensure that their subcontractors comply with all CRC requirements during this Contract period. The instructions and template to complete the CRC Plan requirements can be found at <http://dhs.wisconsin.gov/civilrights/Index.HTM>.
- 6) The Department will monitor the Civil Rights and Affirmative Action compliance of the HMO. The Department will conduct reviews to ensure that the HMO is ensuring compliance by its subcontractors or grantees. The HMO agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the HMO, interview with staff, clients, and applicants for services, subcontractors, grantees, and referral agencies. The reviews will be conducted according

to Department procedures. The Department will also conduct reviews to address immediate concerns of complainants.

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

5. Non-Discrimination in Employment

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

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

Contractor further agrees not to subject qualified persons to discrimination in employment in any manner or term or condition of employment on the basis of arrest record, conviction record, genetic

testing, honesty testing, marital status, military service, pregnancy or childbirth, or use of legal products during non-work hours outside of the employer's premises, except as otherwise authorized by applicable statutes.

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

With respect to provider participation, reimbursement, or indemnification, the HMO will not discriminate against any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This shall not be construed to require the HMO to contract with providers beyond the number necessary to meet the needs of the BadgerCare Plus and/or Medicaid SSI population. This shall not be construed to prohibit the HMO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities. If the HMO declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.

6. Provision of Services to the HMO Members

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

The HMO must provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under Medicaid fee for services as set forth in 42 CFR § 438.210(a)(2) and 42 CFR § 440.230.

Per 42 CFR § 438.210(a)(3), the HMO:

- a. 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 to members in Medicaid fee for service.
- b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

7. HMO Staffing Level to Support Providers

At the time of contract renewal and at service area expansion request, the HMO must have appropriate staffing levels for the entire service area to support contracted provider participation and timely claim payment, per Art. XIV, D, #2.

The HMO must:

- a. Have adequate customer service and help desk staff to answer inquiries from providers (via phone or email); adequate home office or regional provider representatives to provide training to new and ongoing providers on HMO policy, communication methods, correct claim submission and appeal process.
- b. Clearly communicate to providers the availability of support resources provided through the HMO website or Provider Manual, including but not limited to the methods used by the HMO to communicate policy changes, electronic claim submission, claim reconsideration, internal appeal process, and how to appeal to the Department.

The Department reserves the right to request a staffing plan from the HMO at the time of contract renewal and at service area expansion request to demonstrate the HMO has appropriate staffing levels for its entire service area to support provider participation and timely claim payment.

8. Access to Premises

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

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

9. Liability for the Provision of Care

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

10. Subcontracts

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

11. Coordination with Community-Based Health Organizations, Local Health Departments, Division of Milwaukee Child Protective Services, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, School-based Mental Health Services, Birth to Three Program Providers, and Healthiest Wisconsin 2020

Per Art. III, section C, the HMO must have a system in place to coordinate the services it provides to member with services a member receives through community and social support providers.

a. Community-Based Health Organizations

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

The Department encourages the HMO to work closely with community-based health organizations. Community-based health

organizations may also provide services, such as WIC services, that the HMO is required by federal law to coordinate with and refer to, as appropriate.

b. Local Health Departments

The Department encourages the HMO to contract with local health departments for the provision of care to BadgerCare Plus and/or Medicaid SSI members in order to ensure continuity and culturally appropriate care and services. Local health departments can provide HealthCheck outreach and screening, immunizations, blood lead screening services, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases (e.g., tuberculosis, HIV/AIDS, sexually transmitted diseases, hepatitis and others). WIC projects provide nutrition services and supplemental foods, breast feeding promotion and support; and immunization screening. Many projects screen for blood lead poisoning during the WIC appointment.

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

c. Child Welfare Coordination

HMOs must designate at least one staff member to serve as a contact with county child welfare agencies and the Division of Milwaukee Child Protective Services (DMCPS), in the Wisconsin Department of Children and Families. If the HMO chooses to designate more than one contact person the HMO should identify the service area for which each contact person is responsible. The Department encourages HMOs to designate a staff member with at

least two years of experience working in a child welfare agency, or who has attended child welfare training through the Wisconsin Child Welfare Training Partnership.

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

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

d. Prenatal Care Coordination (PNCC) Agencies

The HMO must sign a memorandum of understanding (MOU) with all agencies in the HMO service area that are BadgerCare Plus-enrolled PNCC agencies. The purpose of the MOU is to ensure coordination of care between the HMO that provides medical services, and the PNCC agency that provides care coordination to ensure women are linked to the medical and non-medical services they need to have a healthy pregnancy outcome.

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

e. School-Based Services (SBS) Providers

The HMO must use its best effort and document attempts to sign a MOU with all SBS providers in the HMO service area to ensure continuity of care and to avoid duplication of services. School

based services are paid FFS when provided by a BadgerCare Plus enrolled SBS provider. However, in situations where a member's course of treatment is interrupted due to school breaks, after school hours or during the summer months, the HMO is responsible for providing and paying for all BadgerCare Plus covered services. The HMO must not consider SBS (e.g. physical, occupational, and speech and language therapy services) as automatically duplicative when it is considering the medical necessity of a requested community based service.

MOUs must be signed every three years as part of certification. If no changes have occurred, then both the school and the HMO must sign off that no changes have occurred and documentation to this effect must be submitted to the Bureau of Benefits Management upon request. HMOs must conduct outreach to schools that do not have a MOU with the health plan, at a minimum, every two years. The HMO must submit evidence that it attempted to obtain a MOU or contract in good faith.

f. Targeted Case Management (TCM) Agencies

The HMO must interface with the case manager from the TCM agency to identify what BadgerCare Plus and/or Medicaid SSI covered services or social services are to be provided to a member. The HMO is not required to pay for medical services directed outside of their provider network by the case manager unless prior authorized by the HMO.

g. Birth to Three Program Providers

HMOs must contract with Birth to 3 Program agencies within their service area to authorize and pay claims for their members that are enrolled in the Birth to 3 Program for Medicaid HMO reimbursable physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services provided as Birth to 3 Program services.

Birth to 3 Program services must be provided by PT, OT, and SLP providers who are employed by, or under agreement with, Birth to 3 Program agencies to provide Birth to 3 Program services. A HMO is not providing access and reimbursement for Birth to 3

Program services by authorizing PT, OT, and SLP services by a network provider to a child under age 3 if the child does not have an assessment and Individualized Family Service Plan (IFSP) and/or the provider is not employed/contracted by the Birth to 3 Program agency.

HMOs must authorize PT, OT, or SLP Birth to 3 Program services if these services are provided in conjunction with the Birth to 3 Program initial evaluation and assessment and the services are identified in the member's (IFSP) and requested at the same frequency, intensity, and duration listed in the IFSP. HMOs should not impose additional medical necessity criteria for Birth to 3 Program services. HMOs are encouraged to follow ForwardHealth policy for prior authorization of Birth to 3 Program services by not requiring Birth to 3 Programs to frequently re-submit authorization requests to the HMO.

HMOs are encouraged to follow the ForwardHealth policy for prior authorization of therapy services provided outside the Birth to 3 Program, and to require receipt of the completed Child Enrollment Status Regarding Birth to 3 Program form prior to authorizing any PT, OT, or SLP for a child under 3. HMOs may impose their standard medical necessity criteria when authorizing therapy services outside the Birth to 3 Program for a child under 3.

In addition to contracting with Birth to 3 Program agencies to authorize and pay claims for Medicaid HMO reimbursable program services (PT, OT, SLP), HMOs are encouraged to develop MOUs with county Birth to Three Program agencies in their service area.

Wisconsin's [Birth to 3 Program](http://www.dhs.wisconsin.gov/children/birthto3/) (<http://www.dhs.wisconsin.gov/children/birthto3/>) is a federally mandated program with oversight by the U.S. Department of Education, Office of Special Education Programs (OSEP) under Part C of the Individuals with Disabilities Act. The Birth to 3 Program provides early intervention services for children ages birth to 36 months with developmental delays and disabilities and is available in all 72 counties; the Department of Health Services (DHS) contracts with each county to establish and maintain a Birth to 3 Program.

HMOs can find a list of county contacts for Birth to Three programs at:

<http://www.dhs.wisconsin.gov/children/birthto3/contacts/countycontacts.asp>

h. Healthiest Wisconsin 2020

The Department encourages HMOs to serve as Healthiest Wisconsin 2020 partners. This includes the HMO working towards objectives that influence the health of the public and long-term goals for the decade. More information on Healthiest Wisconsin 2020 can be found at:

<http://www.dhs.wisconsin.gov/hw2020/>

12. Clinical Laboratory Improvement Amendments (CLIA)

The HMO must use only certain laboratories. All laboratory testing sites providing services under this Contract must have a valid CLIA certificate along with a CLIA identification number, and comply with federal CLIA regulations as specified by [42 CFR Part 493](#), 42 CFR 263a, and Wisconsin Administrative Code, Chapter 105, [DHS 105.42\(1-2\)](#) and [DHS 105.46](#) – Medical Assistance. Those laboratories with certificates must provide only the types of tests permitted under the terms of their certification.

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

D. Confidentiality of Records and HIPAA Requirements

The parties agree that all information, records, and data collected in connection with this Contract will be protected from unauthorized disclosure as provided in [Chapter 49, Subchapter IV, Wis. Stats.](#), [DHS 108.01, Wis. Adm. Code](#), [42 CFR 431 Subpart F](#), [42 CFR 438 Subpart F](#) and 45 CFR [160](#), [162](#), and [164](#) and any other confidentiality law to the extent that these requirements apply. Except as otherwise required by law, rule or regulation, access to such information shall be limited by the HMO and the Department to persons who, or agencies which, require the information in order to perform their duties related to this Contract, including the U.S. Department of Health and Human Services and such others as may be required by the Department.

1. Duty of Non-Disclosure and Security Precautions

Contractor shall not use Confidential Information for any purpose other than the limited purposes set forth in the Agreement. Contractor shall hold the Confidential Information in confidence, and shall not disclose such Confidential Information to any persons other than those directors, officers, employees, and agents ("Representatives") who have a business-related need to have access to such Confidential Information in furtherance of the limited purposes of this Agreement and who have been apprised of, and agree to maintain, the confidential nature of such information in accordance with the terms of this Agreement. Contractor shall be responsible for the breach of this Agreement by any of its Representatives.

Contractor shall institute and/or maintain such procedures as are reasonably required to maintain the confidentiality of the Confidential Information, and shall apply the same level of care as it employs to protect its own confidential information of like nature.

Contractor shall ensure that all indications of confidentiality contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. If requested by the State, Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed.

If requested by the State, Contractor shall return or destroy all Individually Identifiable Health Information and Personally Identifiable Information it holds upon termination of this Agreement.

2. Limitations on Obligations

The obligations of confidentiality assumed by Contractor pursuant to this Agreement shall not apply to the extent Contractor can demonstrate that such information:

- is part of the public domain without any breach of this Agreement by Contractor;
- is or becomes generally known on a non-confidential basis, through no wrongful act of Contractor;

- was known by Contractor prior to disclosure hereunder without any obligation to keep it confidential;
- was disclosed to it by a third party which, to the best of Contractor's knowledge, is not required to maintain its confidentiality;
- was independently developed by Contractor; or
- is the subject of a written agreement whereby the State consents to the disclosure of such Confidential Information by Contractor on a non-confidential basis.

3. Legal Disclosure

If Contractor or any of its Representatives shall be under a legal obligation in any administrative, regulatory or judicial circumstance to disclose any Confidential Information, Contractor shall give the State prompt notice thereof (unless it has a legal obligation to the contrary) so that the State may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor and its Representatives shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

4. Unauthorized Use, Disclosure, or Loss

If Contractor becomes aware of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Agreement, or if any Confidential Information is lost or cannot be accounted for, Contractor shall notify the State's (Contract Manager/Contact Liaison/Privacy Officer) within the same business day the Contractor becomes aware of such use, disclosure, or loss. Such notice shall include, to the best of the Contractor's knowledge at that time, the persons affected, their identities, and the Confidential Information disclosed.

The Contractor shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The Contractor shall reasonably cooperate with the State's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its Confidential Information, including complying with a reasonable Corrective Action Plan.

If the unauthorized use, disclosure, or loss is of Personally Identifiable Information, or reasonably could otherwise identify individuals, Contractor shall, at its own cost, take any or all of the following measures that are directed by the State as part of a Corrective Action Plan:

- a. Notify the affected individuals by mail or the method previously used by the State to communicate with the individual. If the Contractor cannot with reasonable diligence determine the mailing address of the affected individual and the State has not previously contacted that individual, the Contractor shall provide notice by a method reasonably calculated to provide actual notice.
 - Notify consumer reporting agencies of the unauthorized release.
 - Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the State for one year from the date the individual enrolls in credit monitoring.
 - Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as established by the State.
 - Adequately staff customer service telephone lines to assure an actual wait time of less than five (5) minutes for callers.

5. Trading partner requirements under HIPAA

For the purposes of this section Trading Partner means the HMO.

a. Trading Partner Obligations

- Trading Partner must not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation ([45 CFR Part 162.915\(a\)](#)).
- Trading Partner must not add any data elements or segments to the maximum data set as proscribed in the

HHS Transaction Standard Regulation ([45 CFR Part 162.915\(b\)](#)).

- Trading Partner must not use any code or data elements that are either marked “not used” in the HHS Transaction Standard’s implementation specifications or are not in the HHS Transaction Standard’s implementation specifications ([45 CFR Part 162.915\(c\)](#)).
 - Trading Partner must not change the meaning or intent of any of the HHS Transaction Standard’s implementation specifications ([45 CFR Part 162.915\(d\)](#)).
 - Trading Partner must submit a new Trading Partner profile form in writing if any of the information provided as part of the Trading Partner profile form is modified.
- b. Trading Partner understands that there exists the possibility that the Department or others may request an exception from the uses of a standard in the HHS Transaction Standards. If this occurs, Trading Partner must participate in such test modification ([45 CFR Part 162.940 \(a\) \(4\)](#)).
- c. Trading Partners or Trading Partner’s Business Associate have responsibilities to adequately test business rules appropriate to their types and specialties.
- d. Trading Partner or their Business Associate agrees to cure transaction errors or deficiencies identified by the Department.
- e. Trading Partner or Trading Partner’s Business Associate understands that from time-to-time HHS may modify and set compliance dates for the HHS Transaction Standards. Trading Partner or Trading Partner’s Business associate must incorporate by reference any such modifications or changes ([45 CFR Part 160.104](#)).
- f. The Department and the Trading Partner agree to keep open code sets being processed or used for at least the current billing period or any appeal period, whichever is longer ([45 CFR Part 162.925 \(c\)\(2\)](#)).

g. Privacy

- The Trading Partner or the Trading Partner's Business Associate will comply with all applicable state and federal privacy statutes and regulations concerning the treatment of Protected Health Information (PHI).
- The Department and the Trading Partner or Trading Partner's Business Associate will promptly notify the other party of any unlawful or unauthorized use or disclosure of PHI that may have an impact on the other party that comes to the party's attention, and will cooperate with the other party in the event that any litigation arises concerning the unlawful or unauthorized disclosure or use of PHI.
- The Department retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by the Trading Partner, Trading Partner's Business Associate, or any agent, contractor or third Party that received PHI from the Trading Partner.

h. Security

- The Department and the Trading Partner or Trading Partner's Business Associate must maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, security access codes, envelope, backup files, and source documents. Each party will immediately notify the other party of any unauthorized attempt to obtain access to or otherwise tamper with data, data transmissions security access codes, envelope, backup files, source documents other party's operating system when the attempt may have an impact on the other party.
- The Department and the Trading Partner or Trading Partner's Business associate must develop, implement, and maintain appropriate security measures for its own operating system. The Department and the Trading Partner or Trading Partner's Business Associate must document and keep current its security measures. Each party's

security measure will include, at a minimum, the requirements and implementation features set forth in 'site specific HIPAA rule' and all applicable HHS implementation guidelines.

6. Indemnification

In the event of a breach of this Section by the HMO the HMO shall indemnify and hold harmless the State of Wisconsin and any of its officers, employees, or agents from any claims arising from the acts or omissions of the HMO, and its subcontractors, employees and agents, in violation of this Section, including but not limited to costs of monitoring the credit of all persons whose Confidential Information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the State in the enforcement of this Section. In addition, notwithstanding anything to the contrary herein, the HMO shall compensate the State for its actual staff time and other costs associated with the State's response to the unauthorized use or disclosure constituting the breach.

7. Equitable Relief

The HMO acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury will not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the State, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Agreement or under applicable law.

8. Liquidated Damages

The HMO agrees that an unauthorized use or disclosure of Confidential Information may result in damage to the State's reputation and ability to serve the public interest in its administration of programs affected by this Agreement. Such amounts of damages which will be sustained are not calculable with any degree of certainty and thus shall be the amounts set forth herein. Assessment under this provision is in addition to other

remedies under this Agreement and as provided in law or equity. The State shall assess damages as appropriate and notify the HMO in writing of the assessment. The HMO shall automatically deduct the damage assessments from the next appropriate monthly invoice, itemizing the assessment deductions on the invoice.

Liquidated Damages shall be as follows:

- \$100 for each individual whose Confidential Information was used or disclosed;
- \$100 per day for each day that the HMO fails to substantially comply with the Corrective Action Plan under this Section.
- Damages under this Section shall in no event exceed \$50,000 per incident.

9. Compliance Reviews

The State may conduct a compliance review of the HMO's security procedures to protect Confidential Information.

10. Survival

This Section shall survive the termination of the Agreement.

ARTICLE XII

XII. REPORTS AND DATA

A. Required Use of the Secure ForwardHealth Portal

The HMO must request a secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions and other business with DHS. When the HMO requests an account, the designated HMO contact will receive a PIN via their email address. The PIN is used to access specific HMO information on the Portal.

The HMO must assign users roles/permissions within the secure ForwardHealth Portal account to ensure only authorized users have access to data and functions provided. The HMO must ensure all users understand and comply with all HIPAA regulations.

Detailed information can be found at:

<https://www.forwardhealth.wi.gov/WIPortal/Account/Setup/tabId/111/Default.aspx>

B. Access to and/or Disclosure of Financial Records

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

C. Access to and Audit of Contract Records

Throughout the duration of this Contract, and for a period of ten years after termination of this Contract, the HMO must provide duly authorized representatives of the state (including the Office of the Inspector General) or federal government access to all records and material relating to the HMO's provision of and reimbursement for activities contemplated under the Contract. Such access shall include the right to inspect, audit and reproduce all such records and material, including but not limited to computer records system, invoices, and

to verify reports furnished in compliance with the provisions of this Contract. All information so obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations. Refusal to provide required materials during an audit may subject the HMO to sanctions in Article XIV, Section C.

D. Encounter Data and Reporting Requirements

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

1. Data Management and Maintenance: The HMO must have a system that is capable of processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, and meeting reporting requirements. The required formats and timelines are specified in Article XII, Section K.
 - a. The HMO must participate in HMO encounter technical workgroup meetings scheduled by the Department.
 - b. The HMO must capture and maintain a claim record of each service or item provided to members, using CMS 1500, UB-04, HIPAA transaction code sets, or other claim, or claim formats that are adequate to meet all reporting requirements of this Contract. The original claim submitted by the provider must be stored and retrievable upon request by either the Department or CMS.
 - c. The database must be a complete and accurate representation of all services the HMO provided during the Contract period.
 - d. The HMO is responsible for monitoring the integrity of the database, and facilitating its appropriate use for such required reports as encounter data and targeted performance improvement studies.

- e. The HMO is responsible for maintaining unique identifiers assigned by the Department or its designee such as the identification number assigned to each submitted encounter. The HMO must maintain all national code sets and Department specific fields as defined in ForwardHealth and the HMO Encounter User Guide.
 - f. The HMO is responsible for updating and testing new versions of national codes sets and/or state specific code set.
 - g. The HMO must submit at least 90% of adjudicated clean claims as encounters within 90 days, 99% within 150 days, and 100% within 240 days. The only exception is when the claim is suspended due to a dispute with the provider. If an HMO paid encounter is denied within the Department's Medicaid Management Information System (MMIS), the HMO has 90 days to resolve the encounter to priced status within the system.
 - h. The HMO shall not alter encounters with dates of service older than two years of the current year. For example, if the current calendar year is 2015, the HMO must not alter encounters with a date of service of 2012 or older.
2. Program Integrity and Data Usage: The HMO shall establish written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable data processing and safeguarding requirements and standards under the contract, and all applicable Federal and state requirements. This documentation must be kept current and be provided to the department upon request.
- a. This requirement extends to all subcontractors to the extent that the subcontractor is delegated responsibility by the HMO. The HMO is responsible for ensuring that data usage agreements and procedures are in place with providers and contractors that facilitate complete, accurate and timely encounter submissions to the Department.
 - b. The Department retains the right to analyze encounter data and use it for any purpose it deems necessary. The Department will ensure that the analysis does not violate the integrity of the reported data submitted by the HMO.
3. Testing and Certification Requirements: The electronic test encounter data files are subject to Department review and approval before production data is accepted by the Department. Production encounters or other documented encounter data must be used for the test data files.

- a. The HMO must notify the Department of all significant personnel changes and system changes that may impact the integrity of the data, including new claims processing vendors and significant changes in personnel.
 - b. A new HMO must test the encounter data set until the Department is satisfied that the HMO is capable of submitting valid, accurate, and timely encounter data according to the schedule and timetable. A new HMO must become certified to submit compliant encounters within six months of their start date.
 - c. The HMO must provide a three month notice to the Department in advance of transition to a new claims processing system and/or third party administrator. The new system must become certified by the Department or its designee to submit compliant encounters within six months of its start date.
4. Data Exchange Requirements: All encounter submissions must be in a HIPAA compliant ASC X12 transaction format.
- a. The HMO must follow the data specifications defined in the Encounter User Guide and must submit encounters that conform to national standards as well as specific Departmental requirements.
 - b. The HMO must process all the HMO specific files as defined in the [HMO Matrix](#) on ForwardHealth. All enrollment, encounters, response, capitation, provider, error reports and special program files must be processed in a timely and accurate manner.
5. Performance Requirements: The HMO must submit accurate and complete encounter data that the Department can use for rate-setting, P4P, Federal Reporting, special programs and any other purpose deemed necessary by the Department. The HMO must track metrics used by the Department to confirm that data is accurate and complete. Any deficiencies in the metrics must be reported to the Department within 15 days of the HMO identifying the problem. The HMO must complete a quarterly progress report due on April 30th, July 30th, October 30th and January 30th. The Progress Report and Template is posted to the Managed Care Section in ForwardHealth. The completed progress report and/or any deficiencies in the metrics should be submitted to DHSDMSBFM@dhs.wisconsin.gov.
6. The Chief Operating Officer or their designated authority must attest to the following metrics included on the report:

- a. Encounter Volume — The HMO must submit encounters with a consistent volume from month to month. HMOs provide expected average monthly volume on the quarterly progress report. An inconsistency is defined as a volume that is sustained for more than three months that is greater than 10 percent lower than the expected monthly volume.
 - b. Pricing Percentage —The HMO must achieve and maintain a consistent Pricing Percentage of 95 percent for a 12 month period over all Institutional, Professional and Dental claim types. The HMO must report a deficiency in pricing percent that lasts greater than three months.
 - c. Encounter Completeness for Rate Base Periods — The HMO must provide an estimate of the completeness of their encounter data for the base period. Completeness is defined in the Progress Report and Template. The Department expects the HMO to achieve a level of completeness that the Department and the Department’s actuaries agree are credible for rate-setting purposes.
 - d. The HMO must identify any gaps or defects in the data using the Data Exclusions section of the quarterly progress report. The HMO must identify data exclusions in enough detail to allow the Department’s actuaries to preserve as much data as possible for rate-setting purposes and exclude only the time period or category or data that is problematic. For example, if there is missing data for a time period, the HMO should provide exact dates of service that should be excluded.
7. Non-Compliance Resolution Process: The Department shall have the right to audit any records of the HMO and to request any additional information. If at any time the Department determines that the HMO has not complied with any requirement in this section, the Department will issue a corrective action to the HMO. The HMO shall comply within the timeframe defined in the corrective action. If the HMO fails to comply, the Department may pursue action against the HMO as provided under Article XIV, Section C.

E. Encounter Data Quality Criteria

HMOs must meet the following encounter data quality criteria on an annual basis.

- The submitted encounter data for the overlapping year in the base period must not exceed a 5% missing data adjustment as determined by the

Department's actuary. An example of an overlapping year in the base period is: for the CY2018 rates, the two base periods are CY2015 and CY2016. The overlapping year is CY2015 as it was used in both the CY2017 and CY2018 rates.

- The submitted encounter data for the current year in the base period must not exceed a 10% missing data adjustment as determined by the Department's actuary. An example of a current year in the base period is: for the CY2018 rates, the two base periods are CY2015 and CY2016. The current year is CY2016 as it is the newest base period year.

The encounter data quality criteria will be applied starting with the 2019 rate setting process which will use CY2016 as the overlapping year and CY2017 as the current year. In future years, the Department will communicate annually what the overlapping and current base period years are as part of the rate-setting process. If a HMO is unsure what the overlapping and current years are for rate setting, it is their responsibility to seek clarification from the department.

The missing data adjustment is calculated by dividing the HMO's financial report template per member per month (PMPM) for each base period by the corresponding year's HMO paid PMPM reported in the encounter data. For the purposes of the quality calculation, the percentage will be rounded up or down to the nearest whole percentage (e.g. 5.4% rounds to 5% and 5.5% rounds to 6%).

The Department will notify each HMO annually as part of the rate setting process what their missing data adjustment is for each of the base periods.

1. Right of Appeal

HMOs will have no more than 45 days from the date they receive their missing data adjustment to submit an appeal letter to the Department.

The appeal letter can be sent to the BFM email box at:
DHSDMSBFM@dhs.wisconsin.gov.

If the Department determines the appeal to be valid, the missing data adjustment will be updated for the rate setting process to reflect the new value. The HMO may also be required to resubmit any of the impacted encounter data or financial template information outlined in the appeal.

2. Failure to Meet the Encounter Data Criteria

HMOs will be subject to financial penalties outlined below for each year in which they fail to meet the encounter data criteria. Penalties will begin with the 2019 rate setting process. In addition to the financial penalties, the HMO will be placed on a corrective action plan (CAP) as a result of the Department finding the HMO out of compliance with encounter data quality standards.

- a. First year: A \$100,000 penalty and/or \$1,500 per day for each day beyond the deadline that the HMO fails to meet the encounter data quality criteria.
- b. Second year: A \$200,000 penalty and/or \$1,500 per day for each day beyond the deadline that the HMO fails to meet the encounter data quality criteria.
- c. Third year: A \$500,000 penalty and/or \$1,500 per day for each day beyond the deadline that the HMO fails to meet the encounter data quality criteria. The department may also elect to end auto-enrollment in addition to the financial penalties above. Or, the department may separately choose to terminate the contract at its discretion.
- d. Fourth year: Contract termination.

The option to combine a lump sum penalty for a given year with a \$1,500 daily penalty, as noted in each above scenario, will be assessed at the department's discretion.

If an HMO is assessed the \$1,500 per day penalty in any scenario, the time period of the assessment will begin from the encounter data extract date for that year and extend until the HMO provides the required level of encounter data, which must be successfully processed by the Department in order to bring the HMO into compliance with data quality standards.

A HMO must fail the encounter data criteria in consecutive years in order to progress to the higher level penalties. A HMO meeting all of the encounter data criteria for a year resets the penalties to the beginning year. An example of the progressive penalties is outlined below:

- Example: A HMO fails one of the encounter data criteria for two years in a row. The HMO would be subject to the second year penalty.
- Example: A HMO fails one of the encounter data criteria for two years in a row. In the third year it successfully meets all of the criteria. In the fourth year it fails one of the criteria and will be assessed the first year penalty.

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

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

1. Encounter Record for Each Member Service

An encounter record for each service provided to members covered under this Contract. The encounter data set must include at least those data elements specified in the Encounter User Guide or elements required by the national standards.

2. Formal Grievances

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

3. Birth Cost (BadgerCare Plus Only)

As specified in Addendum IV, B.

G. Records Retention

The HMO must retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including paper and electronic claim forms, for a period of not less than ten years from the date of termination of this Contract. Records involving matters that are the subject of litigation or audit shall be retained for a period of not less than ten years following the termination of litigation or audit. Copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, if the Department approves the microfilming procedures as reliable and supported by an effective retrieval system.

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

H. Reporting of Corporate and Other Changes

The HMO must report to the Department any change in corporate structure or any other change in information previously reported, such as through the application for certification process. The HMO must report the change as soon as possible, but no later than 30 days after the effective date of the change.

1. Any change in information relevant to ineligible organizations.
2. Any change in information relevant to ownership and business transactions of the HMO.

I. Provider and Facility Network Data Submission

1. The HMO that contracts with the Department to provide BadgerCare Plus and/or Medicaid SSI services must submit a detailed provider network and facility file monthly and when the HMO experiences significant change with respect to network adequacy (as defined in Art. V, F.), to the State's FTP. The file must be submitted using the format specified in the HMO Provider Network Specification Guide provided by the Department.
2. The provider network and facility file shall include only Medicaid-enrolled providers who are contracted with the HMO to provide contract services to BadgerCare Plus and Medicaid SSI members.
3. HMO must submit complete and accurate provider network and facility data. The Department will provide the HMO with the required file format layout and data fields. The Department retains the right to conduct audits of provider and facility data for completeness and accuracy during the contract period. Incomplete or inaccurate provider and/or facility data may subject the HMO to administrative sanctions outlined in Article XIV, Section C.

J. Financial Report

The HMO is required to submit financial reports per the schedule and instructions provided in the financial report template.

Within 30 days of the due date of the first financial report associated with the base period data, the HMO is required to submit a letter from its internal auditor or vendor verifying the financial report meets CMS Citation 438.3(m) and was audited in accordance with generally accepted accounting principles and generally accepted auditing standards.

The letter must be on official HMO letterhead and be of sufficient quality to allow the department to post it to the ForwardHealth Portal per the CMS requirement.

Additionally, the HMO must provide the department all work papers used to verify that the financial report template was accurate per the CMS Citation 438.3(m).

If the auditor is unable to verify the accuracy of the financial template the HMO must notify the department immediately with a plan which will allow them to submit a template which is verifiable per the CMS citation.

The letter and work papers must be submitted to the Department at both DHSDMSBFM@dhs.wisconsin.gov and DHSOIGManagedCare@dhs.wisconsin.gov.

The Financial Report Template can be found on the [ForwardHealth](#) Portal.

If the HMO is unable to deliver any of the required materials by the due date, they must request an extension within five business days by emailing the request to: DHSDMSBFM@dhs.wisconsin.gov. The HMO must provide an alternative due date as part of the request.

The HMO will be responsible for using the most updated version of the guide posted to the website. Questions on the financial reports should be directed by email to: DHSDMSBFM@dhs.wisconsin.gov.

Financial and Encounter Independent Audit

The Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the financial and encounter data submitted by, or on behalf of, each HMO no less frequently than once every three years.

The HMO must comply timely with all reasonable requests made by the independent auditor. This includes but is not limited to providing them on-site work space and access to materials and staff necessary to perform the audit.

K. Contract Specified Reports and Due Dates

MONTHLY REPORTS		
Summary Hospital Access Payment Report	Summary of prior month's access payment. Email report to BFM Hospital Section.	Addendum IV, F
Summary Critical Access Hospital (CAH) Access Payment Report	Summary of prior month's access payment. Email report to BFM Hospital Section.	Addendum IV, G Article XVI, L, 2
HMO Newborn Report	Listing of births occurring in prior month. Email or fax to fiscal agent on SFTP. This report contains PHI and is used for enrollment purposes.	Addendum IV, C Use form in contract
HMO Provider Network	List of all providers in the HMO network. Submit via the SFTP. (<i>See the File Submission Specification Guide</i>)	Article V, F
Maternity Kick Payment Report Template	Used to identify births for reimbursement. Submit password protected report to BFM on fiscal agent SFTP site. This report contains PHI and is used for payment purposes. (For more details see the Maternity Kick Payment Guide at https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%login/tabid/38/Default.aspx)	Article XVI, F
QUARTERLY REPORTS		
1ST QUARTER: (Jan-March); 2ND QUARTER: (April – June); 3RD QUARTER: (July – Sept); 4TH QUARTER: (Oct – Dec)		
Attestation Form	Send quarterly attestation form to the BFM . Due date schedule is: 1 st Quarter – April 30 2 nd Quarter – July 30 3 rd Quarter – Oct 30 4 th Quarter – Jan 30	Addendum IV, H Forms are located in ForwardHealth.
Encounter Data Coordination of Benefit Report	Send quarterly Coordination of Benefit reports to your BBM managed care contract monitor, by password protected attached email. Due date is 45 days within end of quarter.	Addendum IV, A Use form in contract
Formal/ Informal Grievance Experience Summary Report	Send quarterly summary grievance reports to BBM by either hardcopy or password protected attached email. Report includes PHI. Due date is within 30 days of end of quarter.	Addendum IV, E Use form in contract
Ventilator Dependent Form and Report	Ventilator reports are due 30 days after the end of each quarter. The reports include PHI and should be sent to the attention of the BFM Ventilator Analyst.	Article XVI, J Use form in contract.
ANNUAL REPORTS		
Member Communication and Education /	Send to your BBM managed care contract monitor via password protected email attachment. Marketing Plan due on second Friday of January.	Article VI, A, 1-4 Article VI, D

Outreach Plan		
Dental Service QI Report	Send to BBM contract monitor by password protected email attachment. Submit annually on first business day of July.	Article X, H
Performance Improvement Project (PIP) Final Project	Send to your BBM managed care contract monitor and EQRO contact by password protected email attachment. Report due on the 1 st business day of July for the prior calendar year.	Article X, J
Annual Financial Report	Financial report for the previous calendar year to BFM by SFTP. Report is due on May 30.	Article XII, I
Initial Performance Improvement Project (PIP)	Send to your BBM managed care contract monitor and EQRO contact by password protected email attachment. Topic Selection on first business day of December for the next calendar year.	Article X, J
PPACA Health Insurance Fee (HIF) Report	Send to BFM once per year on September 10 th the following information: NAIC Exhibits, IRS Letter 5067C, WI HIF MA Calculation Template (based on the IRS Letter 5067C), signed attestation form, and other materials outline in the HIF guide. The DHS guide, template and the Attestation form are found in the ForwardHealth portal. Send to BFM by SFTP.	Article XVI, G
OB Medical Home Annual Report	Previous year report due to BBM via DHSOBMH@wi.gov inbox. Due date is the first business Monday of June.	Article IV, D.7
OTHER REPORTS		
Affirmative Action Plan Submit every 3 years	AA/CRC Office in the format specified on Vendor Net. Send to dhscontractcompliance@dhs.wisconsin.gov	Article XI, C, 4
Civil Rights Compliance Letter of Assurance and Plan	AA/CRC Office in the format specified in Article XI, C.4.b. Send to AA/CRC Coordinator dhscontractcompliance@dhs.wisconsin.gov	Article XI, C.4.b
Encounter Data File in (837I, 837P, 837D) format.	Send to Fiscal agent on SFTP.	Article XII, E
Court Ordered Birth Cost Report.	Send report to your by password protected email attachment. This report contains PHI. Submit on an as needed basis, and return via specified method from DHS Administrative staff.	Addendum IV, B
Communicable Disease Reporting (by HMO providers).	HMO providers must send report to the local health department . Report of human immunodeficiency virus (HIV) will be made directly to the State Epidemiologist . Providers should submit on an as needed basis.	Article XII, L
Fraud, Waste and Abuse Investigations.	The HMO must report allegations of fraud, waste, and abuse (both provider and member) to the Department within 15 days of the suspected activity coming to the attention of the HMO. Submit on an as needed basis.	Article XII, M.2
Abortions, Hysterectomies and Sterilizations.	The HMO must comply with state and federal compliance requirements for abortions, hysterectomies and sterilizations. Submit form with signatures on an as needed basis.	Article IV, F
Privacy and Security Incidents	Send information to your BBM managed care contract monitor the same day an incident occurs. Submit on an as needed basis.	Article XI, D

BFM = Bureau of Fiscal Management
 BBM = Bureau of Benefits Management

Report Mailing	Department of Health Services	Department of Health Services	Fiscal Agent Managed Care Unit
	Address: Bureau of Benefits 6470 Management P.O. Box 309 Madison, WI 53701-0309	Bureau of Fiscal Management P.O. Box 309 Madison, WI 53701-0309	P.O. Box Madison, WI 53716-0470
	Attn: AA/CRC Coordinator Department of Health Services Affirmative Action Rights Compliance P.O. Box 7850 Madison, WI 53707-7850	Department of Health Services BFM - Ventilator Dependent Analyst 1 West Wilson St. Room 318 Madison, WI 53701	

The Department electronically produces multiple reports and resources for use by BadgerCare Plus and Medicaid SSI HMOs, which are listed at the following website:

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage.

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

The Department electronically produces multiple reports and resources for use by BadgerCare Plus and Medicaid SSI HMOs, which are listed at the following website:

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage.

L. Communicable Disease Reporting

As required by [Wis. Stats. 252.05](#), mandated providers affiliated with a BadgerCare Plus and/or Medicaid SSI HMO shall report the appearance, suspicion or diagnosis of a communicable disease or death resulting from a communicable disease to the local health department for any member treated or visited by the provider. Reports of human immunodeficiency virus (HIV) infection shall be made directly to the State Epidemiologist. Such reports shall include the name, sex, age, residence, communicable disease, and any other facts required by the local health department and Wisconsin Division of Public Health. Such reporting shall be made within 24 hours of learning about the communicable

disease or death or as specified in [Wis. Adm. Code DHS 145](#). Charts and reporting forms on communicable diseases are available from the local health department. Each laboratory subcontracted or otherwise affiliated with the HMO shall report to the local health department the identification or suspected identification of any communicable disease listed in [Wis. Adm. Code DHS 145](#). Reports of HIV infections shall be made directly to the State Epidemiologist.

M. Program Integrity

1. Administrative and Management Arrangements

The HMO must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. Pursuant to 42 CFR s. 438.608, the HMO arrangements or procedures must include the following:

- Written policies, procedures, and standards of conduct that articulates the organization's commitment to comply with all applicable Federal and State standards.
- The designation of a compliance officer and a compliance committee that is accountable to senior management.
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with contract requirements
- A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
- Effective lines of communication between the compliance officer and the organization's employees.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Establishment and implementation of procedures and a system with dedicated staff for:

- Routine internal monitoring and auditing of compliance risks related to the provider network;
 - Prompt response to compliance issues, both internal and related to the provider network, as they are raised;
 - Investigation of potential compliance problems, both internal and related to the provider network, as identified in the course of self-evaluation and audits;
 - Correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence;
 - Ongoing compliance with the requirements under the contract.
- The Special Investigations Unit (SIU) structure, activities, and performance are subject to audit/review by the OIG. The HMO is required to respond to any corrective action or performance improvement activities specified in the written report to the HMO within the timeframes specified.
 - Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the HMO's contract.
 - Pursuant to [42 CFR 455.20](#), HMO's must have a method for verifying whether services that have been represented to have been delivered by network providers were received by enrollee and the application of such verification process occurs on a regular basis.
 - Provision for use of information in the provider file from the Department notifying the HMO of suspension of payment. The provider file sent by the Department to the HMO will have an added field that will indicate the outcome of the creditable allegation of fraud investigation. The values are:
 - A – ACA suspension of payment is currently active. The HMO must suspend payment based on the effective date for the start of the investigation.

- C – The provider has been cleared of the credible allegation of fraud investigation. There will be an end date for the investigation.
 - T – The provider has been terminated due to the outcome of the credible allegation investigation. The contract’s termination date will be listed in the provider file.
- In addition to the provider file from the Department, the HMO must also respond immediately to email notifications of provider payment suspensions from the DHS Office of the Inspector General resulting from credible allegations of fraud.
- The HMO must have clearly defined criteria, policy, and procedure in place for suspending providers within their network independent of payment suspensions issued by the DHS Office of the Inspector General. This policy and procedure must include notification of BBM and OIG within 24 hours of the suspension of payments.
- The HMO must report the following to the state:
 - All overpayments identified or recovered, specifying the overpayments due to potential fraud;
 - Information about changes to a network provider’s circumstances that may affect the network provider’s eligibility to participate in the managed care program including termination of the provider agreement with the HMO;
 - Through sampling and verification, whether services that have been represented to have been delivered by the network providers were received by enrollees and the application of such verification on a regular basis;
- The HMO must report all potential fraud, waste, and abuse, including credible allegations of fraud, directly to the DHS Office of the Inspector General. HMOs may make a report through the hotline (877-865-3432) or through the online portal (<https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx>).
 - Reports of fraud, waste or abuse from an HMO should not be made anonymously, and these reports may be subject to open records laws.

- Pursuant to [42 CFR 455.23](#) the authority of determining credible allegations of fraud rests with the Department of Health Services, all reports of potential Medicaid fraud must first be made to the Department's Office of the Inspector General.
 - If an HMO forwards a report of potential Medicaid fraud to any additional state or federal agency, the HMO shall notify the Office of the Inspector General of that referral.
- If the HMO makes or receives annual payments under the contract of at least \$5,000,000, there must be a provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about right of employees to be protected as whistleblowers.
 - Whistleblowers may report program integrity concerns to the ~~Bureau of Benefits Management~~ or the DHS Office of the Inspector General. Whistleblowers may make a report through the hotline (877-865-3432) or through the online portal (<https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx>). The HMO is responsible for ensuring employees have access to this information.
 - DMS and OIG are responsible for collaborating to investigate and resolve all reports made by whistleblowers.

2. Fraud, Waste and Abuse Investigations

The HMO agrees to cooperate with the Affordable Care Act (ACA) suspension of payment requirements, and with the Department on fraud and abuse investigations. The HMO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

- In addition, the HMO agrees to report allegations of fraud, waste, and abuse (both provider and member) to the Department within 15 business days of the suspected fraud, waste, or abuse coming to

the attention of the HMO. The HMO should collect preliminary information including available data, statements from appropriate parties, and other materials supporting the allegations. Following the report of the alleged fraud, waste and abuse, the HMO should continue to investigate the allegations of fraud unless otherwise advised by DHS OIG, Department of Justice Medicaid Fraud Control and Elder Abuse Unit, or other law enforcement or regulatory entity. Failure on the part of the HMO to cooperate or report fraud, waste, or abuse may result in any applicable sanctions under Article XIV, Section C.

- The HMO must submit the Quarterly Program Integrity Reporting Log to OIG on a quarterly basis. The log must be completed thoroughly and accurately and is due no later than the last business day of the following month. The Quarterly Program Integrity Reporting Log consists of the following three separate reporting components:
 - Program Integrity Log; Captures complaints regarding fraud, waste, and abuse received by the HMO warranting preliminary investigation.
 - Provider Education Log; Captures education given to network providers related to billing practices, billing errors, or fraud, waste, and abuse. HMO's should differentiate between education that originates from a complaint, provider- requesting training, and regularly scheduled training opportunities.
 - Overpayment Recovery Log; Captures all recoveries whether identified by the HMO or by the Department.

The template will be submitted to the Department at DHSOIGManagedCare@wisconsin.gov. The recovery portion of this report will be subject to OIG audit to validate the recovery of overpayments identified by DMS and OIG. In addition to the quarterly templates, the HMO must provide a cumulative report on an annual basis using the Program Integrity Reporting Template provided by the Department. The reporting schedule may be adjusted based on the needs of the capitation rate-setting process.

3. Treatment of Recoveries

Pursuant to 42 CFR s. 438.608, the HMO must recover all overpayments that were made to network providers including those overpayments attributed to fraud, waste, and abuse. In the event that the HMO discovers the overpayment, the HMO recovers the payments and retains the funds. In the event that the Department identifies the overpayment, the HMO recovers and subsequently retains the funds. With regard to overpayments identified by the HMO, OIG, or DMS, there are no situations wherein the HMO is not permitted to retain the recovered overpayment. This provision does not apply to recoveries retained through federal False Claims Act cases or other such investigations.

The HMO must require the network providers to report and return any overpayments received by the network providers. The HMO must inform the network providers of the HMO's process to return overpayments. The HMO must require the network providers to return the overpayment within 60 days of the provider's discovery of the overpayment and must notify the HMO in writing of the reason for the overpayment. Any treatment of recoveries shall be appropriately reflected in the encounter data.

N. Non-Disclosure of Trade Secrets and Confidential Competitive Information

1. To the extent that encounter records, medical-loss ratio reports, or other submissions/reports include or have the capacity to reveal amount(s) paid by the HMO to provider(s), the HMO and the Department agree that those records, reports or submissions constitute trade secrets under the Wisconsin Uniform Trade Secrets Act, [Wis. Stats., s. 134.90\(1\)\(c\)](#), and must remain confidential to protect the competitive market position of the HMO. The Department agrees such records, reports or submissions are thus exempt from disclosure under [s. 19.36\(5\)](#), Wis. Stats. regardless of whether said information is specifically, separately designated as such by the HMO at the time of submission or reporting to the Department.
2. If the Department receives an open records request, subpoena, or similar request involving the information described in Paragraph 1, the Department shall notify the HMO of the request without unreasonable delay. Upon such request, the Department shall take all reasonable steps to prevent the disclosure of such information. In the event that disclosure of information is compelled pursuant to a writ of mandamus or other court order, the Department agrees to redact any otherwise proprietary, confidential, or trade secret information prior to said disclosure, subject to the terms of the order.

3. In the event the designation of the confidentiality of this information is challenged, the HMO agrees to provide legal counsel or other necessary assistance to defend the designation of records, reports, or submissions as a trade secret. The Department shall, without charge to the HMO, reasonably cooperate with such defense, to include providing legal counsel, testimony, and attestations regarding the protection of confidential and proprietary information that qualifies as a trade secret. Notwithstanding the foregoing, the HMO shall have the sole right and discretion to direct the defense to settle, compromise, or otherwise resolve such defense. Should any order or judgment be issued against the Department, the HMO will hold the Department harmless and indemnify the Department for costs and damages assessed against the Department as a result of designating records, reports, or submissions as trade secret(s).

ARTICLE XIII

XIII. FUNCTIONS AND DUTIES OF THE DEPARTMENT

A. Utilization Review and Control

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

B. Department Audit Schedule

The HMO will be notified approximately 30 days prior to regularly scheduled, routine audits being conducted via a letter from the Department.

C. HMO Review of Study or Audit Results

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

D. Vaccines for Children (BadgerCare Plus Only)

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

E. Fraud and Abuse Training

The Department will provide fraud and abuse detection training to the HMO annually. The Department will provide training for HMOs on implementation of suspension of payments to providers with a credible allegation of fraud.

F. Provision of Data to the HMO

The Department will provide to the HMO immunization information from the Wisconsin Immunization Registry, to the extent available.

G. Conflict of Interest

The Department will maintain state employee conflict of interest safeguards at least equal to federal safeguards (41 USC 423).

ARTICLE XIV

XIV. CONTRACTUAL RELATIONSHIP

A. Delegations of Authority

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

- There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate, or out of compliance with HIPAA privacy or security requirements.
- Before any delegation, the HMO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.
- The HMO shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review at least once per contract period.
- If the HMO identifies deficiencies or areas for improvement, the HMO and the subcontractor shall take corrective action.
- If the HMO delegates selection of providers to another entity, the HMO retains the right to approve, suspend, or terminate any provider selected by that entity.

B. Subcontracts

This Article does not apply to subcontracts between the Department and the HMO. The Department shall have sole authority to determine the conditions and terms of such subcontracts. Subcontractor (hereinafter identified as subcontractor) agrees to abide by all applicable provisions of the HMO's contract with the Department of Health Services, hereinafter referred to as the BadgerCare Plus and Medicaid SSI HMO Contract. Subcontract compliance with the BadgerCare Plus and Medicaid SSI HMO Contract specifically includes but is not limited to the requirements specified below.

1. Subcontract Standard Language

The HMO must ensure that all subcontracts are in writing and include the following standard language when applicable:

- a. Subcontractor uses only BadgerCare Plus and/or Medicaid SSI-enrolled providers in accordance with this Contract.
- b. No terms of this subcontract are valid which terminate legal liability of the HMO.
- c. Subcontractor agrees to participate in and contribute required data to HMO Quality Assessment/Performance Improvement programs.
- d. Subcontractor agrees to abide by the terms of this Contract for the timely provision of emergency and urgent care. Where applicable, subcontractor agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by the HMO in accordance with this Contract.
- e. Subcontractor agrees to submit HMO encounter data in the format specified by the HMO, so that the HMO can meet the Department specifications required by this Contract. The HMO will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.
- f. Subcontractor agrees to comply with all non-discrimination requirements.
- g. Per 42 CFR 438.3(k), subcontractor agrees to comply with all audit and record retention and inspection requirements of [42 CFR 438.230\(c\)\(3\)\(i-iv\)](#) and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements. Specifically, the State (including the Office of Inspector General), CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to

any aspect of services and activities performed, or determination of amounts payable under the HMO's contract with the State. This right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

- h. Per 42 CFR 438.230, subcontractor agrees to provide representatives of the HMO, as well as duly authorized agents or representatives of the Department (including the Office of the Inspector General) and the federal Department of Health and Human Services, access to its premises and its contracts, medical records, billing (including contractual rates agreed upon between the HMO and the subcontractor), and administrative records. If the State (including the Office of the Inspector General), CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. Refusal will result in sanctions or penalties in Article XIV, Section C against the HMO for failure of its subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.
- i. Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in this Contract.
- j. Subcontractor agrees to ensure confidentiality of family planning services.
- k. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus and/or Medicaid SSI benefits (e.g., COB recovery procedures that delay or prevent care).
- l. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.
- m. Subcontractor agrees not to bill BadgerCare Plus and/or Medicaid SSI members for medically necessary services covered under this

Contract and provided during the members' period of HMO enrollment. Subcontractor also agrees not to bill members for any missed appointments while the members are eligible under the BadgerCare Plus and/or Medicaid SSI Programs. This provision will remain in effect even if the HMO becomes insolvent. However, if a member agrees in writing to pay for a non-covered service, then the HMO, HMO provider, or HMO subcontractor can bill.

The standard release form signed by the member at the time of services does not relieve the HMO and its providers and subcontractors from the prohibition against billing a BadgerCare Plus or Medicaid SSI member in the absence of a knowing assumption of liability for a non-covered service. The form or other type of acknowledgment relevant to BadgerCare Plus or Medicaid SSI member liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus or Medicaid SSI.

- n. Within 15 business days of the HMO's request subcontractors must forward medical records pursuant to grievances to the HMO. If the subcontractor does not meet the 15 business day requirement, the subcontractor must explain why and indicate when the medical records will be provided.
- o. Subcontractor agrees to abide by the terms regarding appeals to the HMO and to the Department regarding the HMO's nonpayment for services providers render to members.
- p. Subcontractor agrees to abide by the HMO marketing/informing requirements. Subcontractor will forward to the HMO for prior approval all flyers, brochures, letters and pamphlets the subcontractor intends to distribute to its members concerning its HMO affiliation(s), or changes in affiliation, or relating directly to the BadgerCare Plus and/or Medicaid SSI population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the HMO and the Department.
- q. Subcontractor agrees to abide by the HMO's restraint policy, which must be provided by the HMO. Members have the right to

be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.

2. Subcontract Submission Requirements

a. Changes in Established Subcontracts

1) The HMO must submit changes in previously approved subcontracts to the Department for review and approval before they take effect. This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services.

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

2) The Department will review the subcontract changes and respond to the HMO within 15 business days. If the Department does not respond to the request for review within 15 business days of submission, the HMO must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within five business days of this contact.

b. New Subcontracts

The HMO must submit new subcontracts to the Department for review and approval before they take effect. If the Department does not respond to the request for review within 15 business days of submission, the HMO must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within five business days of this contact.

3. Review and Approval of Subcontracts

The Department may approve, approve with modification, or deny subcontracts under this Contract at its sole discretion. The Department

may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the state and BadgerCare Plus and/or Medicaid SSI members, including but not limited to the proposed subcontractor's past performance. The Department will:

- a. Give the HMO:
 - 120 days to implement a change that requires the HMO to find a new subcontractor, and
 - 60 days to implement any other change required by the Department.
 - b. Acknowledge the approval or disapproval of a subcontract within 15 business days after its receipt from the HMO.
 - c. Review and approve or disapprove each new subcontract before the Contract takes effect. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to this Contract.
 - d. Ensure that the HMO has included the standard subcontract language as specified in Section B, 1 of this Article (except for specific provisions that are inapplicable in specific HMO management subcontract).
4. Transition Plan

The HMO may be required to submit transition plans when a primary care provider(s), mental health provider(s), gatekeeper or dental clinic terminates their contractual relationship with the HMO. The transition plan will address continuity of care issues, member notification and any other information required by the Department to ensure adequate member access. The Department will approve, deny, or modify the transition plan within 15 business days of receipt or prior to the effective date of the subcontract change.

5. Notification Requirements Regarding Subcontract Additions or Terminations

The HMO must:

a. Notify the Department of Additions or Terminations

The HMO must notify the Department within 10 days of subcontract additions or terminations when those changes are substantial and impact member access. Those notifications could involve:

- A clinic or group of physicians, mental health providers, or dentists,
- An individual physician,
- An individual mental health provider and/or clinic,
- An individual dental provider and/or clinic.

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

b. Notify the Department of a Termination or Modification that Involves Reducing Access to Care

The HMO must notify the Department within 7 days of any notice by the HMO to a subcontractor, or any notice to the HMO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could substantially reduce member access to care. This Department notification must be to both the HMO's Contract Monitor and through the submission of an updated provider network to the FTP server.

If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then the Department may invoke the remedies pursuant to this Contract. These remedies include contract termination (notice to the HMO and opportunity to correct are provided for), suspension of new enrollment, and giving members an opportunity to enroll in a different HMO.

In addition to the monthly submission, the HMO must submit an updated provider and facility file when there has been a significant

change with respect to network adequacy, as defined by the Department, in the HMO's operations that would affect adequate capacity and services.

c. Notify Members of Provider Terminations

Not less than 30 days prior to the effective date of the termination, the HMO must also send written notification to members whose PCP, mental health provider, gatekeeper or dental clinic terminates a contract with the HMO. The Department must approve all notifications before they are sent to members.

6. Management Subcontracts

The Department will review HMO management subcontracts to ensure that:

- a. Rates are reasonable.
- b. They clearly describe the services to be provided and the compensation to be paid.
- c. Any potential bonus, profit-sharing, or other compensation, not directly related to the cost of providing goods and services to the HMO, is identified and clearly defined in terms of potential magnitude and expected magnitude during this Contract period. Any such bonus or profit-sharing must be reasonable compared to the services performed. The HMO must document reasonableness. A maximum dollar amount for such bonus or profit-sharing shall be specified for the Contract period.

The requirements addressed in a. through c. are not required for non-BadgerCare Plus and/or Medicaid SSI members if the HMO wishes to have separate arrangements for the non-members.

C. Remedies for Violation, Breach, or Non-Performance of Contract

1. Suspension of New Enrollment

Whenever the Department determines that the HMO is out of compliance with this Contract, the Department may suspend the HMO's right to

receive new enrollment under this Contract. When exercising this option, the Department, must notify the HMO in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the Contract.

The Department may also notify members of the HMO's non-compliance and provide an opportunity to enroll in another HMO.

2. Department-Initiated Enrollment Reductions

The Department may reduce the maximum enrollment level and/or number of current members whenever it determines that the HMO has failed to provide one or more of the Contract services required under the Contract or the HMO has failed to maintain or make available any records or reports required under this Contract that the Department needs to determine whether the HMO is providing contract services as required. The HMO will have at least 30 days to correct the non-compliance prior to the Department taking any action set forth in this paragraph. The Department may reduce enrollment sooner than the time period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized.

3. Other Enrollment Reductions

The Department may also suspend new enrollment or disenroll members in anticipation of the HMO not being able to comply with federal or state law at its current enrollment level. Such suspension shall not be subject to the 30 day notification requirement.

4. Withholding of Capitation Payments and Orders to Provide Services

Notwithstanding the provisions of this Contract, the Department may withhold portions of capitation payments as liquidated damages or otherwise recover damages from the HMO on the following grounds:

- a. Whenever the Department determines that the HMO has failed to provide one or more of the medically necessary covered services required under the Contract, the Department may either order the HMO to provide such service, or withhold a portion of the HMO's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

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

When it withholds payments under this section, the Department must submit to the HMO a list of the participants for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

If the Department acts under this section and subsequently determines that the services in question were not covered services:

- If the Department withheld payments, it will restore to the HMO the full capitation payment; or
- If the Department ordered the HMO to provide services under this section, it will pay the HMO the actual documented cost of providing the services.

- b. If the HMO fails to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such data or information in the required form or format, by the deadline specified by the Department, the Department may immediately impose liquidated damages in the amount of \$1,500 per day for each day beyond the deadline that the HMO fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the HMO's capitation payments.

Additionally, if it is found that the HMO failed to submit accurate and complete encounter data prior to the submission deadlines, the Department will be considered damaged. The HMO may be held responsible for reimbursing the Department for the staffing and out-of-pocket costs incurred by the Department and its contractors associated with reviewing the delayed data submission, and developing and publishing revised rates.

- c. If the HMO fails to comply with state and federal compliance requirements for abortions, hysterectomies and sterilizations, the Department may impose liquidated damages in the amount of \$10,000.
- d. The HMO must meet the Department's aggregate standards for submitting encounter data as outlined in Article XII (D) or liquidated damages may apply based on "erred" data.
- e. The term "erred encounter record" means an encounter record that failed an edit when a correction is expected by the Department, unless the record is otherwise priced and included in the HMO encounter data. This does not apply to records for out-of-state emergency services that are not moved from the erred table due to the inability to match to the provider file. If the HMO fails to correct an error to the encounter record within the time frame specified, the Department may assess liquidated damages of \$5 per erred encounter record per month until the error has been corrected or the issue has been resolved to the Department's satisfaction. The liquidated damage amount will be deducted from the HMO's capitation payment. When applied, these liquidated damages will be calculated and assessed on a monthly basis.

If upon audit or review, the Department finds that the HMO has removed an erred encounter record without the Department's approval, the Department may assess liquidated damages for each day from the date of original error notification until the date of correction.

- The Department may assess \$5 per record per month until the encounter record has been fixed, for each encounter record found to be different from the provider claim for the

procedure code, units of service, diagnosis code, modifier code, charge field, and TPL paid amount.

At a minimum, HMOs must submit a consistent volume of encounters each month based on a calendar year average.

- If it is found that an HMO submitted inaccurate or incomplete encounter data that was used in the development of the current rates, the Department may assess damages associated with the reporting error and data that the HMO failed to submit. The damages will be up to the priced amount of the inaccurate encounter records and the estimated amount or actuarial adjustment for the amount that HMO failed to submit.
- f. Whenever the Department determines that the HMO has failed to perform the administrative functions, the Department may withhold a portion of future capitation payments sufficient to directly compensate the Department for the program's costs of providing health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.
- g. 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.
- h. Notwithstanding the provisions of this subsection, in any case where the Department deducts a portion of capitation payments under the Contract, the following procedures will be used:
- The Department will notify the HMO's contract administrator no later than the second business day after the Department's deadline that the HMO has failed to submit the required data or the required data cannot be processed.
 - 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.

- If the HMO submits encounter data late but submits it within five business days from the deadline, the Department will rescind liquidated damages if the data can be processed according to the criteria published in the HMO Encounter Data User Manual or elements required by the national standards. The Department will not edit the data until the process period in the subsequent month.
- If the HMO submits any other required data or report but in the required format within five business days from the deadlines, the Department will rescind liquidated damages and immediately process the data or report.
- If the HMO repeatedly fails to submit required data or reports, or submits data that cannot be processed, the Department will require the HMO to develop a corrective action plan to comply with the Contract requirements that must meet Department approval.
- After the corrective action plan has been implemented, if the HMO continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under Section C, 1 (Suspension of New Enrollment), or under Section C, 2 (Department-Initiated Enrollment Reductions) of this Article, or both, in addition to liquidated damages that may have been imposed for a current violation.
- If the HMO notifies the Department that it will discontinue contracting with the Department at the end of a contract period, but reports or data are due for a contract period, the Department retains the right to withhold up to two months of capitation payments otherwise due the HMO that will not be released to the HMO until all required reports or data are submitted and accepted after expiration of the Contract. Upon determination by the Department that the reports and data are accepted, the Department will release the monies withheld.

- i. Health Needs Assessment Screening (BadgerCare Plus Childless Adults only)

HMOs who do not meet their HNA Screening targets for the Childless Adults population as defined in Article III, A. 2 of this contract will be subject to financial performance penalties.

The penalty amount will be the lesser of either \$250,000 or 25% of the monthly administrative capitation rate for the proportion of the BadgerCare Plus Childless Adult (CLA) membership for whom the HMO fails to meet the HNA performance target in the calendar year.

The Department will notify HMOs of their appeal rights prior to any financial performance penalties being implemented.

- j. SSI Comprehensive Assessment – Case Management (Medicaid SSI HMOs only)

The Quality Guide will outline requirements pertaining to SSI care management assessments.

- k. Withholding of Capitation Payments and Orders to Provide Services

Payments provided for under the contract will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in [42 CFR 438.730](#).

Specifically, the State may recommend that CMS impose the denial of payment for new members when an HMO with a contract to provide BadgerCare Plus and/or Medicaid SSI services if the State determines that the HMO acts or fails to act as specified in Article XIV, Section C. 7 of the contract. The State's determination becomes CMS' determination for purposes of section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days. When the State decides to recommend imposing the sanctions described in 42 CFR 438.730(e), this recommendation becomes CMS' decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days. If the State's determination becomes CMS' determination, the State will take the following

options: (1) Give the HMO written notice of the nature and basis of the proposed sanction; (2) Allow the HMO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction; (3) May extend the initial 15-day period for an additional 15 days if: (i) The HMO submits a written request that includes a credible explanation of why it needs additional time; (ii) The request is received by CMS before the end of the initial period; (iii) CMS has not determined that the HMO's conduct poses a threat to an enrollee's health or safety.

If the HMO submits a timely response to the notice of sanction, the State: (i) Conducts an informal reconsideration that includes review of the evidence by a State agency official who did not participate in the original recommendation; (ii) Gives the HMO a concise written decision setting forth the factual and legal basis for the decision; (iii) Forwards the decision to CMS. The State's decision will become CMS' decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS. If CMS reverses or modifies the State decision, the agency sends the HMO a copy of CMS' decision.

1. Failure to successfully report usable data using the ASC X12 837 HIPAA Compliant Transaction or the Financial Report information may result in a 1% withhold to the HMO's administration rate. The amount will be withheld from the capitation payment until the HMO is able to submit usable data.

If the HMO is unable to submit usable data by the period of time defined by the Department when withholding the payment, the amount withheld will be forfeited.

If either party terminates the contract during the period that payment is withheld, the amount will be automatically forfeited.

Data is determined usable if it can be used in the rate-setting process in its entirety for the encounter data base years used to establish the rates.

5. Inappropriate Payment Denials

The HMO that inappropriately fails to provide or deny payments for services may be subject to suspension of new enrollments, withholding, in full or in part, of capitation payments, contract termination, or refusal to contract in a future time period, as determined by the Department. The Department will select among these sanctions based upon the nature of the services in question, whether the failure of denial was an isolated instance or a repeated pattern or practice, and whether the health of a member was injured, threatened or jeopardized by the failure or denial. These sanctions apply not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal was made (i.e., the Department knows about the documented abuse from other sources).

6. Sanctions

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny BadgerCare Plus and/or Medicaid SSI payments to the HMO for members who enroll after the date on which the HMO has been found to have committed one of the violations identified in the federal law. State payment for members of the contracting organization is automatically denied whenever, and for as long as, federal payment for such members has been denied as a result of the commission of such violations. The state may impose sanctions if the HMO has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

7. Sanctions and Remedial Actions

Remedial Actions

The Department may pursue all sanctions and remedial actions with the HMO that is taken with FFS providers if it determines, based on findings from onsite surveys, enrollee or other complaints, financial status, or any other source, that an HMO acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the HMO is required to provide, under law or under this contract, to an enrollee covered under the contract.
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of

enrollment or refusal to enroll a member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

- Misrepresents or falsifies information that it furnishes to CMS or to the Department.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans.
- Distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.
- Violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act, or any implementing regulations.

The State must give CMS written notice whenever it imposes or lifts a sanction for one of the violations listed above. This notice must be given no later than 30 days after the State imposes or lifts a sanction and must specify the affected HMO, the kind of sanction, and the reason for the State's decision to impose or lift a sanction.

Financial Penalties

The Department may pursue all sanctions and remedial actions with the HMO that are taken with FFS providers including any civil monetary penalties in the following specified amounts:

- A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or false statements to members, potential members or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
- A maximum of \$100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.
- A maximum of \$15,000 for each member the State determines was not enrolled because of a discriminatory practice (subject to the \$100,000 overall limit above).

- A maximum of \$25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The State must deduct from the penalty the amount of overcharge and return it to the affected member(s).

The Department will provide written notice of all intermediate sanctions (other than required temporary management) that explains the basis and nature of the sanction and any due process protections the state elects to provide.

8. Temporary Management

The state will impose temporary management, as provided in [42 CFR 438.706](#), when there is continued egregious behavior by the HMO, including, but not limited to behavior that is described in [42 CFR 438.700](#), or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

- There is substantial risk to members' health; or
- The sanction is necessary to ensure the health of the HMO's members while improvements are made to remedy violations under [438.700](#) or until there is an orderly termination or reorganization of the HMO.

The state must impose temporary management (regardless of any other sanction that may be imposed) if it finds that an HMO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act, or this section of the contract. The state must also grant enrollees the right to terminate enrollment.

The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.

The state may not terminate temporary management until it determines that the HMO can ensure that the sanctioned behavior will not recur.

9. Termination and Modification of Contract

a. Termination by Mutual Consent

This Contract may be terminated at any time by mutual written agreement of both the HMO and the Department.

b. Unilateral Termination

Before the State terminates an HMO contract under 42 CFR §438.708, the State must provide the HMO a pre-termination hearing. The State will give the HMO written notice of its intent to terminate, the reason for termination, and the time and place of the hearing. After the hearing, the State will give the HMO written notice of the decision affirming or reversing the proposed termination of the contract and, for affirming the decision, the effective date of termination. For an affirming decision, give enrollees of the HMO notice of the termination and information, consistent with 42 CFR §438.10, on their options for received Medicaid services following the effective date of termination.

In addition, this Contract between the parties may be terminated by either party as follows:

- 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 for a reason other than HMO non-compliance may impose an obligation upon the Department to pay the Contractor's reasonable and necessarily incurred termination expenses.
- 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 its intent to terminate this Contract and give the other party 30 days to correct the identified violation, breach or non-performance of Contract. If such violation,

breach or non-performance of Contract is not satisfactorily addressed within this time period, the exercising party may terminate this Contract. The termination date shall always be the last day of a month. The Contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that member health or welfare is jeopardized by continued enrollment in the HMO.

- Either party may terminate this Contract if federal or state funding of contractual services rendered by the Contractor become or will become permanently unavailable. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the Contractor will be temporarily suspended or unavailable, the Department shall immediately notify the Contractor, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, the Department or the Contractor may suspend performance of any or all of the Contractor's obligations under this Contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or Contractor shall attempt to give notice of suspension of performance of any or all of the Contractor's obligations by 60 days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the Contractor may remove suspension hereunder by written notice to the Department, to be made within 30 days from the date the funds are reinstated. In the event the Contractor elects not to reinstate services, the Contractor shall give the Department written notice of its reasons for such decision, to be made within 30 days from the date the funds are reinstated. The Contractor shall make such decision in good faith and will provide to the Department documentation supporting its decision. In the event of termination under this Section, this Contract shall terminate without termination costs to either party.

- This contract may be terminated by the HMO due to dissatisfaction with the final capitation rates, which will be effective based on negotiations with HMOs. The HMO must notify the Department within 30 days of notice of the final rates if the HMO intends to terminate its contract with the Department. The HMO must also notify the Department within 30 days if it intends to decrease its service area due to the final capitation rates. In the event of termination under this paragraph, the Contract will terminate without termination costs to either party and, for purposes of section D., will be considered a termination under paragraph 1. To assure the smooth transition of members, the termination of the Contract or the decrease in service area will be effective no less than 90 days, and no more than 120 days, after HMO notification to DHS of the intent to terminate the Contract or decrease the HMO's service area.

10. Obligations of Contracting Parties Upon Termination

When termination of the Contract occurs, the following obligations must be met by the parties:

- a. Where this Contract is terminated unilaterally by the Department due to failure to carry out the substantive terms of this contract by the HMO; failure to meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act; or by mutual consent with termination initiated by the HMO:
 - The Department will be responsible for notifying all members of the date of termination and process by which the members will continue to receive contract services.
 - The HMO will be responsible for all expenses related to said notification.
 - The Department will grant the HMO a hearing before termination by the Department occurs. The Department will notify the members of the hearing and allow them to disenroll from the HMO without cause.

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

- The Department will be responsible for notifying all members of the date of termination and process by which the members will continue to receive contract services.
- The Department may be responsible for all expenses relating to said notification.

c. Where this Contract is terminated for any reason the following payment criteria will apply:

- Any payments advanced to the HMO for coverage of members for periods after the date of termination will be returned to the Department within the period of time specified by the Department.
- The HMO will supply all information necessary for the reimbursement of any outstanding BadgerCare Plus and/or Medicaid SSI claims within the period of time specified by the Department.
- If a contract is terminated, recoupments will be handled through a payment by the HMO to the Department within 90 days of contract termination.

d. If a HMO initiates termination of the contract mid-year for any other reason than those listed under Article XIV, C.9(2), or initiates a major reduction in service area or populations served, the HMO will at minimum be responsible for the following requirements to assist in the smooth transition of impacted members:

- Notification to the Department at least 90 days prior to the termination effective date.
- Compliance with a transition plan which may include, but is not limited to, development of a communication plan for

DHS approval, additional data-sharing reports for transitioning members, and timelines for outstanding financial reconciliation.

- Costs of the Department's notifications to impacted members and providers, which may include mailed notices, ForwardHealth Member and/or Provider Updates, and/or phone outreach.
- Transition costs associated with the Department's staff and IT resources necessary to facilitate transition of members out of the HMO upon contract termination.
- Pay for Performance withhold reconciliation: If a HMO terminates the contract before sufficient time has elapsed for relevant HEDIS measures to be calculated for that year (e.g., before 11 months of continuous enrollment are completed), the HMO is not eligible for any performance bonuses for the Measurement Year, and is subject to the P4P withhold for the months the HMO had enrollment during the Measurement Year. The Department reserves the right to calculate the HMO's performance against the Measurement Year's benchmarks to determine if the HMO will earn back the withhold by:
 - Applying the HMO's previous measurement year's P4P results to the termination year's performance benchmarks; or
 - If the HMO's previous year's P4P results are not available for any measures, the Department reserves the right to calculate P4P results using the most recent 12 months of complete data available (for example, using data from July 1 of the previous calendar year to June 30 of the current calendar year). The cost incurred by the Department for such calculations will be added to the transition costs listed above.

- If a HMO does not have data that applies under the first and second bullets above, DHS will review P4P calculations on an individual basis.

11. HMO Mergers

For the purpose of this section, a merger or acquisition means a change in controlling interest of an HMO, including an asset or stock purchase.

This contract between the Health Maintenance Organization (HMO) and the State of Wisconsin and the monies which may become due may not be assigned, transferred, pledged or hypothecated in any way by the HMO, including by way of an asset or stock purchase by the HMO, without the express prior written approval of the Department.

In the event that the merger or acquisition of an HMO is approved by the Office of the Commissioner of Insurance, the Department shall allow the surviving HMO to participate in the Medicaid program unless it would be detrimental to Medicaid members or the Medicaid program, as determined by the Department through its certification standards. In order to participate in the Medicaid program, the surviving HMO must meet OCI standards, accept the terms and rates of the current HMO contract, and meet DHS certification requirements.

The Department retains the authority to determine what will occur with the non-surviving HMO's Medicaid enrollees. These determinations will be made on an individualized basis based on what is in the best interests of the membership.

HMOs must notify the Department of any proposed merger or acquisition immediately, but no fewer than 180 days prior to the proposed date of merger or acquisition, unless the Department waives the 180 day requirement at its discretion.

12. Modification

This Contract may be modified at any time by written mutual consent of the HMO and the Department or when modifications are mandated by changes in federal or state laws, rules or regulations. If changes in state or federal laws, rules or regulations require the Department to modify its contract with the HMO, the HMO will receive written notice.

If the Department changes the reporting requirements as specified in Article XII, Section K during the Contract period, the HMO shall have 180 days to comply with such changes or to initiate termination of the Contract.

D. Interpretation of Contract Language

When disputes arise, the Department has the right to final interpretation and/or application of the Contract language. The HMO will abide by the interpretation and/or application.

ARTICLE XV

XV. FISCAL COMPONENTS/PROVISIONS

A. Billing Members

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

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

The HMO and its providers and subcontractors must not bill a BadgerCare Plus or Medicaid SSI member for medically necessary covered services provided to the member, for which the State does not pay the HMO; or the State or the HMO does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member's period of HMO enrollment, except for allowable co-payments and premiums established by the Department for covered services provided during the member's period of enrollment in BadgerCare Plus. In addition, the HMO must ensure that its Medicaid members are not held liable for payments for medically necessary covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the HMO covered the services directly. This contract limits a member's liability for cost sharing to the amounts listed in the ForwardHealth online handbook.

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

B. Physician Incentive Plans

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

The HMO shall fully comply with the physician incentive plan requirements specified in [42 CFR s. 417.479\(d\) through \(g\)](#) and the requirements relating to subcontracts set forth in [42 CFR s. 417.479\(i\)](#), as those provisions may be amended from time to time. HMO contracts must provide for compliance with the requirements set forth in [422.208](#) and [422.210](#).

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

If physician/group put at substantial financial risk for services not provided by physician/group, the HMO must ensure adequate stop-loss protection to individual physicians and conduct annual enrollee surveys.

The HMO must provide adequate and timely information on its physician incentive plan to any member upon request.

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

The disclosure to the State includes the following, and will be reported in a format determined by the Department:

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

- The HMO must report panel size, and if patients are pooled, the approved method used.

If the physician/group is at substantial financial risk, the HMO must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

C. Enhanced Physician Reimbursement for Medical Home Practice Design

The HMO may provide enhanced reimbursement to primary care provider practices that function as a medical home. If the HMO plans to implement enhanced physician reimbursement, please submit the following strategies:

- Whether the HMO provides such a reimbursement and if so identify which provider practices are recipients.
- The criteria the HMO uses to identify practices that function as a medical home and are eligible for this reimbursement.
- The HMO's process for evaluating practices annually as to whether they meet the criteria.
- How this reimbursement process is implemented.
- Evidence that they are supplying their in-network providers with materials that explain in detail what their medical home criteria are, and how a clinic would be reimbursed for functioning as a medical home.

D. Payment Requirements/Procedures

The HMO is responsible for the payment of all contract services provided to members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Rosters generated for the coverage period.

The HMO is also responsible for the provision, or authorizing the provision of, services to members with valid ForwardHealth ID cards indicating HMO enrollment (via Electronic Voice Response or WiCall), without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the enrollment rosters must be reported to VEDSHMOSupport@wisconsin.gov for resolution. The HMO must continue to provide and authorize provision of all contract services

until the discrepancy is resolved, including members who were PENDING on the Initial Roster and held a valid ForwardHealth ID card indicating HMO enrollment for the coverage period (via Electronic Voice Response or WiCall), but did not appear as a CONTINUE on the Final Roster.

If a member shows on the Initial enrollment roster as PENDING and later shows on the Final roster as a DISENROLL, the HMO will not be liable for services after the date the disenrollment is effective.

1. Claims Retrieval

The HMO must maintain a claim processing system that can upon request identify date of receipt, adjudication action on all claims types (i.e., paid, denied, suspended, etc.), and date of adjudication. In addition, claim processing system must be identify, within the individual claim, the services provided and the diagnoses of the members using nationally accepted coding systems as specified in the Encounter User Guide. Finally, the claim processing system must be capable of identifying the provider of services National Provider Identifier (NPI), or atypical identifier if applicable, and their associated taxonomy numbers and CLIA numbers.

2. Thirty Day Payment Requirement

The HMO must pay at least 90% of adjudicated clean claims from subcontractors/providers for covered medically necessary services within 30 days of receipt of a clean claim, 99% within 90 days and 100% within 180 days of receipt, except to the extent subcontractors/providers have agreed to later payment.

HMO agrees not to delay payment to a subcontractor/provider pending subcontractor/provider collection of third party liability unless the HMO has an agreement with the subcontractor/provider to collect third party liability.

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

The HMO must pay for covered services provided by a non-HMO contracted provider to a disabled participant less than three years of age,

or to any participant pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-HMO contracted provider, and extending until the HMO issues a written denial or referral. This requirement does not apply if the HMO issues a written denial of referral within seven days of receiving the request for referral.

4. Payment of HMO Referrals to Non-Affiliated Providers

For HMO approved referrals to non-affiliated providers, the HMO must either establish payment arrangements in advance, or the HMO is liable for payment only to the extent that BadgerCare Plus and/or Medicaid SSI pays, including Medicare deductibles, or would pay, its FFS providers for services excluding Hospital Access Payments, Hospital P4P Withhold, and Ambulatory Surgery Center Access Payments. Refer to Article VIII for policy on Provider Appeals.

- For Non-Affiliated Providers, the Department will adjudicate Provider Appeals according to FFS benefit policy and reimbursement, including PA requirements, emergency and post stabilization definition and other contract provisions. Refer to Article VIII, Provider Appeals.
- Should there be an appeal resolution determined by the Department to be in the Provider's favor, the HMO must waive standard timely filing guidelines and allow the provider 60 days to rebill for services.

5. Health Professional Shortage Area (HPSA) Payment Provision

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

However, this does not require the HMO to pay more than the enhanced FFS rate or the actual amount billed for these services. The HMO shall

ensure that the money for HPSA payments is paid to the physicians and is not used to supplant funds that previously were used for payment to the physicians. The HMO must develop written policies and procedures to ensure compliance with this provision. These policies must be available for review by the Department, upon request.

The specified enhanced payment amounts are available in the Monthly HMO Max Fee Extract for the relevant HPSA procedure codes (BAF codes beginning with H). The procedure codes that qualify for the HPSA incentive are available on [ForwardHealth](#).

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

If the HMO contracts with a Medicaid enrolled FQHC or RHC for the provision of services to its members, the HMO must pay at a minimum the Medicaid FFS rate or the equivalent aggregate FFS rate by provider. The HMO must retain records demonstrating that they are meeting this requirement. The records must be available within 30 days of the Department's request for information and be made available to CMS upon request.

The HMO must pay at least 90% of adjudicated clean claims from FQHC or RHC providers for covered medically necessary services within 30 days of receipt of a clean claim, 99% within 90 days and 100% within 180 days of receipt, except to the extent that providers have agreed to later payment.

7. Hospitalization at the Time of Enrollment or Disenrollment

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

Hospitalization in this section is defined as an inpatient stay at a Medicaid-enrolled hospital as defined in [Wis. Adm. Code DHS 101.03\(76\)](#).

Discharge from one hospital and admission to another within 24 hours for

continued treatment shall not be considered a discharge under this section. Discharge is defined here as it is in the UB-04 Manual.

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

- a. Loss of BadgerCare Plus or Medicaid SSI eligibility occurs.
- b. Disenrollment occurs because there is a voluntary Disenrollment from the HMO as a result of one of the conditions in Article II, B(1) in which case the HMO's liability shall terminate upon disenrollment being effective.
- c. Disenrollment is due to a medical status code change which includes:
 - SSI for BadgerCare Plus members only.
 - 503 case (503 cases are SSI cases that continue Medicaid SSI eligibility when Social Security cost of living increases cause an SSI member to lose SSI eligibility).
 - Institutionalized enrollment.

In these three exceptions, the HMO's liability shall not exceed the period for which it is capitated. When calculating the HMO liability for the member, the HMO should take the total stay allowed divided by the total number of days hospitalized to determine a daily rate. The daily rate would then be multiplied by the number of days the member was enrolled in the HMO.

8. Members Living in a Public Institution (BadgerCare Plus, and Medicaid SSI Plans)

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

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

9. Payment to Provider Pending Credentialing Approval

The HMO must pay a Medicaid-enrolled provider for services provided to a member of the HMO while the provider's complete application for credentialing is pending approval by the HMO. If the provider's application is ultimately denied by the HMO, the HMO is not liable for the services provided. This provision does not apply to HMOs who are NCQA-accredited.

10. Calculation of Non-listed Max Fee Rate

When a rate is not listed on the FFS max fee schedule, the HMO may determine their own payment methodology for determining the rate for affiliated and non-affiliated providers. The Department may request documentation of methodology if a provider appeal is submitted based on this derived payment amount.

11. The HMO is prohibited from making payment to a provider for provider-preventable conditions (42 CFR 438.6(f)(2)(i)).

All provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made must be reported by all providers to the HMO per 42 CFR 438.6(f)(2)(ii).

Refer to Article X, B.3 for a comprehensive listing of provider-preventable conditions.

ARTICLE XVI

XVI. PAYMENTS TO THE HMO

A. Actuarial Basis

The capitation rates and non-capitated rates, where appropriate, are calculated on an actuarial basis set forth in [42 CFR 438.6](#).

Payment shall not be made with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

Payment shall not be made with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title; except for “in lieu of” services outlined in this contract.

B. Annual Negotiation of HMO Payments

The monthly payment rates, where appropriate, are recalculated on an annual basis.

- The HMO will have 30 days from the date of the written notification to accept the new payment rates in writing or to initiate termination or non-renewal of the Contract.
- A non-response after 30 days constitutes acceptance of the rates.
- The payment rates are not subject to renegotiation by the HMO once they have been accepted.
- The Department may elect to renegotiate rates as required by changes in federal or state laws, rules or regulations.
- The Department may adjust payment rates to reflect the implementation of material provider rate changes. The rate adjustment would be certified as actuarially sound and approved by CMS in the form of a contract amendment.

C. Capitation Rates

The Department agrees to pay the HMO a monthly prospective payment based on the capitation rates provided that the HMO is in full compliance with all contract requirements. See Article IV(A) for specific services that are included and excluded from the capitated rates. The capitation rates shall be prospective and based on an actuarially sound methodology as required by federal regulations.

The capitation rate shall not include any amount for recoupment of losses incurred by the HMO under previous contracts. Nor does it include services that are not covered under the State Plan with the exception of in lieu of services which currently include non-acute residential mental health services for SSI and SSI-related Medicaid only members and alternative mental health services, substituted for acute mental health services for members²¹ - 64.

The Reimbursement Schedule provides more information about the specific payments and adjustment process can be found on the ForwardHealth Portal in the Managed Care Organization section:

<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>.

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

D. Recoupments

The Department will recoup the HMO payments as described below:

1. The Department will recoup HMO current capitation payments for the following situations where a member's HMO status has changed before the first day of a month for which a capitation payment had been made:
 - a. Member moves out of the HMO's service area.
 - b. Member enters a public institution.
 - c. Member dies.
 - d. Correction of a computer or human error.
2. The Department will recoup the HMO capitation payments for the following situations where the Department initiates a change in a member's HMO status on a retroactive basis, reflecting the fact that the HMO was not able to provide services. In these situations, recoupments for multiple months' capitation payments are more likely.
 - a. Correction of a computer or human error, where the person was never really enrolled in the HMO.
 - b. Disenrollments of members for continuity of care reasons, or as specified in Article II, B.

3. If membership is disputed between two HMOs, the Department will be the final arbitrator of HMO membership and reserve the right to recoup an inappropriate capitation payment.
4. If the HMO member moves out of the HMO's service area, the member will be disenrolled from the HMO on the date the member moved as verified by the eligibility worker. If the eligibility worker is unable to verify the member's move, the HMO may mail a "certified return receipt requested" letter to the member to verify the move. The member must sign for the letter. A copy of the letter and the signed return receipt must be sent to the Department or its designee within 20 days of the member's signature date. If the criteria are met, the effective date of the disenrollment is the first of the month in which the certified returned receipt requested letter was sent. Documentation that fails to meet the 20 day criteria will result in disenrollment the first day of the month that the HMO supplied information to the Department or its designee. This policy does not apply to extended service area requests that have been approved by the HMO unless the member moves out of the extended service area or the HMO's service area. Any capitation payment made for periods of time after disenrollment will be recouped.
5. The Department will recoup HMO non-capitated payments for the following situations:
 - a. Correction of a computer or human error.
 - b. A reconciliation process.
 - c. Per the instructions from a reimbursement guide.

E. Risk adjustment payments or recoupments

Risk adjustment payments or recoupments will be made to the HMO based on chronicity adjustments during the rate development process. The risk adjustment scores will be applied to the rate prospectively and an annual reconciliation will be calculated based on actual enrollment. This may result in additional payments to or recoupments from the HMO.

F. Maternity Kick Payment Guide

1. Each month the HMO must submit a Maternity Kick Payment Report Template, which lists deliveries processed by the HMO in the previous month. The completed template must be placed on the HMO's secure FTP site. The monthly Maternity Kick Payment Report Template is the source document the Department uses to issue monthly reimbursement for maternity deliveries to the HMO.

2. The Maternity Kick Payment Guide can be found on the ForwardHealth Portal in the Managed Care Organization section:
<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>
3. The HMO will be responsible for using the most updated version of the guide posted to ForwardHealth. Questions on the guide, template and/or reimbursement should be directed by email to:
DHSDMSBFM@dhs.wisconsin.gov.

G. Health Insurance Fee Reimbursement

The Patient Protection and Affordable Care Act (PPACA) imposed an annual fee on health insurance providers based on their net written premiums (“Annual Fee”). The Department shall reimburse the Contractor for the Wisconsin-specific Medicaid amount of the Annual Fee. The Department shall add an adjustment for the non-deductibility of the Annual Fee for Federal and State tax purposes (the “gross-up”).

- 1) Health Insurance Fee (HIF) Reimbursement Methodology Guide and WI HIF MA Calculation Template

The guide and template outlining the reporting requirements necessary to receive reimbursement can be found on the ForwardHealth Portal in the Managed Care Organization section. The website is below:

<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>

- 2) Reporting Timeframes

The HMO shall submit the following reports to the Department each calendar year in order to receive reimbursement for HIF for the current year. The schedule below outlines several key dates associated with HIF. Only the date in bold requires the HMO to submit reports to the Department:

<i>Date</i>	<i>Explanation</i>
1-Apr	MCOs submit the NAIC MA filing for the prior year with OCI
15-Apr	IRS Form 8963 is filed with the IRS
15-Jul	Corrections to the April 15 filing sent to the IRS

31-Aug	IRS will issue the tax bill to the MCOs
10-Sep	MCOs submit NAIC Exhibits, the entire IRS Letter 5066C, IRS Letter 5067C, final IRS Form 8963 and complete WI HIF MA Calculation Template (based on 5067C), exhibit for other MA contracts and Signed Attestation
25-Sep	The DHS will determine final reimbursement associated with the HIF the BadgerCare Plus and SSI Contract
30-Sep	MCO tax payment is due to the IRS
31-Dec	The Department will issue an adjusted capitation rate report based on the reimbursement provided in the current year

The non-bolded dates are provided for reference only. The HMO is responsible to inform the Department within 5 business days of the due date if an extension is necessary beyond the required dates.

Failure to submit any document, including the attestation form, that the Department finds necessary to calculate and verify the requested Medicaid reimbursement will forfeit the HMO’s right to reimbursement. If the HMO is not subject to the Annual Fee or waives its right to Medicaid reimbursement and fails to submit the attestation form indicating this, this failure will be considered noncompliance with the Contract’s Article XII reporting requirements.

Failure to submit all of the requested documents by the due dates may result in the reimbursement being delayed.

3) Capitation Rate Report Adjustment

The Department will provide reimbursement for the Annual Fee and gross-up to the HMOs by approximately September 30, of each calendar year.

As the means to report this reimbursement to the federal Centers for Medicare and Medicaid Services (CMS) the current year’s capitation rate will be retrospectively adjusted to reflect the reimbursement. The Department will issue a retroactive capitation rate report adjustment by approximately December 31, of each calendar year outlining the per member per month values associated with the reimbursement. The rate will be based on the annualized enrollment from the current

calendar year. The HIF capitation rate report per member per month values will not be subject to retroactive enrollment adjustments as the HMO's reimbursement and member months will be fixed at the time of the rate report adjustment. This rate report adjustment is solely for the purpose of reporting to CMS and will not result in additional payment to the HMO.

4) HMOs Participating in a Wisconsin Medicaid Program Other Than, Or In Addition To, BadgerCare Plus and SSI Wisconsin Medicaid Programs

HMOs participating in a Wisconsin Medicaid program impacted by the Annual Fee but not governed by this Contract, such as participating in a Medicaid long-term care program, should seek reimbursement from the contracting entity for that program.

HMOs in the BadgerCare Plus and SSI Medicaid program and in other Wisconsin Medicaid contracts must clearly separate the premiums associated with each contract in a separate exhibit as well as apply all appropriate deductions. Only the premiums associated with this Contract should appear in the template calculation.

5) Noncompliance

The Department shall have the right to audit any records of the HMO and to request any information to determine if the HMO has complied with the requirements in this section. If at any time the Department determines that the HMO has not complied with any requirement in this section, the Department will issue an order to the HMO to comply. The HMO shall comply within 15 calendar days after receipt of the order. If the HMO fails to comply after an order, the Department may pursue action against the HMO as provided under Article XII. Additionally, action may include forfeiture of the reimbursement.

6) Payment Disputes

The Department shall have the right to adjust the reimbursement outside the information provided by the HMO in the guide or template.

The HMO may dispute the reimbursement amount by sending a letter to the Department no later than 30 days after receipt of payment. After 30 days, the HMO waives the right to dispute the reimbursement amount.

7) Resolution of Reporting Errors

If the HMO discovers a reporting error, the Department's Bureau of Fiscal Management in the Division of Medicaid Services must be contacted in writing within 15 days of the discovery.

Errors discovered after the retroactive capitation rate report adjustment is issued will be applied to the following year's reimbursement.

HMOs are responsible for using the most updated version of the guide posted to the website. Questions should be directed by email to: DHSDMSBFM@dhs.wisconsin.gov.

H. Reinsurance

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

I. Coordination of Benefits (COB), Third Party Liability (TPL) and Subrogation

The HMO must actively pursue, collect and retain all monies from all available resources for services to members covered under this Contract except where the amount of reimbursement the HMO can reasonably expect to receive is less than the estimated cost of recovery (this exception does not apply to collections for ventilator dependent patients). For purposes of both COB and TPL, and pursuant to the federal Deficit Reduction Act (P.L. 109-171, Sec. 6035), the HMO shall use cost avoidance when possible, except as otherwise permitted herein. While the HMO cannot recoup payment pending third party liability recovery, it may request additional information from a provider or member prior to payment in order to determine whether there is a payer that is primary to Medicaid.

1. Cost effectiveness of recovery is determined by, but not limited to time, effort, and capital outlay required to perform the activity. Upon the request of the Department, the HMO must be able to specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which the HMO determines seeking reimbursement would not be cost effective. Recovery activities include COB, TPL and pursuit of the HMO's subrogation rights under the Ch. 49 of the WI Statutes. Pursuant to Ch. 49 and Wis. Adm. Code DHS 106, the HMO shall have the same COB and collection rights as the Department, and may require providers to code claims for liability in order to assist with recovery efforts.

2. The HMO must also seek to coordinate benefits with other available resources before claiming reimbursement from the Department for all services meeting the cost effectiveness threshold:
 - a. Other available resources for benefit coordination and recovery may include, but are not limited to, all other state or federal medical care programs that are primary to BadgerCare Plus and/or Medicaid SSI, group or individual health insurance, ERISAs, service benefit plans, disability insurance policy, the insurance of absent parents who may have insurance to pay medical care for spouses or minor members, subrogation/worker's compensation collections, and any other available medical payments coverage that is issued without regard to liability (even if contained within a liability insurance policy). To the extent medical payments coverage has been issued directly to a member instead of the HMO or provider for reimbursement of specific claims, the HMO may require such claims to be paid by the member out of these funds.
 - b. Subrogation collections are any recoverable amounts arising out of the settlement or other resolution of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the HMO under Act 31, Laws of 1989, s. 49.89(9). After attorneys' fees and expenses have been paid, the HMO will collect the full amount paid on behalf of the member (subject to applicable law). Similarly, the HMO shall have the right to require a full accounting of claims already paid by a liability insurer under medical payments coverage prior to its payment to verify that the HMO is not issuing payment on a claim that has already been paid by an alternate funding source. To the extent a claim is undisputed (for example, worker's compensation or personal injury) and the third party insurer is covering related medical expenses, such insurance shall be considered primary to Medicaid for such claims and should make payment on any related claim(s) prior to payment by the HMO.
 - c. In accordance with federal law, certain prenatal care and preventive pediatric services may only be recovered through post-payment billing (pay and chase). Post-payment billing will also be done in situations where the third party liability (TPL) is derived from a parent whose obligation to pay is being enforced by the

State Child Support Enforcement Agency and the provider has not received payment within 30 days after the date of service.

3. Section 1912(b) of the Social Security Act must be construed in a beneficiary-specific manner. The purpose of the distribution provision is to permit the beneficiary to retain TPL benefits to which he or she is entitled except to the extent that BadgerCare Plus and/or Medicaid SSI (or the HMO on behalf of BadgerCare Plus and/or Medicaid SSI) is reimbursed for its costs. The HMO is free, within the constraints of state law and this Contract, to make whatever case it can to recover the costs it incurred on behalf of its member. It can use the max fee schedule, an estimate of what a capitated physician would charge on a FFS basis, the value of the care provided in the market place, or some other acceptable proxy as the basis of recovery. However, any excess recovery, over and above the cost of care (however the HMO chooses to define that cost), must be returned to the beneficiary. The HMO may not collect from amounts allotted to the beneficiary in a judgment or court-approved settlement, except those related to past medical expenses paid by the HMO. In the event any judgment or settlement is not itemized, the HMO shall be free, subject to applicable law, to work with the member, other insurance, and/or attorneys to resolve the Medicaid lien in a fair and equitable manner.
4. To ensure compliance, the HMO must maintain records of all COB collections and report them to the Department on a quarterly basis. The COB report must be submitted in the format specified in this Contract (Addendum 4, A). The HMO must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for members. The HMO must seek third party coverage information from all available resources.
5. The HMO must seek third party coverage information from all available resources. This includes accessing and reviewing member's TPL/COB information in the ForwardHealth portal. The HMO is required to submit TPL discrepancies to the Department in the format and manner prescribed by the Department.
6. COB and TPL collections are the responsibility of the HMO or its subcontractors. Subcontractors must report COB information to the HMO. The HMO and its subcontractors must not pursue collection from the

member, but directly from the third party payer. Access to medical services must not be restricted due to COB collection.

7. The following requirement applies if the Contractor (or the Contractor's parent firm and/or any subdivision or subsidiary of either the Contractor's parent firm or of the Contractor) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organization(s), and/or employer self-insurer health plan(s):
 - a. Throughout the Contract term, these insurers and third-party administrators must comply in full with the provision of [Wis. Stats., Subsection 49.475](#). Such compliance must include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided must be consistent with the Department's written specifications.
 - b. Throughout the Contract term, these insurers and third-party administrators must also accept and properly process post payment billings from the Department's fiscal agent for health care services and items received by BadgerCare Plus and Medicaid SSI members.
8. If at any time during the Contract term any of the insurers or third party administrators fails, in whole or in part to collect from third party payers, except as otherwise permitted herein, the Department may take the remedial measures specified in this Contract.

J. Ventilator Dependent Members

To qualify for a ventilator dependent payment, a member must require equipment that provides total respiratory support or the member must have died while on total respiratory support. This equipment may be a volume ventilator, negative pressure ventilator, continuous positive airway pressure (CPAP) system, or a Bi (inspiratory and expiratory) PAP. The member may need a combination of these systems. Any equipment used only for the treatment of sleep apnea does not qualify as total respiratory support.

1. BadgerCare Plus Criteria

The BC+ enrolled member must be inpatient and have total respiratory support for at least 30 days. Total respiratory support must be required for a total of six or more hours per 24 hour period. The total respiratory support does not need to be continuous during that period. Day one is the day that the member is placed on the ventilator. If the member is on the ventilator for less than six hours on the first day, the use must continue into the next day and be more than six total hours. Each day that the member is on the ventilator for part of any day, as long as it is part of the six total hours per 24 hours, it counts as a day for enhanced funding.

If a member is removed from the ventilator to be transferred to home or a hospice/skilled nursing facility prior to the 30 day ventilator requirement and he/she dies within 48 hours of the transfer, the Department will pay all Medicaid covered services to the end of the month or the member's date of death, whichever comes first. This applies to a member being removed from the ventilator in 2016 or after.

The need for total respiratory support must be supported by either:

- a. appropriate medical documentation that include:
 - a copy of the member's admission history and physical exam,
 - discharge summary,
 - physician and nurse's notes that pertain to the member's ventilator use

- b. a signed statement from the physician that includes:
 - member's name, date of birth, Medicaid ID# and the primary diagnosis.
 - The name of the hospital with the admit/discharge dates.
 - Dates the member was on a ventilator or CPAP
 - Statement must specify whether the member was on a ventilator or CPAP.

If the member is transferred to home or a hospice/skilled nursing facility the Department will need medical documentation that includes the member's date of death and the date of the transfer. Documentation must

be submitted at the same time as the quarterly reports as specified in Article XII, K.

1. Medicaid SSI Criteria

The member had an inpatient stay for a minimum of four days or an inpatient stay less than four days length if the member died while on total respiratory support. The SSI member must have one of the following qualifying LTC or APR-DRG codes. APR DRG codes require a supporting ICD- Procedure Codes:

MS-DRG	Description	APR DRG	ICD PROC	Description
870	Septicemia or Severe Sepsis w MV 96+ Hours	720	5A1955Z	Septicemia & Disseminated Infections and; Respiratory Ventilation, Greater than 96 Consecutive Hours
927	Extensive third degree burn with skin graft with; 5A1955Z (Respiratory ventilation, Greater than 96 consecutive hours)	841	5A1955Z	Extensive 3rd degree burns w skin graft; Respiratory Ventilation, Greater than 96 Consecutive Hours
933	Extensive third degree burn without skin graft with; 5A1955Z (Respiratory ventilation, Greater than 96 Consecutive hours)	843	5A1955Z	Extensive 3rd degree or full thickness burns w/o skin graft Respiratory Ventilation, Greater than 96 Consecutive Hours
003	Tracheostomy with mechanical ventilation 96+ hours or principle diagnosis except face, neck, and mouth diagnosis with major OR procedure	004	N/A	Tracheostomy w MV 96+ hours w extensive procedure or ECMO
004	Tracheostomy with mechanical ventilation 96+ hours or principle diagnosis except face, neck, and mouth diagnosis without major OR procedure	005	N/A	Tracheostomy w MV 96+ hours w/o extensive procedure
207	Respiratory system diagnosis with ventilator support 96+ hours.	130	N/A	Respiratory system diagnosis w ventilator support 96+ hours

If an SSI member is removed from the ventilator to be transferred to home or a hospice/skilled nursing facility prior to the four day ventilator requirement and he/she dies within 48 hours of the transfer, the Department will pay all Medicaid covered services to the end of the month or the member's date of death, whichever comes first. This applies to a member being removed from the ventilator in 2016 or after.

The need for total respiratory support must be documented by a copy of the UB-04 or a copy equivalent to the UB-04 with at least one of the LTC or APR-DRG codes (with the designated ICD-10-PCS procedure code)

listed above or a copy of the member’s admission history and physical exam, discharge summary, physician and nurse’s notes that pertain to the member’s ventilator use. If a member is transferred to home or a hospice/skilled nursing facility the Department will need medical documentation that includes the member’s date of death and the date of the transfer. Documentation must be submitted at the same time as the quarterly reports as specified in Article XII, K.

The Department may approve additional LTC or APR DRGs if the medical records and ICD procedure code documents that the member was on continuous mechanical ventilation for 96 or more continuous hours and had an inpatient stay for a minimum of four days or lesser length if the member died while on total respiratory support.

2. Reporting Requirements

The HMO must submit detailed claims in an Excel file via the SFTP site. Supporting documentation such as medical records, attestation form and the ventilator cost summary should be submitted as a hard copy only. The reports must be submitted to the Department’s Bureau of Fiscal Management on a quarterly basis as specified in Article XII, K and contain all the data elements specified below. Ventilator reports are due 30 days after the end of each quarter. The reports include PHI and should be sent to the attention of the BFM Ventilator Analyst.

	Data Elements
1.	HMO Name
2.	HMO Provider Payee Number
3.	Eligibility Code: V-Vent
4.	Member BadgerCare Plus or Medicaid SSI MA Number
5.	Member Last Name
6.	Member First Name
7.	Member’s Date of Birth: mmddyy
8.	Member’s Gender: F (female) or M (male)
9.	BadgerCare Plus or Medicaid SSI Provider Last Name
10.	BadgerCare Plus or Medicaid SSI Provider First Name
11.	Date of Services: From Date (mmddyy) (In ascending order not by provider.)
12.	Date of Service: To Date (mmddyy)
13.	Primary Diagnosis Code 1: ICD-10-PCS or APR DRG
14.	ICD PROC: required for SSI Members with APR DRG Codes only

15.	Quantity: Do not zero fill
16.	Procedure: CPT, ICD-10-PCS, HCPCS, DRG
17.	Procedure Description: CPT, ICD-10-PCS, HCPCS, DRG
18.	Amount Billed: Include decimal (do not zero fill)
19.	Amount Paid: Include decimal (do not zero fill)
20.	Total Amount Billed for Each Individual Member: Include decimal (do not zero fill)
21.	Total Amount Paid for Each Individual Member: Include decimal (do not zero fill)
22.	Hospital Admit Date
23.	Hospital Discharge Date

If the HMO is contracted to serve both BadgerCare Plus and Medicaid SSI members the reports must be submitted separately and include a completed Attestation form (Addendum IV, G).

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

3. Payment Requirements

The HMO’s Medicaid reimbursement will not exceed 135% of the aggregate total Medicaid fee-for-service costs of providing BadgerCare Plus and/or Medicaid SSI covered services to BadgerCare Plus and Medicaid SSI HMO members who meet the ventilator dependent criteria. Reimbursement will only be for Medicaid covered services paid by the HMO. Other associated costs, such as administration or interest, will not be reimbursed.

a. Enhanced Funding

1) Newborns (BadgerCare Plus Only)

The period of enhanced funding for newborns who are on total respiratory support at birth, will begin with the newborn's date of birth and will end on the last day of the month of the qualifying hospital stay. If the newborn dies while on total respiratory support the enhanced funding will end on the date of death. The newborn may be removed from the ventilator to spend time with family and friends prior to his/her date of death.

2) All Other Members

The period of enhanced funding for all other members who meet the ventilator dependency criteria will begin on the first day of the month the member was hospitalized and will end on the last day of the month of the qualifying hospital stay. If the member dies while on total respiratory support the enhanced funding will end on the date of death. The member may be removed from the ventilator to spend time with family and friends prior to his/her date of death.

b. Payment Adjustments

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

- Reimbursement(s) already paid to the HMO in the form of capitation payments for members who qualify as being ventilator dependent will be deducted from the HMO's quarterly payment.
- Costs for medical services provided to ventilator dependent members who are retroactively disenrolled are not payable. The HMO must back out the cost of care that was provided during the period the member was retroactively disenrolled from their reports. If services are submitted for payment they will be denied and the costs will be deducted from the HMO's quarterly payment.

- Costs for services provided after the enrollee’s date of death are not covered by the Medicaid program. If services are submitted for payment they will be denied and the costs will be deducted from the HMO’s quarterly payment.

c. Payment Dispute Resolution

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

d. Ventilator Cost Summary Report Format

VENTILATOR COST SUMMARY

HMO Name: _____
Report Period: _____
Number of Cases Reported: _____

Category of Service	Amount Billed	Amount Paid
Inpatient		
Outpatient		
Physician		
Pharmacy		
All Other		
Total		

MAIL TO: Department of Health Services
 BFM – Ventilator Analyst
 1 West Wilson Street
 Room 318
 P.O. Box 309
 Madison, WI 53701-0309

K. Hospital Access Payment for Non-Critical Access Hospitals

The Department will pay the HMO a monthly hospital inpatient access payment and a monthly hospital outpatient access payment within the limits of the budgeted allocation from the hospital assessment fund. The Department's monthly hospital access payments to the HMOs are made as prospective "per member per month" payments, unadjusted for risk adjustment.

The HMO shall make payments to eligible hospitals based on the number of qualifying inpatient discharges and outpatient claims in the previous month. Payments must be sent to hospitals within 15 calendar days after the HMO receives the monthly amounts from the Department. These payments are in addition to any amount the HMO is required by agreement to pay the hospital for provision of services to HMO members.

An "eligible hospital" means a Medicaid-enrolled Wisconsin hospital that is not a critical access hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital. A list of qualifying hospitals is available from the Department upon request.

"Qualifying inpatient discharges and outpatient claims" are inpatient discharges and outpatient claims for which the HMO made payments to eligible providers in the month preceding the Department's monthly access payment to the HMO for services to the HMO's Medicaid and BadgerCare Plus members, other than Childless Adult (CLA) Plan members or members who are eligible for both Medicaid and Medicare. The HMO shall exclude all members who are dually-eligible and all dual-eligible claims. If a third party pays the claim in full, and the HMO does not make a payment, the claim shall not count as a qualifying claim for the hospital access payment. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for the hospital access payment.

1. Method of payment to hospitals

- a. Payments must be sent to eligible hospitals within 15 days of the HMO receiving the hospital access payments from the Department. The HMO shall pay out the full amounts of hospital access payments. The HMO will base its hospital payments upon the number of qualifying inpatient discharges and outpatient claims regardless of the amount of the base claims payment for those

inpatient discharges and outpatient claims. The HMO shall pay each eligible hospital based upon its percentage of the total number of qualifying inpatient discharges and outpatient claims for all eligible hospitals. If the HMO has no qualifying claims for a specific category:

- 1) A specific category is denied as the separate payment provided by the Department for either BadgerCare Plus or Medicaid SSI and either Inpatient or Outpatient. An example of a Hospital Access Payment specific category for Non-Critical Access Hospital is BadgerCare Plus/Inpatient.
- 2) The HMO shall return payment within 15 calendar days after payment is due to providers or within 30 calendar days after the HMO receives the monthly amount from the Department.
- 3) The return payment will include details of the associated Department check or EFT number, its purpose, specific category, and the month the Department payment was received.
- 4) The HMO will submit notice of returned payment to DHSDMSBFM@dhs.wisconsin.gov with subject: HMO Access Payment Return.

b. An example of the payment methodology is as follows:

HMO A receives \$1 million for inpatient access payments and \$500,000 for outpatient access payments in the month of June. HMO A distributes inpatient and outpatient access payments to eligible hospitals received from the Department in June according to the following formula:

- 1) Inpatient: HMO A counts 1,000 inpatient qualifying discharges paid in May (excluding Medicare crossover claims and claims paid for Childless Adult (CLA) Plan members) to three eligible hospitals.

Hospital X was paid for 300 discharges by HMO A in the month of May, and therefore, will receive 30% of the total inpatient access payment HMO A received from the Department in June.

- 2) Outpatient: HMO A counts 2,000 outpatient qualifying claims paid in May (excluding Medicare crossover claims and claims paid for Childless Adult (CLA) Plan members) to five eligible hospitals.

Hospital X was paid for 400 claims by HMO A in the month of May, and therefore, will receive 20% of the total outpatient access payment HMO A received from the Department in June.

2. Monthly reporting requirements

- a. The HMO shall send a report along with its monthly payment to each eligible hospital that contains the following information:
- The amount of the hospital access payments received from the Department for inpatient discharges;
 - The amount of the hospital access payments received from the Department for outpatient claims;
 - That hospital's number of qualifying inpatient discharges;
 - That hospital's number of qualifying outpatient claims;
 - The total number of qualifying inpatient discharges for all qualifying hospitals;
 - The total number of qualifying outpatient claims;
 - Access payment amount per qualifying inpatient discharge;
 - Access payment amount per qualifying outpatient claims;
 - The amount of the total payment to that hospital.
- b. The HMO shall use the Access Payment Portal to report all access payments to providers to the Department. The link to the Access Payment Portal is: <https://wihmo.pegus.com/>.
- c. The HMO must complete the payment information within the Access Payment Portal within 15 calendar days of receipt of payment from the Department.
- d. If the Access Payment Portal is unavailable for a period of time greater than 48 hours, the HMO must contact the Department immediately upon discovery and submit payment information

using approved methodologies by the Department as described below.

- e. The HMO is no longer required to submit the report in Addendum F and H unless instructed by the Department due to the unavailability of the Access Payment Portal. In these situations the HMO will submit the reports in Addendum F and H within 15 calendar days of receipt of payment from the Department. These submissions will use the rounding methodology as described:
 - 1) Initially calculate payment to the fourth decimal.
 - 2) Round down the payment to the nearest hundredth or send decimal point.
 - 3) Take the difference between the Departments payment and the total of the rounded down payment.
 - 4) Distribute this difference one penny at a time in descending order from highest to lowest in utilization (NOTE: Only include providers with at least one utilization.)
 - 5) If providers have the same utilization amount, then distribute it alphabetically in ascending order.

3. Noncompliance

The Department shall have the right to audit any records of the HMO to determine if the HMO has complied with the requirements in this section J. If at any time the Department determines that the HMO has not complied with any requirement in this section L, the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department's determination of noncompliance. If the HMO fails to comply after an order, the Department may terminate the contract as provided under Article XIV, C.9.

Upon request, the HMO must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

If the HMO fails to send payment to the hospital within 15 calendar days of receiving the hospital access payment from the Department, the HMO will pay an assessment to the Department equal to three percent of the delayed payment.

4. Payment disputes

If the HMO or the hospital dispute the monthly amount that the HMO is required to pay the hospital, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The HMO or hospital may request a contested case hearing under Ch. 227 on the Department's determination.

5. Resolution of Reporting Errors

The HMO shall adjust prior hospital access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient claims. If an error is discovered, the Bureau of Fiscal Management must be contacted in writing within 15 calendar days of the discovery. Corrections will be adjusted on a prospective basis. Corrections will be adjusted using the Portal functionality. HMOs will be responsible for making these adjustments. If the Portal function is unavailable then the HMO will submit a Department-approved plan to address the error.

L. Critical Access Hospital (CAH) Access Payment

Within the limits of the budgeted allocation from the Critical Access Hospital (CAH) assessment fund, the Department will pay the HMO a monthly CAH inpatient access payment and a monthly CAH outpatient access payment. The Department's monthly CAH access payments to the HMOs are made as prospective "per member per month" payments, unadjusted for risk adjustment.

The HMO shall make payments to eligible CAHs based on the number of qualifying inpatient discharges and outpatient claims in the previous month. Payments must be sent to the CAH within 15 calendar days after the HMO receives the monthly amounts from the Department. These payments are in addition to any amount the HMO is required by agreement to pay the CAH for provision of services to HMO members.

An "eligible CAH" means a Medicaid-enrolled Wisconsin CAH that is not an acute care hospital, an institution for mental disease, a rehabilitation hospital, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of

an acute care hospital. A list of qualifying CAH is available from the Department upon request.

“Qualifying discharges and claims” are inpatient discharges and outpatient claims for which the HMO made payments to eligible providers in the month preceding the Department’s monthly access payment to the HMO for services to the HMO’s Medicaid and BadgerCare Plus members, other than Childless Adult (CLA) Plan members or members who are eligible for both Medicaid and Medicare. HMOs shall exclude all members who are dually-eligible and all dual-eligible claims. If a third party pays the claim in full, and the HMO does not make a payment, the claim shall not count as a qualifying claim for the CAH access payment. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for the CAH access payment.

1. Method of payment to hospitals

- a. Payments must be sent to eligible CAH(s) within 15 days of the HMO receiving the CAH access payments from the Department. The HMO shall pay out the full amounts of CAH access payments. The HMO will base its CAH payments upon the number of qualifying inpatient discharges and the number of qualifying outpatient claims regardless of the amount of the base claims payment for those discharges and claims. The HMO shall pay each eligible CAH based upon its percentage of the total number of qualifying claims for all eligible CAH(s). If the HMO has no qualifying claims for a specific category:
 - 1) A specific category is denied as the separate payment provided by the Department for either BadgerCare Plus or Medicaid SSI and either Inpatient or Outpatient. An example of a Hospital Access Payment specific category for Non-Critical Access Hospital is BadgerCare Plus/Inpatient.
 - 2) The HMO shall return payment within 15 calendar days after payment is due to providers or within 30 calendar days after the HMO receives the monthly amount from the Department.
 - 3) The return payment will include details of the associated Department check or EFT number, its purpose, specific category, and month Department payment was received.

- 4) The HMO will submit notice of returned payment to DHSDMSBFM@dhs.wisconsin.gov with subject: HMO Access Payment Return.

- b. An example of the payment methodology is as follows:

HMO A receives \$1 million for inpatient access payments and \$500,000 for outpatient access payments in the month of June. HMO A distributes inpatient and outpatient access payments to eligible CAH(s) received from the Department in June according to the following formula:

- 1) Inpatient: HMO A counts 1,000 inpatient qualifying discharges paid in May (excluding Medicare crossover claims and claims paid for Childless Adult (CLA) Plan members) to three eligible CAH(s).

CAH X was paid for 300 discharges by HMO A in the month of May, and therefore, will receive 30% of the total inpatient access payment HMO A received from the Department in June.

- 2) Outpatient: HMO A counts 2,000 outpatient qualifying claims paid in May (excluding Medicare crossover claims and claims paid for Childless Adult (CLA) Plan members) to five eligible CAH(s).

CAH X was paid for 400 claims by HMO A in the month of May, and therefore, will receive 20% of the total outpatient access payment HMO A received from the Department in June.

2. Monthly reporting requirements

- a. The HMO shall send a report along with its monthly payment to each eligible CAH that contains the following information:
 - The amount of the CAH access payment received from the Department for inpatient discharges;
 - The amount of the CAH access payments received from the Department for outpatient claims;

- That CAH's number of qualifying inpatient discharges;
 - That CAH's number of qualifying outpatient claims;
 - The total number of qualifying inpatient discharges for all qualifying CAH(s);
 - The total number of qualifying outpatient claims;
 - Access payment amount per qualifying inpatient discharge;
 - Access payment amount per qualifying outpatient claim;
 - The amount of the total payment to that CAH.
- b. The HMO shall use the Access Payment Portal to report all access payments to providers to the Department. The link to the Access Payment Portal is: <https://wihmo.pcgus.com/>.
- c. The HMO must complete the payment information within the Access Payment Portal within 15 calendar days of receipt of payment from the Department.
- d. If the Access Payment Portal is unavailable for a period of time greater than 48 hours, the HMO must contact the Department immediately upon discovery and submit payment information using approved methodologies by the Department as described below.
- e. The HMO is no longer required to submit the report in Addendum G and H unless instructed by the Department due to the unavailability of the Access Payment Portal. In these situations the HMO will submit the reports in Addendum F and H within 15 calendar days of receipt of payment from the Department. These submissions will use the rounding methodology as described:
- 1) Initially calculate payment to the fourth decimal.
 - 2) Round down the payment to the nearest hundredth or send decimal point.
 - 3) Take the difference between the Departments payment and the total of the rounded down payment.
 - 4) Distribute this difference one penny at a time in descending order from highest to lowest in utilization (NOTE: Only include providers with at least one utilization.)
 - 5) If providers have the same utilization amount, then distribute it alphabetically in ascending order.

3. Noncompliance

The Department shall have the right to audit any records of the HMO to determine if the HMO has complied with the requirements in this section

L. If at any time the Department determines that the HMO has not complied with any requirement in this section L, the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department's determination of noncompliance. If the HMO fails to comply after an order, the Department may terminate the contract as provided under Article XIV, C.9.

Upon request, the HMO must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

If the HMO fails to send payment to the CAH within 15 days of receiving CAH access payment from the Department, the HMO will pay an assessment to the Department equal to three percent of the delayed payment.

4. Payment disputes

If the HMO or the CAH dispute the monthly amount that the HMO is required to pay the CAH, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The HMO or CAH may request a contested case hearing under CH. 227 on the Department's determination.

5. Resolution of Reporting Errors

The HMO shall adjust prior CAH access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient claims. If an error is discovered, the Bureau of Fiscal Management must be contacted in writing within 15 days of the discovery. Corrections will be adjusted using the Portal functionality. HMOs will be responsible for making these adjustments. If the Portal function is unavailable then the HMO will submit a Department-approved plan to address the error.

M. Payment Method

All payments, recoupments, and debit adjustments for payments made in error, distributed by the Department to the HMO, will be made via Electronic Funds Transfer (EFT) via enrollment through the secure ForwardHealth Portal account.

HMOs are responsible for maintaining complete and accurate EFT information in order to receive payment. If a HMO fails to maintain complete and accurate information and DHS makes a payment to an incorrect account, the Department will be held harmless and will not reissue a payment.

All arrangements between the financial institution specified for EFT and the HMO must be in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.

EFT information provided by the HMOs via their secure ForwardHealth Portal account constitute a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of [s.49.49\(1\) and \(4m\), Wis. Stats.](#), and if any such information is false, criminal or other penalties may be imposed under these laws.

The requirements and obligations for EFT are in addition to any and all other requirements and obligations applicable to HMO in connection with their contract and their participation in any program that is part of ForwardHealth, including but not limited to requirements and obligations set forth in federal and state statutes and rules and applicable handbooks and updates.

N. Encounter Base Payment Federal Reporting

As the means to report this reimbursement to the federal Centers for Medicare and Medicaid Services (CMS), the current year's capitation rate will be retrospectively adjusted to reflect payments made via the Encounter Based Payment Methodology, except for Maternity Kick Payments which will still be set prospectively. The Department will issue a retroactive capitation rate report amendment by approximately December 31 of the following rate year outlining the per member per month values associated with the reimbursement. The rate will be based on the annualized enrollment from the calendar year in which the costs were incurred in the report. The rate report amendment per member per month values will not be subject to retroactive enrollment adjustments as the HMO's reimbursement and member months will be fixed at the time of the rate report adjustment. This rate report adjustment is solely for the purpose of reporting to CMS and will not result in additional payment to the HMO.

ARTICLE XVII

XVII. HMO SPECIFIC CONTRACT TERMS

A. Documents Constituting Contract

1. Current Documents

In addition to this base agreement, the Contract between the Department and the HMO includes, existing BadgerCare Plus and/or Medicaid SSI provider publications addressed to the HMO, the terms of the most recent HMO certification application issued by this Department prior to HMO contracts, any questions and answers released pursuant to said HMO certification application by the Department, and the HMO's signed application. In the event of any conflict in provisions among these documents, the terms of this base agreement will prevail. The provisions in any question and answer document will prevail over the HMO certification application. The HMO certification application terms shall prevail over any conflict with the HMO's actual signed application.

2. Future Documents

The HMO is required by this Contract to comply with all future Wisconsin Health Care Programs Online Handbooks and Contract Interpretation Bulletins issued pursuant to this Contract. The documents listed in this section constitute the entire Contract between the parties. No other oral or written expression constitutes any part of this Contract.

B. Disclosure Statement(s) of Ownership or Controlling Interest in an HMO and Business Transactions

1. Ownership or Controlling Interest Disclosure Statement(s)

- a. Pursuant to 42 CRF § 455.104 HMO's, and subcontracted disclosing entities and fiscal agents, must provide the following disclosures to the Department:
 - The name and address of any person (individual or corporation) with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable

primary business address, every business location, and P.O. Box.

- Date of birth and Social Security number (in the case of an individual).
- Other tax identification number (in the case of a corporation) with ownership or control interest in the disclosing entity (or fiscal or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest.

- Calculation of 5% Ownership or Control is as follows:

The percentage of direct ownership or control is the percentage interest in the capital, stock or profits.

The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation that owns 80% of the stock of the HMO, the person owns 8% of the HMO.

The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest that a person owns in that obligation by the percent of the HMO's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the HMO's assets, the person owns 6% of the HMO.

- Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity is a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

- The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
 - The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).
- b. Disclosure from any provider or disclosing entity is due at any of the following times:
- Upon the provider or disclosing entity submitting the provider application.
 - Upon the provider or disclosing entity executing the provider agreement.
 - Upon request of the department during the re-validation of the enrollment process.
 - Within 35 days after any changes in ownership of the disclosing entity.
- c. Disclosure from fiscal agents are due at any of the following times:
- Upon the fiscal agent executing the contract with the Department.
 - Upon renewal or extension of the contract.
 - Within 35 days after any changes in ownership of the fiscal agent.
- d. Disclosure from HMO's are due at any of the following times:
- Upon the HMO executing the contract with the Department.
 - Upon renewal or extension of the contract.
 - Within 35 days after any change in ownership of the managed care entity.

HMOs must disclose all ownership and controlling interest to the Department upon request or as federally required. The HMO may supply this information on a separate report or submit reports filed with the state's insurance or health regulators as long as these reports provide the necessary information for the prior 12 month period.

As directed by the CMS Regional Office (RO), the Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If the HMO has not supplied this information, a contract with the HMO is not considered

approved for this period of time and no FFP is available for the period of time preceding the disclosure.

A managed care entity may not knowingly have as a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's a person who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under the Federal Acquisition Regulation or who has an employment, consulting, or other agreement for the provision of items and services that are significant and material to the entity's obligations under its contract with the state.

If the Department finds that the HMO has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department:

- Must notify the Secretary of noncompliance.
- May continue an existing agreement with the HMO unless the Secretary directs otherwise.
- May not renew or otherwise extend the duration of an existing agreement with the HMO unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

2. Business Transaction Disclosures

The HMO must report to the Department information related to business transactions in accordance with 42 CFR § 455.105. The HMO must be able to submit this information within 35 days of the date of written request from the Department.

- a. The ownership of any subcontractors with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- b. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

If the BadgerCare Plus and Medicaid SSI HMO Contract is being renewed or extended, the HMO must disclose information on those business transactions that occurred during the prior contract period.

If the Contract is an initial contract with BadgerCare Plus and/or Medicaid SSI, but the HMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving BadgerCare Plus and/or Medicaid SSI enrollment. All of these HMO business transactions must be reported.

3. Disclosure by providers: information on persons convicted of crimes

In accordance with 42 CFR 455.106:

- a. The HMO must disclose to the Department the identity of any person who:
 - Has ownership or control interest in the provider, or is an agent or managing employee of the provider, and
 - Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or title XX service program since the inception of those programs.
- b. The HMO shall report to the Department within 20 working days of receipt of the following:
 - Any information regarding excluded or convicted individuals or entities, including those in paragraph (C)(a) above;
 - Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a provider.
- c. Denial or termination or provider participation
 - The Department may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the title XX service Program.
 - The Department may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (C)(a) of this section.

C. Miscellaneous

1. Indemnification

The HMO agrees to defend, indemnify and hold the Department harmless with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees that are related to or arise out of:

- a. Any failure, inability, or refusal of the HMO or any of its subcontractors to provide contract services.
- b. The negligent provision of contract services by the HMO or any of its subcontractors.
- c. Any failure, inability or refusal of the HMO to pay any of its subcontractors for contract services.

2. Independent Capacity of Contractor

The Department and the HMO agree that the HMO and any agents or employees of the HMO, in the performance of this Contract, will act in an independent capacity, and not as officers or employees of Department.

3. Omissions

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

4. Choice of Law

This Contract is governed by and construed in accordance with the laws of the State of Wisconsin. The HMO shall be required to bring all legal proceedings against the Department in Wisconsin state courts.

5. Waiver

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract will impair that right or power or be construed as a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other will not be construed as a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement contained herein.

6. Severability

If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties will be relieved of all obligations arising under such provision. If such provision does not relate to payments or services to members and if the remainder of this Contract is not affected then each provision not so affected will be enforced to the fullest extent permitted by law.

7. Survival

The terms and conditions contained in this Contract that by their sense and context are intended to survive the completion of performance shall so survive the completion, expiration or termination of the Contract. This specifically includes, but is not limited to recoupments and confidentiality provisions.

8. 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.

9. Headings

The article and section headings used herein are for reference and convenience only and do not affect its interpretation.

10. Assignability

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

11. Right to Publish

The HMO must obtain prior written approval from the Department before publishing any material on subjects addressed by this Contract.

12. Media Contacts

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

D. HMO Specific Contract Terms

1. Initial Contract Period

The respective rights and obligations of the parties as set forth in this Contract shall commence on January 1, 2018, and unless earlier terminated, shall remain in full force effective through December 31, 2019. The specific terms for enrollment, rates, risk-sharing, dental and chiropractic coverage are as specified in the Contract.

2. Renewals

By mutual written agreement of the parties, there may be one one-year renewal of the term of the Contract. An agreement to renew must be effected at least 30 days prior to the expiration date of any contract term. The terms and conditions of the Contract shall remain in full force and effect throughout any renewal period, unless modified under the provision of the Contract.

3. Specific Terms of the Contract

- a. The specific terms in the HMO's completed application for certification are incorporated into this Contract, including whether dental services and chiropractic services will be provided by the HMO.

- b. For each rate period in this Contract, the HMO agrees, at minimum, to maintain the service area that was in effect at the time the HMO accepted the rates. This provision does not prevent the HMO from expanding to new service areas as approved by the Department.
- c. The HMO's service area and maximum enrollment are specified in its certification application.
- d. Rates are determined for county(ies) in which enrollment is accepted.
- e. Adjusted rates - Rates may be changed to reflect legislative changes in BadgerCare Plus and/or Medicaid SSI reimbursement or changes in approved services. Rate changes may occur during the rate year or in rare instances, retroactively.
- f. The Department shall calculate chronicity or risk adjustment scores as part of the rate development methodology depending on the availability of data. The risk adjustment scores will be applied prospectively to the rate schedule in the rate exhibits provided by the Department. The Department may adjust the HMO prospective risk score if a significant variance in chronicity occurs from the risk adjustment score that was used to adjust the base rates. Any such adjustment will take effect no sooner than 45 days after calculating the variance. Any risk score changes applied to a given HMO will also impact other HMO risk scores due to budget neutrality requirements.
- g. An annual risk adjustment reconciliation will be calculated based on actual enrollment. This may result in additional payments to or recoupments from the HMO. The adjustments will be budget neutral to the Department.

E. Noncompliance

The Department shall have the right to audit any records of the HMO and to request any information to determine if the HMO has complied with the requirements in this section. If at any time the Department determines that the HMO has not complied with any requirement in this article, the Department will issue an order to the HMO to comply. The HMO shall comply within 15 calendar

days after receipt of the order. If the HMO fails to comply after an order, the Department may pursue action against the HMO as provided under Article XIV. Additionally, the HMO may be required to forfeit the reimbursement.

F. Payment Disputes

The Department shall have the right to adjust the reimbursement outside the information provided by the HMO in the guide or template.

The HMO may dispute the reimbursement amount by sending a letter to the Department no later than 30 days after receipt of payment. After 30 days, the HMO waives the right to dispute the reimbursement amount.

G. Resolution of Reporting Errors

If the HMO discovers a reporting error, the Department's Bureau of Fiscal Management in the Division of Health Care Access and Accountability must be contacted in writing within 15 days of the discovery.

Errors discovered after the retroactive capitation rate amendment is issued will be applied to the following year's reimbursement.

H. Contracted Populations

We agree to provide services for the following Medicaid populations (check appropriate line(s)):

_____ BadgerCare Plus New Contract for Certified Service Areas

_____ Medicaid SSI New Contract for Certified Service Areas

_____ Other HMO-Specific Agreement: _____

In WITNESS WHEREOF, the State of Wisconsin has executed this agreement:

HMO Name	State of Wisconsin
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM I

I. MEMORANDA OF UNDERSTANDING

A. MOU Submission Requirements

The HMO must submit to the Department copies of new MOUs, or changes in existing MOUs for review and approval before they take effect. This requirement will be considered met if the Department has not responded within 15 business days after receipt of the MOU.

The HMO shall submit MOUs referred to in this Contract and this Addendum to the Department upon the Department's request and during the certification process if required by the Department.

B. Emergency Services MOU or Contract

The HMO may have a contract or an MOU with hospitals or urgent care centers within the HMO's service area(s) to ensure prompt and appropriate payment for emergency services.

1. The MOU Shall Provide For:

- a. The process for determining whether an emergency exists.
- b. The requirements and procedures for contacting the HMO before the provision of urgent or routine care.
- c. Agreements, if any, between the HMO and the provider regarding indemnification, hold harmless or any other deviation from malpractice or other legal liability which would attach to the HMO or provider in the absence of such an agreement.
- d. Payments for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.
- e. Assurance of timely and appropriate provision of and payment for emergency services.

2. The HMO's Liability for Emergency Situations

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

C. County and Other Human Service Agencies MOU or Contract Requirements for Services Ordered by the Courts

The HMO must make a good faith attempt to negotiate either an MOU or a contract with the county(ies) in their service area. The MOU, contract, or written documentation of a good faith attempt must be available when requested by the Department. Failure of the HMO to have an MOU, contract or a demonstrated good faith effort, as specified, by the Department, may result in the application by the Department of remedies, specified under this Contract. For guidance on expectations for coordination with counties and Institutes for Mental Disease (IMDs), please see DMHSAS/DHCAA Memo Series 2009-02, February 20, 2009, available on the Department's website.

1. MOU Requirement with Boards Created Under Wis. Stats., §. [51.42](#), [51.437](#) or [46.23](#).

At a minimum the MOU must specify the conditions under which the HMO will either reimburse the Board(s) or another contract provider, or directly cover medical services, including, but not limited to, examinations ordered by a court, specified by the Board's designated assessment agency in a member's driver safety plan as provided under [DHS 62](#). It is the responsibility of both the HMO and the Board to ensure that courts order the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full BadgerCare Plus and/or Medicaid SSI rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own provider arrangements, the HMO is not liable. Reasonable arrangements, in this situation, are Medicaid-enrolled providers with facilities and services to safely meet the medical and psychiatric needs of the member within a prompt and reasonable time frame. The MOU shall further specify reimbursement arrangements between the HMO and the Board's provider for assessments performed by the Board's designated assessment agency under [DHS 62](#), Intoxicated

Driver Program rules. The MOU shall also specify other reporting and referral relationships if required by the Board or the HMO.

2. MOU Requirement with the Department of Social Services (DSS) Created Under [Wis. Stats., s. 46.21 or 46.22](#), or the Human Service Department Created Under [Wis. Stats., s. 46.23](#).

At a minimum the MOU must specify that the HMO will reimburse the DSS or its provider if the HMO cannot provide the treatment, or will directly cover medical services including examinations and treatment which are ordered by a court. It is the responsibility of both the HMO and the DSS to ensure that courts order the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full BadgerCare Plus and/or Medicaid SSI rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own provider arrangements, the HMO is not liable. The MOU will also specify the reporting and referral relationships for suspected cases of child abuse or neglect pursuant to [Wis. Stats., s. 48.981](#). The MOU shall also specify a referral agreement for HMO members who are physically disabled and who may be in need of supportive home care or other programming provided or purchased by the county agency. The MOU may specify that evaluations for substitute care will be provided by a provider acceptable to both parties; the DSS may require in the MOU that the HMO specify expert providers acceptable to the DSS and the HMO in dealing with court-related children's services, victims of child abuse and neglect, and domestic abuse.

The HMO and the counties may develop alternative MOU language, if both parties agree. However, all elements defined above must be addressed in the MOU. As an alternative to an MOU, the HMO may enter into contracts with the counties. Any contracts the HMO enters into with the counties must be in compliance with Part A of this Addendum and would supersede any MOU requirements.

ADDENDUM II

II. STANDARD MEMBER HANDBOOK LANGUAGE FOR BADGERCARE PLUS AND MEDICAID SSI

INTERPRETER SERVICES

English – For help to translate or understand this, please call 1-800-xxx-xxxx (TTY).

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-xxx-xxxx (TTY).

Russian – Если вам не всё понятно в этом документе, позвоните по телефону 1-800-xxx-xxxx (TTY).

Hmong – Yog xav tau kev pab txhais cov ntaub ntauv no kom koj totaub, hu rau 1-800-xxx-xxxx (TTY).

Interpreter services are provided free of charge to you.

IMPORTANT [HMO NAME] TELEPHONE NUMBERS

Customer Service	1-800-xxx-xxxx	[Hours/Days Available]
Emergency Number	1-800-xxx-xxxx	Call 24 hours a day, seven days a week
TDD/TTY	1-800-xxx-xxxx	

WELCOME

Welcome to [HMO Name]. As a member of [HMO Name], you should get all your health care from doctors and hospitals in the [HMO Name] network. See [HMO Name] Provider Directory for a list of these providers. You may also call our Customer Service Department at 1-800-xxx-xxxx. Providers accepting new patients are marked in the Provider Directory.

USING YOUR FORWARDHEALTH ID CARD

Your ForwardHealth ID card is the card you will use to get your BadgerCare Plus or Medicaid SSI benefits. Your ForwardHealth ID card is different from your HMO card. Always carry your ForwardHealth ID card with you, and show it every time you go to the doctor or hospital and

every time you get a prescription filled. You may have problems getting health care or prescriptions if you do not have your card with you. Also bring any other health insurance cards you may have. This could include any ID card from your HMO or other service providers.

CHOOSING A PRIMARY CARE PHYSICIAN

When you need care, it is important to call your primary care physician first. It is important to choose a primary care physician to manage all your health care. You can choose a primary care physician from the list of doctors accepting new patients, as marked in the [HMO Name] Provider Directory. HMO doctors are sensitive to the needs of many cultures. To choose a primary care physician or to change primary care physicians, call our Customer Service Department at 1-800-xxx-xxxx. Your primary care physician will help you decide if you need to see another doctor or specialist and, if appropriate, give you a referral. Remember, you must get approval from your primary care physician before you see another doctor.

Women may see a women's health specialist, such as an Obstetrician and Gynecologist (OB/GYN) or nurse midwife, without a referral in addition to choosing from their primary care physician .

Rural Area Resident (Only One HMO in your County)

[Note to HMO: Only include this section if you have rural service areas.]

If you live in a rural area with only one HMO and your current primary care physician is not a [HMO Name] provider, you may continue to see this provider for up to 60 days. Please call your HMO as soon as you enroll to let them know who your provider is. If this provider is still not in the HMO network after 60 days, you will be given a list of participating providers to make a new choice.

ACCESSING THE CARE YOU NEED

Emergency Care

Emergency care is care that is needed right away. Some examples are:

- Choking
- Convulsions
- Prolonged or repeated seizures
- Serious broken bones
- Severe burns
- Severe pain
- Severe or unusual bleeding
- Suspected heart attack
- Suspected poisoning
- Suspected stroke
- Trouble breathing

- Unconsciousness

If you need emergency care, try to go to a [HMO Name] provider for help. If your condition cannot wait, go to the nearest provider (hospital, doctor, or clinic). Call 911 or your local police or fire department emergency services if the emergency is very severe and you are unable to get to the nearest provider.

If you must go to a non-[HMO Name] hospital or provider, call [HMO Name] at 1-800-xxx-xxxx as soon as you can to tell us what happened.

Remember, hospital emergency rooms are for true emergencies only. Unless you have a true emergency, call your doctor or our 24-hour emergency number at [1-800-xxx-xxxx] before you go to the emergency room. If you do not know if your illness or injury is an emergency, call *[Note to HMO: Insert applicable instructions here—call clinic, doctor, 24-hour number, nurse line, etc.]*. We will tell you where you can get care.

Urgent Care

Urgent care is care you need sooner than a routine doctor's visit, but it is **not** emergency care. Some examples are:

- Bruises
- Minor burns
- Minor cuts
- Most broken bones
- Most drug reactions
- Bleeding that is not severe
- Sprains

You must get urgent care from [HMO Name] doctors unless you first get our approval to see a non-[HMO Name] doctor. Do not go to a hospital emergency room for urgent care unless you get approval from [HMO Name] first.

Care When You Are Away From Home

Follow these rules if you need medical care but are too far away from home to go to your regular primary care physician or clinic:

- For true emergencies, go to the nearest hospital, clinic, or doctor. Call [HMO Name] at 1-800-xxx-xxxx as soon as you can to tell us what happened.
- For urgent or routine care away from home, you must first get approval from us to go to a different doctor, clinic, or hospital. This includes children who are spending time away from home with a parent or relative. Call us at 1-800-xxx-xxxx for approval to go to a different doctor, clinic, or hospital.

Care During Pregnancy and Delivery

If you become pregnant, please let [HMO Name] and your income maintenance (IM) agency know right away, so you can get the extra care you need. You do not have copayments when you are pregnant.

You must go to a [HMO Name] hospital to have your baby. Talk to your [HMO Name] doctor to make sure you know which hospital you are to go to when it is time to have your baby. Do not go out of area to have your baby unless you have [HMO Name] approval. Your [HMO Name] doctor knows your history and is the best doctor to help you.

Also, talk to your doctor if you plan to travel in your last month of pregnancy. We want you to have a healthy birth and a good birthing experience, so it may not be a good time for you to be traveling.

WHEN YOU MAY BE BILLED FOR SERVICES

Covered and Noncovered Services

Under BadgerCare Plus and Medicaid SSI, you do not have to pay for covered services other than required copayments. The amount of your co-pay cannot be greater than it would have been in fee-for-service. To help ensure that you are not billed for services, you must see a provider in [HMO Name]'s network. The only exception is for emergencies. If you are willing to accept financial responsibility and make a written payment plan with your provider, you may ask for noncovered services. Providers may bill you up to their usual and customary charges for noncovered services.

If you get a bill for a service you did not agree to, please call 1-800-xxx-xxxx.

Copayments

Under BadgerCare Plus, [HMO Name] and its providers and subcontractors may bill you small service fees, called copayments. The following members do not have to pay copayments:

- Medicaid SSI members
- Nursing home residents
- Pregnant women
- Members younger than 19 years old who are members of a federally recognized tribe
- Members younger than 19 years old with incomes at or below 100 percent of the federal poverty level

Medical Services Received Outside Wisconsin

If you travel outside Wisconsin and need emergency care, health care providers in the area where you travel can treat you and send the bill to [HMO Name]. You may have copayments for emergency services provided outside Wisconsin.

[HMO Name] does not cover any services, including emergency services, provided outside the United States, Canada, and Mexico. If you need emergency services while in Canada or Mexico, [HMO Name] will cover the service only if the doctor's or hospital's bank is in the United States. Other services may be covered with HMO approval if the provider has a U.S. bank. Please call [HMO Name] if you get any emergency services outside the United States.

If you get a bill for services, call our Customer Service Department at 1-800-xxx-xxxx right away.

OTHER INSURANCE

If you have other insurance in addition to [HMO Name], you must tell your doctor or other health care provider. Your doctor or other health care provider must bill your other insurance before billing [HMO Name]. If your [HMO Name] doctor or other health care provider does not accept your other insurance, call the HMO Enrollment Specialist at 1-800-291-2002. The HMO Enrollment Specialist can tell you how to use both insurance plans.

SERVICES COVERED BY [HMO NAME]

[HMO Name] is responsible for providing all medically necessary covered services under BadgerCare Plus and Medicaid SSI. *[Note to HMO: Information you provide for these sections must be approved by the Department of Health Services.]*

Mental Health and Substance Abuse Services

[Note to HMO: The language you use in this section may vary based on which plan you are talking about. See the summary of covered services and copayments referenced in Addendum V.]

[HMO Name] provides mental health and substance abuse (drug and alcohol) services to all members. If you need these services, call *[Note to HMO: Insert primary care physician, behavioral health manager, customer service, etc., as appropriate]*. If you need immediate help, you can call the Crisis Hotline at 1-800-xxx-xxxx or our 24-Hour Nurse Line at 1-800-xxx-xxxx, which is open seven days a week.

All services provided by [HMO Name] are private.

Family Planning Services

[Note to HMO: The language you use in this section may vary based on which plan you are talking about. See the summary of covered services and copayments referenced in Addendum V.]

We provide private family planning services to all members, including minors. If you do not want to talk to your primary care physician about family planning, call our Customer Service

Department at 1-800-xxx-xxxx. We will help you choose a [HMO Name] family planning doctor who is different from your primary care physician.

We encourage you to get family planning services from a [HMO Name] doctor so that we can better coordinate all your health care. However, you can also go to any family planning clinic that will accept your ForwardHealth ID card, even if the clinic is not part of [HMO Name].

Dental Services

[Note to HMO: Use the first statement below if you provide dental services. Use the second statement if you do not provide dental services. If you provide dental services in only part of your service area, use both statements and list the appropriate counties with each statement].

[Statement 1]

[HMO Name] provides all covered dental services. You must go to a [HMO Name] dentist. See the Provider Directory or call our Customer Service Department at 1-800-xxx-xxxx for the names of our dentists.

As a member of [HMO Name], you have the right to a routine dental appointment within 90 days of your request either in writing or over the phone to the Customer Service Department.

[Statement 2]

Dental services are a covered benefit under BadgerCare Plus. You may get covered dental services from a Medicaid-enrolled provider who will accept your ForwardHealth ID card. To find a Medicaid-enrolled provider:

1. Go to www.forwardhealthwi.gov.
2. Click on the Members link or icon in the middle section of the page.
3. Scroll down and click on the Resources tab.
4. Click on the Find a Provider link.
5. Under Program, select BadgerCare Plus.

Or, you can call ForwardHealth Member Services at 1-800-362-3002.

If you have a dental emergency, you have the right to obtain treatment within 24 hours of your request. A dental emergency is a need for immediate dental services to treat severe dental pain, swelling, fever, infection, or injury to the teeth. If you are experiencing a dental emergency:

- If you already have a dentist who is with [HMO Name]:
 - Call the dentist's office.
 - Tell the dentist's office that you or your child is having a dental emergency.
 - Tell the dentist's office what the exact dental problem is. This may be something like a severe toothache or swollen face.
 - Call us if you need help with getting a ride to or from your dental appointment.

- If you do **not** currently have a dentist who is with [HMO Name]:
 - Call *[Note to HMO: insert dental benefits manager or HMO, as appropriate.]*. Tell us that you or your child is having a dental emergency. We can help you get dental services.
 - Tell us if you need help with getting a ride to or from the dentist's office.

[Alternative language for HMOs whose dental benefits manager handles appointments for emergencies.]

Call [HMO Name] if you need help with getting a ride to or from the dentist's office. We can help with getting a ride.

For help with a dental emergency, call x-xxx-xxx-xxxx.

Chiropractic Services

[Note to HMO: Use the first statement below if you provide chiropractic services. Use the second statement if you do not provide chiropractic services.]

[Statement 1]

[HMO Name] provides covered chiropractic services for BadgerCare Plus and Medicaid SSI members. You must go to a [HMO Name] chiropractor. See the Provider Directory or call the Customer Service Department at 1-800-xxx-xxxx for the names of our chiropractors.

[Statement 2]

Chiropractic services are a covered benefit under BadgerCare Plus and Medicaid SSI. You may get covered chiropractic services from a Medicaid-enrolled provider who will accept your ForwardHealth ID card. To find a Medicaid-enrolled provider:

1. Go to www.forwardhealthwi.gov.
2. Click on the Members link or icon in the middle section of the page.
3. Scroll down and click on the Resources tab.
4. Click on the Find a Provider link.
5. Under Program, select BadgerCare Plus.

Or, you can call ForwardHealth Member Services at 1-800-362-3002.

Vision Services

[HMO Name] provides covered vision services, including eyeglasses; however, some limitations apply. For more information, call our Customer Service Department at 1-800-xxx-xxxx.

Autism Treatment Services

Behavioral treatment services are a covered benefit under BadgerCare Plus. You may get covered autism treatment services from a Medicaid-enrolled provider who will accept your ForwardHealth ID card. To find a Medicaid-enrolled provider:

1. Go to www.forwardhealthwi.gov.
2. Click on the Members link or icon in the middle section of the page.
3. Scroll down and click on the Resources tab.
4. Click on the Find a Provider link.
5. Under Program, select BadgerCare Plus.

Or, you can call ForwardHealth Member Services at 1-800-362-3002.

HealthCheck Services

HealthCheck is a program that covers complete health checkups, including treatment for health problems found during the checkup, for members younger than 21 years old. These checkups are very important. Doctors need to see those younger than 21 years old for regular checkups, not just when they are sick.

The HealthCheck program has three purposes:

1. To find and treat health problems for those younger than 21 years old.
2. To increase awareness of the special health services for those younger than 21 years old.
3. To make those younger than 21 years old eligible for some health care not otherwise covered.

The HealthCheck checkup includes:

- Age appropriate immunizations (shots)
- Blood and urine lab tests (including blood lead level testing when age appropriate)
- Dental screening and a referral to a dentist beginning at 1 year old
- Health and developmental history
- Hearing screening
- Physical examination
- Vision screening

To schedule a HealthCheck exam or for more information, call our Customer Service Department at 1-800-xxx-xxxx.

If you need a ride to or from a HealthCheck appointment, please call the Department of Health Services (DHS) non-emergency medical transportation (NEMT) manager at 1-866-907-1493 (or TTY 1-800-855-2880) to schedule a ride.

Transportation Services

Non-emergency medical transportation (NEMT) is available through the DHS NEMT manager. The NEMT manager arranges and pays for rides to covered services for members who have no other way to receive a ride. Non-emergency medical transportation can include rides using:

- Public transportation, such as a city bus
- Non-emergency ambulances
- Specialized medical vehicles
- Other types of vehicles, depending on a member's medical and transportation needs

Additionally, if you use your own private vehicle for rides to and from your covered health care appointments, you may be eligible for mileage reimbursement.

You must schedule routine rides at least two business days before your appointment. You can schedule a routine ride by calling the NEMT manager at 1-866-907-1493 (or TTY 1-800-855-2880), Monday through Friday, from 7:00 a.m. until 6:00 p.m. You may also schedule rides for urgent appointments. A ride to an urgent appointment will be provided in three hours or less.

Pharmacy Benefits

You may get a prescription from a [HMO Name] doctor, specialist, or dentist. You can get covered prescriptions and certain over-the-counter items at any pharmacy that will accept your ForwardHealth ID card.

You may have copayments or limits on covered medications. If you cannot afford your copayments, you can still get your prescriptions.

CARE EVALUATION/HEALTH NEEDS ASSESSMENT (BadgerCare Plus Childless Adults and SSI Managed Care only)

As a member of [HMO Name], you may be asked to talk with a trained staff member about your health care needs. Your HMO will contact you within the first 60 days of your being enrolled with [HMO Name] to schedule a time to talk about your medical history and the care you need. It is very important that you talk with your HMO so that you can get the care and services you need. If you have questions or would like to contact [HMO Name] directly to schedule a time to talk about your health care needs, please call 1-800-xxx-xxxx.

IF YOU MOVE

If you are planning to move, contact your current Income Maintenance (IM) agency. If you move to a different county, you must also contact the IM agency in your new county to update your eligibility for BadgerCare Plus or Medicaid SSI.

If you move out of [HMO Name's] service area, call the HMO Enrollment Specialist at 1-800-291-2002. The HMO Enrollment Specialist will help you choose a new HMO that serves your new area.

GETTING A SECOND MEDICAL OPINION

If you disagree with your doctor's treatment recommendations, you may be able to get a second medical opinion. Contact your doctor or our Customer Service Department at 1-800-xxx-xxxx for information.

HMO EXEMPTIONS

Generally, you must enroll in an HMO to get health care benefits through BadgerCare Plus and Medicaid SSI. An HMO exemption means you are not required to join an HMO to get your health care benefits. Most exemptions are granted for only a short period of time, primarily to allow you to complete a course of treatment before you are enrolled in an HMO. If you think you need an exemption from HMO enrollment, call the HMO Enrollment Specialist at 1-800-291-2002 for more information.

GETTING HELP WHEN YOU HAVE QUESTIONS OR PROBLEMS

[HMO Name's] Member Advocate

[HMO Name] has a Member Advocate to help you get the care you need. You should contact your Member Advocate for help with any questions about getting health care and solving any problems you may have getting health care from [HMO Name]. You can reach the Member Advocate at 1-800-xxx-xxxx.

External Advocate (for Medicaid SSI Only)

If you have problems getting health care services while you are enrolled with (HMO Name) for Medicaid SSI, call the SSI External Advocate at 1-800-xxx-xxxx.

State of Wisconsin HMO Ombuds Program

The state has designated Ombuds (individuals who provide neutral, confidential and informal assistance) who can help you with any questions or problems you have as an HMO member. The Ombuds can tell you how to get the care you need from your HMO. The Ombuds can also help you solve problems or complaints you may have about the HMO program or your HMO. Call 1-800-760-0001 and ask to talk to an Ombuds.

FILING A COMPLAINT, GRIEVANCE, OR APPEAL

Complaints or Grievances

We would like to know if you ever have a complaint about your care at [HMO Name]. Please call [HMO Name's] Member Advocate at 1-800-xxx-xxxx, or write to us at the following address if you have a complaint:

[HMO Name and Mailing Address]

If you want to talk to someone outside [HMO Name] about the problem, call the HMO Enrollment Specialist at 1-800-291-2002. The HMO Enrollment Specialist may be able to help

you solve the problem or write a formal grievance to [HMO Name] or to the BadgerCare Plus and Medicaid SSI programs.

The address to file a complaint with the BadgerCare Plus and Medicaid SSI programs is:

BadgerCare Plus and Medicaid SSI
Managed Care Ombuds
P.O. Box 6470
Madison, WI 53716-0470
1-800-760-0001

If your complaint or grievance needs action right away because a delay in treatment would greatly increase the risk to your health, please call [HMO Name] as soon as possible at 1-800-xxx-xxxx.

You will not be treated differently from other members because you file a complaint or grievance. Your health care benefits will not be affected.

Appeals

You have the right to appeal to the State of Wisconsin, Division of Hearings and Appeals (DHA), for a fair hearing if you believe your benefits are wrongly denied, limited, reduced, delayed, or stopped by [HMO Name]. An appeal must be made no more than 45 days after the member receives notice of action about the decision being appealed. If you make an appeal before the effective date, the service may continue. You may need to pay for the cost of services if the hearing decision is not in your favor.

If you want a fair hearing, send a written request to:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The hearing will be held with an administrative law judge in the county where you live. You have the right to be represented at the hearing, or you can bring a friend for support. If you need a special arrangement for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (hearing impaired).

You will not be treated differently from other members because you request a fair hearing. Your health care benefits will not be affected.

If you need help writing a request for a fair hearing, please call either the BadgerCare Plus and Medicaid SSI Ombuds at 1-800-760-0001 or the HMO Enrollment Specialist at 1-800-291-2002.

YOUR RIGHTS

Knowing About Physician Incentive Plan

You have the right to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services you might need. To get this information, call our Customer Service Department at 1-800-xxx-xxxx and request information about our physician payment arrangements.

Knowing Provider Credentials

You have the right to information about our providers including the provider's education, board certification, and recertification. To get this information, call our Customer Service Department at 1-800-xxx-xxxx.

Completing an Advance Directive, Living Will, Or Power Of Attorney For Health Care

You have the right to make decisions about your medical care. You have the right to accept or refuse medical or surgical treatment. You have the right to plan and direct the types of health care you may get in the future if you become unable to express your wishes. You can let your doctor know about your wishes by completing an advance directive, living will, or power of attorney for health care. Contact your doctor for more information.

You have the right to file a grievance with the DHS Division of Quality Assurance if your advance directive, living will, or power of attorney wishes are not followed. You may request help in filing a grievance.

Right to Medical Records

You have the right to ask for copies of your medical records from your provider(s). We can help you get copies of these records. Please call 1-800-xxx-xxxx for help. Please note that you may have to pay to copy your medical records. You may correct inaccurate information in your medical records if your doctor agrees to the correction.

Your Member Rights

- You have the right to have an interpreter with you during any BadgerCare Plus and/or Medicaid SSI covered service.
- You have the right to get the information provided in this member handbook in another language or format.
- You have the right to get health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.
- You have the right to get information about treatment options including the right to request a second opinion.

- You have the right to make decisions about your health care.
- You have the right to be treated with dignity and respect.
- You have the right to be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal.
- You have the right to be free to exercise your rights without adverse treatment by the HMO and its network providers.

Your Civil Rights

[HMO Name] provides covered services to all eligible members regardless of the following:

- Age
- Color
- Disability
- National origin
- Race
- Sex

All medically necessary covered services are available and will be provided in the same manner to all members. All persons or organizations connected with [HMO Name] that refer or recommend members for services shall do so in the same manner for all members.

ADDENDUM III

III. GUIDELINES FOR THE COORDINATION OF SERVICES BETWEEN THE HMO, TARGETED CASE MANAGEMENT (TCM) AGENCIES AND CHILD WELFARE AGENCIES

A. HMO Rights and Responsibilities

1. The HMO must designate at least one individual to serve as a contact person for case management providers. If the HMO chooses to designate more than one contact person, the HMO should identify the target populations for which each contact person is responsible.
2. The HMO may make referrals to case management agencies when they identify a member from an eligible target population who could benefit from case management services.
3. If the member or case manager requests the HMO to conduct an assessment, the HMO will determine whether there are signs and symptoms indicating the need for an assessment. In the mental health/substance abuse benefit area, a request for an assessment must be accepted in all situations. If the HMO finds that assessment is needed, the HMO will determine the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the HMO determines that no assessment is needed, the HMO will document the rationale for this decision.
4. The HMO must determine the need for medical treatment of those services covered under the HMO Contract based on the results of the assessment and the medical necessity of the treatment recommended.
5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required.
 - The case planning may be done through telephone contact or means of communication other than attending a formal case planning meeting. If the member requests the HMO case management liaison to attend a case planning meeting, the HMO needs to make every effort to honor this request.

- The HMO must informally discuss differences in opinion regarding the HMO's determination of treatment needs if requested by the member or case manager.
- The HMO case management liaison and the case manager must discuss who will be responsible for ensuring that the member receives the services authorized by and provided through the HMO.
- The HMO's role in the case planning may be limited to a confirmation of the services the HMO will authorize if the member and case manager find these acceptable.

ADDENDUM IV

IV. REPORT FORMS AND WORKSHEETS

A. Coordination of Benefits Quarterly Report Form and Instructions for Completing the Form

In order to comply with CMS reporting requirements, the HMO must submit a Coordination of Benefits (COB) report regarding their BadgerCare Plus and/or Medicaid SSI members. For the purposes of this report, the HMO member is any BadgerCare Plus and Medicaid SSI member listed as an ADD or CONTINUE on the monthly HMO enrollment report(s) that are generated by the Department's Fiscal Agent.

THIRD PARTY LIABILITY (TPL)

Third Party Liability (TPL) – The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the “payer of last resort,” the identification of other payer obligations is a major requirement in the adjudication of claims.

Coordination of Benefits (COB) – Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.

- In Medicaid, there are two primary functions related to detecting TPL obligations:
 1. Cost-avoidance – Determining the presence of TPL obligations before the claim is paid.
 2. Pay-and-chase – Identifying TPL obligations after the claim is paid.
- The following definitions apply to TPL:
 - **Coinsurance** – A portion or percentage of the cost for a specific service or item for which the individual is responsible when the service or item is delivered.
 - **Cost Avoidance** – A method of preventing inappropriate payments under Medicaid and reducing improper Medicaid expenditures. Whenever the Medicaid agency is billed first and a potentially liable third party exists, the Medicaid agency rejects the claim and returns it to the provider to be billed to the primary payer to determine the third party's liability (42 CFR 433.139(b)).
 - **Deductible** – A fixed dollar amount that an individual must pay before the costs of services are covered by an insurance plan.
 - **Estate** – Property (real or personal) in which one has a right or interest at time of death.
 - **Health Insurer** – Includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service benefit plan, and a Managed Care Organization (MCO). (The inclusions are explanatory and not mutually exclusive.)

- **Insurer** – Any private insurer or public insurer
- **Post Payment Recovery (Pay and Chase)** – A method used where Medicaid pays the member’s medical bills and then attempts to recover from liable third parties. Pay and Chase waivers are based on specific services as determined by procedure code or type of service.
- **Third Party** – Any individual, entity, insurer, or program that is, or may be, liable to furnish health care services or to pay for all or part of the costs of medical assistance covered under a Medicaid State plan. Medicaid is generally the payer of last resort. Examples of a third party are employment-related health insurance, medical child support from non-custodial parents, and Medicare. Every Medicaid jurisdiction is required by §1902(a)(25) of the Act to take reasonable measures to determine the legal liability of third party payers.

Birth costs or delivery costs (e.g., routine delivery and associated hospital charges) are not to be included in the report.

The report is to be for the HMO’s entire service area, aggregating separate service areas if the HMO has more than one service area. HMOs are not required to report BadgerCare Plus and SSI COB separately. The report must be completed on a calendar quarterly basis and submitted to the Department’s fiscal agent within 45 calendar days of the end of the quarter being reported.

MAIL TO:

Bureau of Benefits Management
ATTN: (your specific HMO analyst)
Room 350
P.O. Box 309
Madison, WI 53701-0309

FAX TO:

Bureau of Benefits Management
ATTN: (your specific HMO analyst)
Room 350
(608) 266-1096

The COB report form follows this page.

**STATE OF WISCONSIN
BADGERCARE PLUS AND MEDICAID SSI
HMO REPORT ON COORDINATION OF BENEFITS**

Name of HMO _____ Mailing Address _____
Office Telephone _____
Provider Number _____

Please designate below the quarter period for which information is given in this report.
_____, 20__ through _____, 20__

A. Cost Avoidance – The amount reported should be the amount paid by TPL for “Dates of Payment” in the quarter covered by this report. Coinsurance and deductible amounts associated with the BadgerCare Plus and/or SSI program should not be reported.

Amount Cost Avoided: _____

B. Recoveries (Post-Pay Billing/Pay and Chase) – The amount reported should be the amount paid by TPL for “Dates of Recovery” in the quarter covered by this report. Coinsurance and deductible amounts associated with the BadgerCare Plus and/or SSI program should not be reported.

Subrogation/Workers’ Compensation Amount: _____
(e.g., a recovery associated with physical injury).

Other Recoveries Amount: _____
(e.g., All other Third Party Liability (TPL) not specifically noted above.)

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the HMO, except as noted on the report.

Signed: _____
Original Signature of CEO or CFO

Printed Name: _____

Title: _____

Date Signed: _____

B. Court Ordered Birth Cost Requests

County Child Support Agencies (CSA) obtain court orders requiring fathers to repay birth costs that have been paid by FFS as well as the HMO. In some counties, judges will not assign birth costs to the father based upon average costs. Upon request of the Fiscal Agent Contract Monitor, the HMO must provide actual charges less any payments made by a third party payer for the use by the court in setting actual birth and related costs to be paid by the father. Birth cost information must be submitted to the Bureau of Benefits Management within 14 days from the date the request was received by the HMO.

The birth cost report forms follows this page.

BADGERCARE PLUS HMO BIRTH COST REQUEST

PART 1: Local Child Support Agency Portion

PART 1: To be completed by the Local Child Support Agency. Please type or print, in a legible manner.

1. **HMO Name** _____

2. **Mother's Name** _____
(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Address _____
(Street Address)

_____ (City) (State) (Zip Code)

3. **Newborn's Name** _____
(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Date of Birth _____ Sex _____

Note: In cases of multiple births, a form must be completed for each newborn. In addition, the form(s) should not be submitted to the Bureau of Benefits Management until 60 days after the birth.

4. **I certify this information is accurate to the best of my knowledge.**

Name of Local Child Support Agency	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

5. **Mail To:**
Bureau of Benefits Management
ATTN: Birth Costs, Room 350
P.O. BOX 309
MADISON, WI 53701-0309

FAX To:
Bureau of Benefits Management
ATTN: Birth Costs
(608) 266-1096

PART II: HMO Portion

Part II: To be completed by the HMO. Please type or print in a legible manner.

1. **The actual payment for birthing costs for the mother and her baby.**

Mother's Name _____ ID# _____

Baby's Name _____ ID# _____ DOB _____

Hospital/Birthing Center Payment (Mother) \$ _____

Hospital/Birthing Center Payment (Newborn) \$ _____

Physician Payment (Mother) \$ _____

Physician Payment (Newborn) \$ _____

Amount Paid by Other Insurance \$ _____

2. **Comments: (i.e., retroactively disenrolled from [HMO NAME] effective [DATE], services denied)**

[State Denial Reason]: _____

3. **I certify this information is accurate to the best of my knowledge.**

Name of HMO	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

4. **Mail or FAX Part I and Part II within 14 days of receipt to:**

Mail To:

Bureau of Benefits Management
 ATTN: Birth Costs, Room 350
 P.O. Box 309
 Madison, WI 53701-0309

FAX To:

Bureau of Benefits Management
 ATTN: Birth Costs
 (608) 266-1096

C. HMO Newborn Report (BadgerCare Plus Only)

This report should be completed for infants born to mothers who are BadgerCare Plus eligible and enrolled in the HMO at the time of birth of the infant.

The requirements for the [Newborn Report](#) are included in the ForwardHealth online handbook. The handbook includes links to the form and submission instructions.

D. HealthCheck Worksheet

HEALTHCHECK WORKSHEET

DHS will use the HealthCheck worksheet below to measure compliance with the 80% target of HealthCheck comprehensive visits in the 2018 and 2019 BadgerCare Plus and Medicaid SSI HMO Contract. Detailed explanations of various cells in the worksheet are described in the HMO P4P Guide for MY2017.

HMO:

		Age Groups						
		Calculation	< 1	1 – 2	3 – 5	6 – 14	15 – 20	Total
1	# of eligible months for members under age 21	Entered (Total is sum across all age groups)						
2	# of unduplicated members under age 21	Entered						
3	# of recommended screens per age group	Per CMS specifications	5	1.5	1	0.5	0.5	
4	Average period of eligibility in years	Line 1 ÷ Line 2 ÷ 12						
5	Adjusted # of recommended screens per age group	Line 3 x Line 4						
6	Expected # of screens (100% of required screens for ages and months of eligibility)	Line 2 x Line 5 (Total is sum of age groups)						
7	# of screens required to meet the 80% goal	Line 6 x 0.80						
8	Actual # of screens completed	Entered						
9	Did the HMO meet the goal?	Line 8 – Line 7 (If negative, goal was not met)						
10	Penalty	\$10,000 if “Total” for line 9 is negative						

E. Member Complaint and Grievance and Appeal Reporting Form

Grievance Experience Summary Report

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

HMOs should report in sections a. through c. below only those members that grieved or appealed to the HMO's grievance and appeal committee.

a. Grievances Related to Program Administration

Member name and Identification Number	Date Grievance Received	Description of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

b. Grievance Related to Benefit Denial/Reduction

Member Name and Identification Number	Date Grievance Received	Description of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

c. Summary

SUBTOTAL: Program Administration _____
 SUBTOTAL: Benefit Denial/Reduction _____
 TOTAL NUMBER OF GRIEVANCES _____

1. HMO Reporting Form for Member Complaints

HMO Name

First Quarter
 Second Quarter
 Third Quarter
 Fourth Quarter
 Calendar Year 2014
 Calendar Year 2015

TYPE OF COMPLAINT	TOTAL NUMBER OF COMPLAINTS
1. ACCESS PROBLEMS	
2. BILLING ISSUES	
3. QUALITY OF CARE	
4. DENIAL OF SERVICE	
5. OTHER SPECIFY	

General Definitions

1. Access problems include any problem identified by the HMO that causes a member to have difficulty getting an appointment, receiving care, or on culturally appropriate care, including the provision of interpreter services in a timely manner.
2. Billing issues include the denial of a service or a member receiving a bill for a BadgerCare Plus and/or Medicaid SSI covered service that the HMO is responsible for providing or arranging for the provision of that service.
3. Quality of care includes long waiting times in the reception area of providers' offices, rude providers or provider staff, or any other complaint related directly to patient care.
4. Denial of service includes any BadgerCare Plus and/or Medicaid SSI covered service that the HMO denied.
5. Others as identified by the HMO.

Return the completed form to:

Bureau of Benefits Management
 ATTN: Grievances, Managed Care Analyst, Room 350
 P.O. Box 309
 Madison, WI 53701-0309

F. Summary Hospital Access Payment Report to Department of Health Services

This report will be provided to the HMO electronically in the current HMO contract for completion. Hospital Access Payments must be sent to the hospitals within 15 calendar days after the HMO receives the monthly amounts from the Department. HMOs must submit to the Department the following information for each paid hospital within 15 calendar days of receipt of payment from the Department:

Hospital Access Payment

HMO Name	
Month, Year payment was received from the Department	
Month, Year from which hospital discharge and claims data is being reported (i.e. previous month)	
Date the last hospital access payment was sent	
* Grand Total Payment	

* Total payments made to all hospitals should be equal to the total amount the HMO received from the Department. The distribution of these funds by the HMO to hospitals shall be based on eligible discharges and claims in the prior month paid by the HMO to eligible hospitals.

1	2	3	4	5	6	7	8	9	10	11	12	13
MA ID	NPI	Hospital Name	Inpatient Funding Received from DHS	Number of Hospital Qualifying Inpatient Discharges Paid to the Individual Hospital	Number of Total Inpatient Discharges Paid by HMO to All Eligible Hospitals	Percent of the Hospital's Total Inpatient Discharges Paid by the HMO (Column 5 / Column 6)	Payment to Hospital for Inpatient Discharges (Column 4 x Column 7)	Outpatient Funding Received from DHS	Number of Hospital Qualifying Outpatient Claims Paid to the Individual Hospital	Number of Total Outpatient Claims Paid by HMO to All Eligible Hospitals	Percent of the Hospital's Total Outpatient Claims Paid by HMO (Column 10 / Column 11)	Payment to Hospital for Outpatient Claims (Column 9 x Column 12)
		Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

 (Signature)

 (Date)

G. Summary Critical Access Hospital (CAH) Access Payment Report to Department of Health Services

This report will be provided to the HMO electronically in the current HMO contract for completion. Payments must be sent to the hospitals within 15 calendar days after the HMO receives the monthly amounts from the Department. HMOs must submit to the Department the following information for each paid CAH:

Critical Access Hospital (CAH) Access Payment

HMO Name	
Month, Year payment was received from the Department	
Month, Year from which CAH discharge and claims data is being reported (i.e. previous month)	
Date the last CAH access payment was sent	
* Grand Total Payment	

* Total payments made to all CAH(s) should be equal to the total amount the HMO received from the Department. The distribution of these funds by the HMO to CAH(s) shall be based on eligible discharges and claims in the prior month paid by the HMO to eligible CAH(s):

1	2	3	4	5	6	7	8	9	10	11	12	13
MA ID	NPI	Hospital Name	Inpatient Funding Received from DHS	Number of CAH Qualifying Inpatient Discharges Paid to the Individual CAH	Number of Total Inpatient Discharges Paid by HMO to All Eligible CAHs	Percent of the CAH's Total Inpatient Discharges Paid by the HMO (Column 5/ Column 6)	Payment to CAH for Inpatient Discharges (Column 4 x Column 7)	Outpatient Funding Received from DHS	Number of CAH Qualifying Outpatient Claims Paid to the Individual CAH	Number of Total Outpatient Claims Paid by HMO to All Eligible CAH(s)	Percent of the CAH's Total Outpatient Claims Paid by HMO (Column 10 / Column 11)	Payment to CAH for Outpatient Claims (Column 9 x Column 12)
		Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

 (Signature)

 (Date)

H. ATTESTATION

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

- Encounter Data for (quarter)_____ (year) 20__.
- Vent Report for (quarter)_____ for (year) 20__.
- HMO Network Submission (submitted monthly) for (quarter) _____ (year) 20__.
- Maternity Kick Payment Newborn Report for (quarter) _____ (year) 20__.
- Encounter Based Payment Return Report (quarter) _____ (year) 20__.
- Other _____ (Specify Report)

After conducting a reasonably diligent review of the data, documentation and information, I attest that it is accurate, complete and truthful. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under the applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Plan's agreement or contract with the Wisconsin Department of Human Services (DHS). This form must be signed by the HMO CEO, CFO, or their designated authority in order to be considered a valid signature.

(Title)

(HMO Name)

(HMO Signature)

(Date)

ADDENDUM V

V. BENEFITS AND COST SHARING CHART

The Benefits and Cost Sharing Chart is available online at the following website:

<https://www.forwardhealth.wi.gov/WIPortal/Home/Provider%20Login/tabid/37/Default.aspx>

The chart is found in the link under the bullet titled “BadgerCare Plus Standard Plan Covered Services Overview”. This document is for reference only and is subject to change over time. Please see the ForwardHealth Provider Updates for ongoing guidance on detailed benefit policies.

ADDENDUM VI

VI. CY2017 RATE EXHIBITS

A. SSI Medicaid Only Rate Exhibits

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only New HMOs							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	678	1,452	570	1,482	1,198	3,662	9,042
Ages 40-64	1,148	2,083	963	1,919	1,625	5,723	13,461
Ages 65+	29	128	35	243	167	462	1,064
All Ages	1,855	3,663	1,568	3,644	2,990	9,847	23,567
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$388.66	\$413.61	\$412.83	\$471.40	\$514.55	\$583.17	\$503.21
Ages 40-64	\$667.56	\$666.54	\$653.11	\$758.93	\$801.06	\$952.42	\$816.62
Ages 65+	\$421.32	\$443.38	\$439.58	\$506.35	\$549.89	\$629.62	\$554.62
All Ages	\$561.77	\$558.48	\$561.00	\$625.15	\$672.24	\$799.95	\$684.54
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$385.84	\$411.01	\$408.87	\$469.76	\$513.44	\$582.67	\$501.71
Ages 40-64	\$663.86	\$663.13	\$647.93	\$756.78	\$799.61	\$951.76	\$814.64
Ages 65+	\$420.62	\$442.74	\$438.60	\$505.94	\$549.62	\$629.50	\$554.30
All Ages	\$558.44	\$555.49	\$556.35	\$623.32	\$670.99	\$799.38	\$682.83
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$379.24	\$406.35	\$403.41	\$463.70	\$507.60	\$575.36	\$495.40
Ages 40-64	\$652.33	\$654.79	\$637.87	\$746.47	\$789.82	\$939.78	\$803.91
Ages 65+	\$412.45	\$436.54	\$430.71	\$499.10	\$543.34	\$622.26	\$547.38
All Ages	\$548.77	\$548.68	\$548.01	\$614.97	\$662.98	\$789.36	\$673.96
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$376.42	\$403.75	\$399.45	\$462.06	\$506.49	\$574.86	\$493.90
Ages 40-64	\$648.63	\$651.38	\$632.69	\$744.32	\$788.37	\$939.12	\$801.93
Ages 65+	\$411.75	\$435.90	\$429.73	\$498.69	\$543.07	\$622.14	\$547.07
All Ages	\$545.43	\$545.69	\$543.37	\$613.15	\$661.73	\$788.78	\$672.24

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only Anthem Blue Cross Blue Shield							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	1	30	3	21	65	89	209
Ages 40-64	2	53	1	32	72	192	352
Ages 65+	-	4	-	5	10	15	34
All Ages	3	87	4	58	147	296	595
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$489.03	\$459.78	\$447.57	\$497.12	\$578.22	\$751.94	\$624.74
Ages 40-64	\$767.93	\$712.71	\$687.85	\$784.65	\$688.74	\$1,041.78	\$894.08
Ages 65+	\$521.69	\$489.55	\$474.32	\$532.07	\$530.76	\$632.18	\$570.85
All Ages	\$674.96	\$615.23	\$507.64	\$658.77	\$629.12	\$933.88	\$781.00
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$486.21	\$457.18	\$443.61	\$495.48	\$577.11	\$751.44	\$623.58
Ages 40-64	\$764.23	\$709.30	\$682.67	\$782.50	\$687.29	\$1,041.12	\$892.68
Ages 65+	\$520.99	\$488.91	\$473.34	\$531.66	\$530.49	\$632.06	\$570.58
All Ages	\$671.56	\$612.23	\$503.38	\$656.95	\$627.90	\$933.29	\$779.75
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$479.61	\$452.52	\$438.15	\$489.42	\$571.27	\$744.13	\$617.26
Ages 40-64	\$752.70	\$700.96	\$672.61	\$772.19	\$677.50	\$1,029.14	\$881.86
Ages 65+	\$512.82	\$482.71	\$465.45	\$524.82	\$524.21	\$624.82	\$563.80
All Ages	\$661.67	\$605.26	\$496.77	\$648.48	\$620.10	\$922.96	\$770.74
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$476.79	\$449.92	\$434.19	\$487.78	\$570.16	\$743.63	\$616.09
Ages 40-64	\$749.00	\$697.55	\$667.43	\$770.04	\$676.05	\$1,028.48	\$880.46
Ages 65+	\$512.12	\$482.07	\$464.47	\$524.41	\$523.94	\$624.70	\$563.54
All Ages	\$658.26	\$602.25	\$492.50	\$646.67	\$618.88	\$922.37	\$769.49

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only Care Wisconsin Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	2	14	603	6	-	625
Ages 40-64	-	2	14	831	5	-	852
Ages 65+	-	-	-	101	-	-	101
All Ages	-	4	28	1,535	11	-	1,578
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$482.97	\$453.72	\$441.51	\$506.57	\$489.36	\$579.67	\$504.78
Ages 40-64	\$761.87	\$706.65	\$681.79	\$777.38	\$775.87	\$948.92	\$775.63
Ages 65+	\$515.63	\$483.49	\$468.26	\$526.01	\$524.70	\$626.12	\$526.01
All Ages	\$0.00	\$580.19	\$561.65	\$654.46	\$619.59	\$0.00	\$652.38
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$480.15	\$451.12	\$437.55	\$504.93	\$488.25	\$579.17	\$503.09
Ages 40-64	\$758.17	\$703.24	\$676.61	\$775.23	\$774.42	\$948.26	\$773.44
Ages 65+	\$514.93	\$482.85	\$467.28	\$525.60	\$524.43	\$626.00	\$525.60
All Ages	\$0.00	\$577.18	\$557.08	\$652.62	\$618.33	\$0.00	\$650.50
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$473.55	\$446.46	\$432.09	\$498.87	\$482.41	\$571.86	\$497.05
Ages 40-64	\$746.64	\$694.90	\$666.55	\$764.92	\$764.63	\$936.28	\$763.14
Ages 65+	\$506.76	\$476.65	\$459.39	\$518.76	\$518.15	\$618.76	\$518.76
All Ages	\$0.00	\$570.68	\$549.32	\$644.21	\$610.69	\$0.00	\$642.11
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$470.73	\$443.86	\$428.13	\$497.23	\$481.30	\$571.36	\$495.36
Ages 40-64	\$742.94	\$691.49	\$661.37	\$762.77	\$763.18	\$935.62	\$760.94
Ages 65+	\$506.06	\$476.01	\$458.41	\$518.35	\$517.88	\$618.64	\$518.35
All Ages	\$0.00	\$567.68	\$544.75	\$642.37	\$609.43	\$0.00	\$640.22

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only CompCare							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	42	-	35	37	-	-	114
Ages 40-64	47	-	66	43	-	-	156
Ages 65+	-	-	2	4	-	-	6
All Ages	89	-	103	84	-	-	276
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$431.16	\$401.91	\$389.70	\$439.25	\$437.55	\$527.86	\$421.06
Ages 40-64	\$710.06	\$654.84	\$588.42	\$726.78	\$724.06	\$897.11	\$663.21
Ages 65+	\$463.82	\$431.68	\$416.45	\$474.20	\$472.89	\$574.31	\$454.95
All Ages	\$578.44	\$0.00	\$517.55	\$588.10	\$0.00	\$0.00	\$558.66
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$428.34	\$399.31	\$385.74	\$437.61	\$436.44	\$527.36	\$418.27
Ages 40-64	\$706.36	\$651.43	\$583.24	\$724.63	\$722.61	\$896.45	\$659.31
Ages 65+	\$463.12	\$431.04	\$415.47	\$473.79	\$472.62	\$574.19	\$454.35
All Ages	\$575.16	\$0.00	\$512.87	\$586.26	\$0.00	\$0.00	\$555.29
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$421.74	\$394.65	\$380.28	\$431.55	\$430.60	\$520.05	\$412.20
Ages 40-64	\$694.83	\$643.09	\$573.18	\$714.32	\$712.82	\$884.47	\$648.73
Ages 65+	\$454.95	\$424.84	\$407.58	\$466.95	\$466.34	\$566.95	\$447.16
All Ages	\$565.96	\$0.00	\$504.42	\$577.99	\$0.00	\$0.00	\$546.65
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$418.92	\$392.05	\$376.32	\$429.91	\$429.49	\$519.55	\$409.41
Ages 40-64	\$691.13	\$639.68	\$568.00	\$712.17	\$711.37	\$883.81	\$644.84
Ages 65+	\$454.25	\$424.20	\$406.60	\$466.54	\$466.07	\$566.83	\$446.56
All Ages	\$562.67	\$0.00	\$499.73	\$576.14	\$0.00	\$0.00	\$543.28

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only Group Health Coop Eau Claire							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	130	-	263	75	-	-	468
Ages 40-64	248	-	476	103	-	-	827
Ages 65+	4	-	18	4	-	-	26
All Ages	382	-	757	182	-	-	1,321
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$384.33	\$391.70	\$365.63	\$341.38	\$427.34	\$517.65	\$366.94
Ages 40-64	\$713.29	\$644.63	\$603.75	\$659.61	\$713.85	\$886.90	\$643.56
Ages 65+	\$453.61	\$421.47	\$406.24	\$463.99	\$462.68	\$564.10	\$422.41
All Ages	\$598.62	\$0.00	\$516.32	\$524.17	\$0.00	\$0.00	\$541.20
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$381.51	\$389.10	\$361.67	\$339.74	\$426.23	\$517.15	\$363.67
Ages 40-64	\$709.59	\$641.22	\$598.57	\$657.46	\$712.40	\$886.24	\$639.20
Ages 65+	\$452.91	\$420.83	\$405.26	\$463.58	\$462.41	\$563.98	\$421.56
All Ages	\$595.25	\$0.00	\$511.67	\$522.27	\$0.00	\$0.00	\$537.30
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$374.91	\$384.44	\$356.21	\$333.68	\$420.39	\$509.84	\$357.79
Ages 40-64	\$698.06	\$632.88	\$588.51	\$647.15	\$702.61	\$874.26	\$628.67
Ages 65+	\$444.74	\$414.63	\$397.37	\$456.74	\$456.13	\$556.74	\$413.79
All Ages	\$585.43	\$0.00	\$503.26	\$513.79	\$0.00	\$0.00	\$528.47
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$372.09	\$381.84	\$352.25	\$332.04	\$419.28	\$509.34	\$354.52
Ages 40-64	\$694.36	\$629.47	\$583.33	\$645.00	\$701.16	\$873.60	\$624.31
Ages 65+	\$444.04	\$413.99	\$396.39	\$456.33	\$455.86	\$556.62	\$412.94
All Ages	\$582.07	\$0.00	\$498.60	\$511.89	\$0.00	\$0.00	\$524.57

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only Independent Care (ICare)							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	61	2	429	196	999	1,687
Ages 40-64	-	70	3	494	191	2,003	2,761
Ages 65+	-	5	-	70	21	101	197
All Ages	-	136	5	993	408	3,103	4,645
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$486.91	\$396.86	\$445.45	\$482.34	\$419.35	\$601.58	\$542.50
Ages 40-64	\$765.81	\$865.82	\$685.73	\$763.14	\$761.05	\$948.95	\$900.31
Ages 65+	\$519.57	\$487.43	\$472.20	\$529.95	\$528.64	\$630.06	\$580.06
All Ages	\$0.00	\$641.57	\$589.62	\$625.39	\$584.94	\$826.74	\$756.78
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$484.09	\$394.26	\$441.49	\$480.70	\$418.24	\$601.08	\$541.56
Ages 40-64	\$762.11	\$862.41	\$680.55	\$760.99	\$759.60	\$948.29	\$899.26
Ages 65+	\$518.87	\$486.79	\$471.22	\$529.54	\$528.37	\$629.94	\$579.80
All Ages	\$0.00	\$638.62	\$584.93	\$623.58	\$583.71	\$826.14	\$755.80
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$477.49	\$389.60	\$436.03	\$474.64	\$412.40	\$593.77	\$534.83
Ages 40-64	\$750.58	\$854.07	\$670.49	\$750.68	\$749.81	\$936.31	\$887.82
Ages 65+	\$510.70	\$480.59	\$463.33	\$522.70	\$522.09	\$622.70	\$572.84
All Ages	\$0.00	\$632.01	\$576.71	\$615.35	\$576.00	\$815.82	\$746.26
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$474.67	\$387.00	\$432.07	\$473.00	\$411.29	\$593.27	\$533.89
Ages 40-64	\$746.88	\$850.66	\$665.31	\$748.53	\$748.36	\$935.65	\$886.77
Ages 65+	\$510.00	\$479.95	\$462.35	\$522.29	\$521.82	\$622.58	\$572.58
All Ages	\$0.00	\$629.07	\$572.01	\$613.55	\$574.77	\$815.23	\$745.28

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only MHS Health Wisconsin							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	191	319	100	111	105	474	1,300
Ages 40-64	314	351	155	139	108	563	1,630
Ages 65+	8	23	5	16	3	40	95
All Ages	513	693	260	266	216	1,077	3,025
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$458.35	\$376.50	\$385.90	\$491.00	\$422.25	\$505.79	\$449.86
Ages 40-64	\$745.14	\$616.73	\$655.96	\$819.62	\$654.62	\$911.35	\$766.77
Ages 65+	\$477.28	\$445.14	\$429.91	\$487.66	\$486.35	\$587.77	\$515.56
All Ages	\$634.19	\$500.45	\$547.74	\$662.52	\$539.33	\$720.84	\$622.69
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$455.53	\$373.90	\$381.94	\$489.36	\$421.14	\$505.29	\$448.09
Ages 40-64	\$741.44	\$613.32	\$650.78	\$817.47	\$653.17	\$910.69	\$764.32
Ages 65+	\$476.58	\$444.50	\$428.93	\$487.25	\$486.08	\$587.65	\$515.17
All Ages	\$630.86	\$497.51	\$543.11	\$660.69	\$538.06	\$720.27	\$620.60
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$448.93	\$369.24	\$376.48	\$483.30	\$415.30	\$497.98	\$441.91
Ages 40-64	\$729.91	\$604.98	\$640.72	\$807.16	\$643.38	\$898.71	\$753.68
Ages 65+	\$468.41	\$438.30	\$421.04	\$480.41	\$479.80	\$580.41	\$508.17
All Ages	\$621.22	\$490.93	\$534.86	\$652.36	\$530.24	\$710.52	\$611.99
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$446.11	\$366.64	\$372.52	\$481.66	\$414.19	\$497.48	\$440.14
Ages 40-64	\$726.21	\$601.57	\$635.54	\$805.01	\$641.93	\$898.05	\$751.24
Ages 65+	\$467.71	\$437.66	\$420.06	\$480.00	\$479.53	\$580.29	\$507.77
All Ages	\$617.89	\$487.99	\$530.23	\$650.53	\$528.97	\$709.95	\$609.89

Exhibit 18A							
Wisconsin Department of Health Services							
2017 SSI Capitation Rate Development							
Final Capitation Rates Including CDPS, P4P, and Access Payments							
SSI Medicaid Only							
Molina Healthcare							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	14	67	9	15	186	389	680
Ages 40-64	16	61	9	18	196	388	688
Ages 65+	1	13	1	5	19	53	92
All Ages	31	141	19	38	401	830	1,460
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$460.60	\$419.13	\$419.14	\$468.69	\$478.68	\$460.10	\$460.80
Ages 40-64	\$739.50	\$727.34	\$659.42	\$756.22	\$744.42	\$789.70	\$767.52
Ages 65+	\$493.26	\$461.12	\$445.89	\$503.64	\$502.33	\$603.75	\$554.29
All Ages	\$605.60	\$556.34	\$534.36	\$609.49	\$609.69	\$623.35	\$611.23
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$457.78	\$416.53	\$415.18	\$467.05	\$477.57	\$459.60	\$459.81
Ages 40-64	\$735.80	\$723.93	\$654.24	\$754.07	\$742.97	\$789.04	\$766.23
Ages 65+	\$492.56	\$460.48	\$444.91	\$503.23	\$502.06	\$603.63	\$554.04
All Ages	\$602.40	\$553.57	\$529.98	\$607.77	\$608.45	\$622.80	\$610.14
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$451.18	\$411.87	\$409.72	\$460.99	\$471.73	\$452.29	\$453.23
Ages 40-64	\$724.27	\$715.59	\$644.18	\$743.76	\$733.18	\$777.06	\$755.27
Ages 65+	\$484.39	\$454.28	\$437.02	\$496.39	\$495.78	\$596.39	\$547.15
All Ages	\$593.20	\$547.18	\$522.22	\$599.59	\$600.66	\$613.31	\$601.48
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$448.36	\$409.27	\$405.76	\$459.35	\$470.62	\$451.79	\$452.24
Ages 40-64	\$720.57	\$712.18	\$639.00	\$741.61	\$731.73	\$776.40	\$753.97
Ages 65+	\$483.69	\$453.64	\$436.04	\$495.98	\$495.51	\$596.27	\$546.89
All Ages	\$590.00	\$544.41	\$517.84	\$597.87	\$599.42	\$612.76	\$600.39

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only Network Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	93	196	47	58	50	193	637
Ages 40-64	169	332	97	83	60	218	959
Ages 65+	3	19	3	5	8	25	63
All Ages	265	547	147	146	118	436	1,659
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$428.76	\$455.72	\$407.14	\$392.77	\$454.99	\$493.03	\$453.71
Ages 40-64	\$680.17	\$712.15	\$687.48	\$785.42	\$552.70	\$730.78	\$704.62
Ages 65+	\$481.26	\$449.12	\$433.89	\$491.64	\$490.33	\$591.75	\$515.13
All Ages	\$589.69	\$611.13	\$592.67	\$619.37	\$507.07	\$617.57	\$601.08
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$425.94	\$453.12	\$403.18	\$391.13	\$453.88	\$492.53	\$451.82
Ages 40-64	\$676.47	\$708.74	\$682.30	\$783.27	\$551.25	\$730.12	\$701.84
Ages 65+	\$480.56	\$448.48	\$432.91	\$491.23	\$490.06	\$591.63	\$514.74
All Ages	\$586.33	\$608.11	\$587.97	\$617.49	\$505.84	\$617.01	\$598.73
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$419.34	\$448.46	\$397.72	\$385.07	\$448.04	\$485.22	\$445.80
Ages 40-64	\$664.94	\$700.40	\$672.24	\$772.96	\$541.46	\$718.14	\$691.67
Ages 65+	\$472.39	\$442.28	\$425.02	\$484.39	\$483.78	\$584.39	\$507.90
All Ages	\$576.57	\$601.16	\$579.42	\$608.98	\$497.96	\$607.37	\$590.29
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$416.52	\$445.86	\$393.76	\$383.43	\$446.93	\$484.72	\$443.91
Ages 40-64	\$661.24	\$696.99	\$667.06	\$770.81	\$540.01	\$717.48	\$688.89
Ages 65+	\$471.69	\$441.64	\$424.04	\$483.98	\$483.51	\$584.27	\$507.51
All Ages	\$573.21	\$598.14	\$574.72	\$607.10	\$496.74	\$606.81	\$587.94

Exhibit 18A Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments SSI Medicaid Only Trilogy Health Insurance							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	17	-	1	30	64	112
Ages 40-64	-	14	-	1	17	68	100
Ages 65+	-	2	-	-	3	31	36
All Ages	-	33	-	2	50	163	248
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$473.56	\$444.31	\$432.10	\$481.65	\$479.95	\$604.16	\$545.53
Ages 40-64	\$752.46	\$697.24	\$672.38	\$769.18	\$766.46	\$883.99	\$836.72
Ages 65+	\$506.22	\$474.08	\$458.85	\$516.60	\$515.29	\$616.71	\$600.33
All Ages	\$0.00	\$553.42	\$0.00	\$625.42	\$579.48	\$723.29	\$670.90
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$470.74	\$441.71	\$428.14	\$480.01	\$478.84	\$603.66	\$544.54
Ages 40-64	\$748.76	\$693.83	\$667.20	\$767.03	\$765.01	\$883.33	\$835.52
Ages 65+	\$505.52	\$473.44	\$457.87	\$516.19	\$515.02	\$616.59	\$600.17
All Ages	\$0.00	\$550.59	\$0.00	\$623.52	\$578.31	\$722.79	\$669.95
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$464.14	\$437.05	\$422.68	\$473.95	\$473.00	\$596.35	\$538.04
Ages 40-64	\$737.23	\$685.49	\$657.14	\$756.72	\$755.22	\$871.35	\$824.44
Ages 65+	\$497.35	\$467.24	\$449.98	\$509.35	\$508.74	\$609.35	\$593.07
All Ages	\$0.00	\$544.28	\$0.00	\$615.34	\$571.10	\$713.55	\$661.51
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$461.32	\$434.45	\$418.72	\$472.31	\$471.89	\$595.85	\$537.05
Ages 40-64	\$733.53	\$682.08	\$651.96	\$754.57	\$753.77	\$870.69	\$823.25
Ages 65+	\$496.65	\$466.60	\$449.00	\$508.94	\$508.47	\$609.23	\$592.91
All Ages	\$0.00	\$541.45	\$0.00	\$613.44	\$569.92	\$713.05	\$660.56

Exhibit 18A							
Wisconsin Department of Health Services							
2017 SSI Capitation Rate Development							
Final Capitation Rates Including CDPS, P4P, and Access Payments							
SSI Medicaid Only							
Unitedhealthcare Community Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	207	760	97	132	560	1,454	3,210
Ages 40-64	352	1,200	142	175	976	2,291	5,136
Ages 65+	13	62	6	33	103	197	414
All Ages	572	2,022	245	340	1,639	3,942	8,760
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$496.79	\$461.36	\$491.54	\$500.52	\$501.65	\$594.68	\$533.58
Ages 40-64	\$750.03	\$693.80	\$708.93	\$784.69	\$803.74	\$981.83	\$850.54
Ages 65+	\$510.22	\$478.08	\$462.85	\$520.60	\$519.29	\$620.71	\$560.38
All Ages	\$652.94	\$599.82	\$616.83	\$648.73	\$682.65	\$820.98	\$720.68
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10A)							
Ages 19-39	\$493.97	\$458.76	\$487.58	\$498.88	\$500.54	\$594.18	\$532.18
Ages 40-64	\$746.33	\$690.39	\$703.75	\$782.54	\$802.29	\$981.17	\$848.70
Ages 65+	\$509.52	\$477.44	\$461.87	\$520.19	\$519.02	\$620.59	\$560.09
All Ages	\$649.62	\$596.80	\$612.24	\$646.95	\$681.39	\$820.41	\$719.08
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13A)							
Ages 19-39	\$487.37	\$454.10	\$482.12	\$492.82	\$494.70	\$586.87	\$525.91
Ages 40-64	\$734.80	\$682.05	\$693.69	\$772.23	\$792.50	\$969.19	\$838.13
Ages 65+	\$501.35	\$471.24	\$453.98	\$513.35	\$512.74	\$613.35	\$553.24
All Ages	\$639.95	\$589.91	\$604.06	\$638.63	\$673.17	\$810.39	\$710.26
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	\$484.55	\$451.50	\$478.16	\$491.18	\$493.59	\$586.37	\$524.50
Ages 40-64	\$731.10	\$678.64	\$688.51	\$770.08	\$791.05	\$968.53	\$836.30
Ages 65+	\$500.65	\$470.60	\$453.00	\$512.94	\$512.47	\$613.23	\$552.95
All Ages	\$636.64	\$586.89	\$599.46	\$636.84	\$671.91	\$809.81	\$708.65

B. SSI Dual Eligible Rate Exhibits

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible New HMOs							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	185	542	202	231	405	1,001	2,566
Ages 40-64	245	628	210	276	555	2,367	4,281
Ages 65+	202	487	167	243	432	1,886	3,417
All Ages	632	1,657	579	750	1,392	5,254	10,264
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$60.19	\$40.32	\$53.91	\$52.49	\$35.49	\$96.04	\$64.89
Ages 40-64	\$117.05	\$82.91	\$104.14	\$108.81	\$72.39	\$203.57	\$152.93
Ages 65+	\$100.48	\$70.60	\$89.26	\$92.98	\$61.27	\$175.61	\$131.65
All Ages	\$95.11	\$65.36	\$82.32	\$86.33	\$58.20	\$173.05	\$123.83
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$59.49	\$39.73	\$52.87	\$51.65	\$35.13	\$95.83	\$64.42
Ages 40-64	\$116.46	\$82.41	\$103.26	\$108.11	\$72.09	\$203.39	\$152.59
Ages 65+	\$100.13	\$70.30	\$88.74	\$92.56	\$61.09	\$175.50	\$131.45
All Ages	\$94.56	\$64.89	\$81.49	\$85.68	\$57.92	\$172.89	\$123.51
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$50.64	\$33.56	\$45.22	\$45.07	\$27.98	\$87.48	\$56.90
Ages 40-64	\$101.49	\$71.89	\$89.97	\$96.71	\$60.16	\$189.61	\$139.64
Ages 65+	\$89.30	\$62.68	\$79.08	\$84.29	\$52.48	\$165.58	\$122.10
All Ages	\$82.71	\$56.65	\$71.22	\$76.78	\$48.41	\$161.53	\$113.11
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$49.94	\$32.97	\$44.18	\$44.23	\$27.62	\$87.27	\$56.43
Ages 40-64	\$100.90	\$71.39	\$89.09	\$96.01	\$59.86	\$189.43	\$139.30
Ages 65+	\$88.95	\$62.38	\$78.56	\$83.87	\$52.30	\$165.47	\$121.90
All Ages	\$82.16	\$56.17	\$70.38	\$76.13	\$48.13	\$161.37	\$112.79

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible Anthem Blue Cross Blue Shield							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	5	1	1	11	15	33
Ages 40-64	-	4	-	6	21	36	67
Ages 65+	-	7	-	1	13	38	59
All Ages	-	16	1	8	45	89	159
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$53.92	\$40.34	\$48.25	\$52.64	\$35.57	\$96.12	\$64.72
Ages 40-64	\$110.78	\$82.93	\$98.48	\$108.96	\$72.47	\$203.65	\$146.85
Ages 65+	\$94.21	\$70.62	\$83.60	\$93.13	\$61.35	\$175.69	\$136.63
All Ages	\$0.00	\$64.24	\$48.25	\$99.94	\$60.24	\$173.59	\$126.01
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$53.22	\$39.75	\$47.21	\$51.80	\$35.21	\$95.91	\$64.36
Ages 40-64	\$110.19	\$82.43	\$97.60	\$108.26	\$72.17	\$203.47	\$146.56
Ages 65+	\$93.86	\$70.32	\$83.08	\$92.71	\$61.17	\$175.58	\$136.48
All Ages	\$0.00	\$63.79	\$47.21	\$99.26	\$59.96	\$173.43	\$125.76
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$44.37	\$33.58	\$39.56	\$45.22	\$28.06	\$87.56	\$56.81
Ages 40-64	\$95.22	\$71.91	\$84.31	\$96.86	\$60.24	\$189.69	\$133.77
Ages 65+	\$83.03	\$62.70	\$73.42	\$84.44	\$52.56	\$165.66	\$127.15
All Ages	\$0.00	\$55.90	\$39.56	\$88.85	\$50.16	\$162.22	\$115.34
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$43.67	\$32.99	\$38.52	\$44.38	\$27.70	\$87.35	\$56.45
Ages 40-64	\$94.63	\$71.41	\$83.43	\$96.16	\$59.94	\$189.51	\$133.49
Ages 65+	\$82.68	\$62.40	\$72.90	\$84.02	\$52.38	\$165.55	\$126.99
All Ages	\$0.00	\$55.46	\$38.52	\$88.17	\$49.88	\$162.06	\$115.09

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible Care Wisconsin Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	-	1	71	-	-	72
Ages 40-64	-	-	3	51	-	-	54
Ages 65+	-	-	-	74	-	-	74
All Ages	-	-	4	196	-	-	200
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$53.89	\$40.31	\$48.22	\$52.61	\$35.54	\$96.09	\$52.55
Ages 40-64	\$110.75	\$82.90	\$98.45	\$108.93	\$72.44	\$203.62	\$108.35
Ages 65+	\$94.18	\$70.59	\$83.57	\$93.10	\$61.32	\$175.66	\$93.10
All Ages	\$0.00	\$0.00	\$85.89	\$82.55	\$0.00	\$0.00	\$82.62
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$53.19	\$39.72	\$47.18	\$51.77	\$35.18	\$95.88	\$51.71
Ages 40-64	\$110.16	\$82.40	\$97.57	\$108.23	\$72.14	\$203.44	\$107.64
Ages 65+	\$93.83	\$70.29	\$83.05	\$92.68	\$61.14	\$175.55	\$92.68
All Ages	\$0.00	\$0.00	\$84.97	\$81.91	\$0.00	\$0.00	\$81.97
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$44.34	\$33.55	\$39.53	\$45.19	\$28.03	\$87.53	\$45.11
Ages 40-64	\$95.19	\$71.88	\$84.28	\$96.83	\$60.21	\$189.66	\$96.13
Ages 65+	\$83.00	\$62.67	\$73.39	\$84.41	\$52.53	\$165.63	\$84.41
All Ages	\$0.00	\$0.00	\$73.09	\$73.43	\$0.00	\$0.00	\$73.43
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$43.64	\$32.96	\$38.49	\$44.35	\$27.67	\$87.32	\$44.27
Ages 40-64	\$94.60	\$71.38	\$83.40	\$96.13	\$59.91	\$189.48	\$95.42
Ages 65+	\$82.65	\$62.37	\$72.87	\$83.99	\$52.35	\$165.52	\$83.99
All Ages	\$0.00	\$0.00	\$72.17	\$72.79	\$0.00	\$0.00	\$72.78

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible CompCare							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	8	-	15	10	-	-	33
Ages 40-64	16	-	13	9	-	-	38
Ages 65+	6	-	11	3	-	-	20
All Ages	30	-	39	22	-	-	91
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$59.21	\$45.63	\$53.54	\$57.93	\$40.86	\$101.41	\$56.24
Ages 40-64	\$116.07	\$88.22	\$103.77	\$114.25	\$77.76	\$208.94	\$111.43
Ages 65+	\$99.50	\$75.91	\$88.89	\$98.42	\$66.64	\$180.98	\$93.50
All Ages	\$97.59	\$0.00	\$80.25	\$86.49	\$0.00	\$0.00	\$87.48
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$58.51	\$45.04	\$52.50	\$57.09	\$40.50	\$101.20	\$55.35
Ages 40-64	\$115.48	\$87.72	\$102.89	\$113.55	\$77.46	\$208.76	\$110.72
Ages 65+	\$99.15	\$75.61	\$88.37	\$98.00	\$66.46	\$180.87	\$93.05
All Ages	\$97.02	\$0.00	\$79.41	\$85.77	\$0.00	\$0.00	\$86.75
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$49.66	\$38.87	\$44.85	\$50.51	\$33.35	\$92.85	\$47.73
Ages 40-64	\$100.51	\$77.20	\$89.60	\$102.15	\$65.53	\$194.98	\$97.17
Ages 65+	\$88.32	\$67.99	\$78.71	\$89.73	\$57.85	\$170.95	\$83.25
All Ages	\$84.51	\$0.00	\$69.32	\$76.98	\$0.00	\$0.00	\$76.18
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$48.96	\$38.28	\$43.81	\$49.67	\$32.99	\$92.64	\$46.83
Ages 40-64	\$99.92	\$76.70	\$88.72	\$101.45	\$65.23	\$194.80	\$96.45
Ages 65+	\$87.97	\$67.69	\$78.19	\$89.31	\$57.67	\$170.84	\$82.79
All Ages	\$83.94	\$0.00	\$68.48	\$76.26	\$0.00	\$0.00	\$75.46

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible Group Health Coop Eau Claire							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	35	-	97	24	-	-	156
Ages 40-64	39	-	97	21	-	-	157
Ages 65+	40	-	91	19	-	-	150
All Ages	114	-	285	64	-	-	463
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$58.37	\$44.79	\$52.70	\$57.09	\$40.02	\$100.57	\$54.65
Ages 40-64	\$115.23	\$87.38	\$102.93	\$113.41	\$76.92	\$208.10	\$107.39
Ages 65+	\$98.66	\$75.07	\$88.05	\$97.58	\$65.80	\$180.14	\$92.09
All Ages	\$91.96	\$0.00	\$81.08	\$87.59	\$0.00	\$0.00	\$84.66
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$57.67	\$44.20	\$51.66	\$56.25	\$39.66	\$100.36	\$53.71
Ages 40-64	\$114.64	\$86.88	\$102.05	\$112.71	\$76.62	\$207.92	\$106.60
Ages 65+	\$98.31	\$74.77	\$87.53	\$97.16	\$65.62	\$180.03	\$91.62
All Ages	\$91.42	\$0.00	\$80.26	\$86.92	\$0.00	\$0.00	\$83.93
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$48.82	\$38.03	\$44.01	\$49.67	\$32.51	\$92.01	\$45.96
Ages 40-64	\$99.67	\$76.36	\$88.76	\$101.31	\$64.69	\$194.14	\$93.15
Ages 65+	\$87.48	\$67.15	\$77.87	\$88.89	\$57.01	\$170.11	\$81.83
All Ages	\$79.78	\$0.00	\$70.05	\$78.26	\$0.00	\$0.00	\$73.58
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$48.12	\$37.44	\$42.97	\$48.83	\$32.15	\$91.80	\$45.03
Ages 40-64	\$99.08	\$75.86	\$87.88	\$100.61	\$64.39	\$193.96	\$92.36
Ages 65+	\$87.13	\$66.85	\$77.35	\$88.47	\$56.83	\$170.00	\$81.37
All Ages	\$79.24	\$0.00	\$69.23	\$77.59	\$0.00	\$0.00	\$72.85

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible Independent Care (ICare)							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	20	-	50	71	351	492
Ages 40-64	-	67	-	112	103	1,096	1,378
Ages 65+	-	34	-	69	84	785	972
All Ages	-	121	-	231	258	2,232	2,842
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$53.81	\$40.23	\$48.14	\$52.53	\$35.46	\$96.01	\$80.59
Ages 40-64	\$110.67	\$82.82	\$98.37	\$108.85	\$72.36	\$203.54	\$180.17
Ages 65+	\$94.10	\$70.51	\$83.49	\$93.02	\$61.24	\$175.58	\$156.16
All Ages	\$0.00	\$72.32	\$0.00	\$91.93	\$58.58	\$176.80	\$154.72
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$53.11	\$39.64	\$47.10	\$51.69	\$35.10	\$95.80	\$80.27
Ages 40-64	\$110.08	\$82.32	\$97.49	\$108.15	\$72.06	\$203.36	\$179.92
Ages 65+	\$93.75	\$70.21	\$82.97	\$92.60	\$61.06	\$175.47	\$156.02
All Ages	\$0.00	\$71.86	\$0.00	\$91.28	\$58.31	\$176.64	\$154.50
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$44.26	\$33.47	\$39.45	\$45.11	\$27.95	\$87.45	\$72.37
Ages 40-64	\$95.11	\$71.80	\$84.20	\$96.75	\$60.13	\$189.58	\$166.63
Ages 65+	\$82.92	\$62.59	\$73.31	\$84.33	\$52.45	\$165.55	\$146.41
All Ages	\$0.00	\$62.88	\$0.00	\$81.86	\$48.77	\$165.07	\$143.40
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$43.56	\$32.88	\$38.41	\$44.27	\$27.59	\$87.24	\$72.06
Ages 40-64	\$94.52	\$71.30	\$83.32	\$96.05	\$59.83	\$189.40	\$166.39
Ages 65+	\$82.57	\$62.29	\$72.79	\$83.91	\$52.27	\$165.44	\$146.26
All Ages	\$0.00	\$62.42	\$0.00	\$81.22	\$48.50	\$164.91	\$143.17

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible MHS Health Wisconsin							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	63	100	39	31	30	103	366
Ages 40-64	78	105	43	38	33	164	461
Ages 65+	64	96	24	37	20	165	406
All Ages	205	301	106	106	83	432	1,233
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$56.62	\$43.04	\$50.95	\$55.34	\$38.27	\$98.82	\$62.57
Ages 40-64	\$113.48	\$85.63	\$101.18	\$111.66	\$75.17	\$206.35	\$136.14
Ages 65+	\$96.91	\$73.32	\$86.30	\$95.83	\$64.05	\$178.39	\$122.10
All Ages	\$90.83	\$67.55	\$79.33	\$89.66	\$59.15	\$170.03	\$109.68
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$55.92	\$42.45	\$49.91	\$54.50	\$37.91	\$98.61	\$62.02
Ages 40-64	\$112.89	\$85.13	\$100.30	\$110.96	\$74.87	\$206.17	\$135.70
Ages 65+	\$96.56	\$73.02	\$85.78	\$95.41	\$63.87	\$178.28	\$121.85
All Ages	\$90.28	\$67.09	\$78.47	\$89.02	\$58.86	\$169.87	\$109.27
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$47.07	\$36.28	\$42.26	\$47.92	\$30.76	\$90.26	\$54.50
Ages 40-64	\$97.92	\$74.61	\$87.01	\$99.56	\$62.94	\$192.39	\$122.83
Ages 65+	\$85.73	\$65.40	\$76.12	\$87.14	\$55.26	\$168.36	\$112.56
All Ages	\$78.49	\$58.94	\$68.08	\$80.12	\$49.46	\$158.86	\$99.17
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$46.37	\$35.69	\$41.22	\$47.08	\$30.40	\$90.05	\$53.95
Ages 40-64	\$97.33	\$74.11	\$86.13	\$98.86	\$62.64	\$192.21	\$122.39
Ages 65+	\$85.38	\$65.10	\$75.60	\$86.72	\$55.08	\$168.25	\$112.31
All Ages	\$77.94	\$58.47	\$67.22	\$79.48	\$49.17	\$158.70	\$98.76

Exhibit 18B							
Wisconsin Department of Health Services							
2017 SSI Capitation Rate Development							
Final Capitation Rates Including Access Payments							
SSI Dual Eligible							
Molina Healthcare							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	3	17	-	3	51	72	146
Ages 40-64	1	17	-	3	62	140	223
Ages 65+	1	6	3	-	54	102	166
All Ages	5	40	3	6	167	314	535
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$53.92	\$40.34	\$48.25	\$52.64	\$35.57	\$96.12	\$66.71
Ages 40-64	\$110.78	\$82.93	\$98.48	\$108.96	\$72.47	\$203.65	\$156.29
Ages 65+	\$94.21	\$70.62	\$83.60	\$93.13	\$61.35	\$175.69	\$132.54
All Ages	\$73.35	\$62.98	\$83.60	\$80.80	\$57.61	\$169.91	\$124.47
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$53.22	\$39.75	\$47.21	\$51.80	\$35.21	\$95.91	\$66.38
Ages 40-64	\$110.19	\$82.43	\$97.60	\$108.26	\$72.17	\$203.47	\$156.04
Ages 65+	\$93.86	\$70.32	\$83.08	\$92.71	\$61.17	\$175.58	\$132.39
All Ages	\$72.74	\$62.47	\$83.08	\$80.03	\$57.33	\$169.75	\$124.24
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$44.37	\$33.58	\$39.56	\$45.22	\$28.06	\$87.56	\$58.73
Ages 40-64	\$95.22	\$71.91	\$84.31	\$96.86	\$60.24	\$189.69	\$143.05
Ages 65+	\$83.03	\$62.70	\$73.42	\$84.44	\$52.56	\$165.66	\$122.98
All Ages	\$62.27	\$54.24	\$73.42	\$71.04	\$47.93	\$158.47	\$113.81
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$43.67	\$32.99	\$38.52	\$44.38	\$27.70	\$87.35	\$58.40
Ages 40-64	\$94.63	\$71.41	\$83.43	\$96.16	\$59.94	\$189.51	\$142.80
Ages 65+	\$82.68	\$62.40	\$72.90	\$84.02	\$52.38	\$165.55	\$122.83
All Ages	\$61.66	\$53.73	\$72.90	\$70.27	\$47.65	\$158.30	\$113.57

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible Network Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	26	94	23	19	17	46	225
Ages 40-64	40	101	24	7	16	58	246
Ages 65+	30	87	25	13	11	58	224
All Ages	96	282	72	39	44	162	695
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$56.16	\$42.58	\$50.49	\$54.88	\$37.81	\$98.36	\$57.04
Ages 40-64	\$113.02	\$85.17	\$100.72	\$111.20	\$74.71	\$205.89	\$119.74
Ages 65+	\$96.45	\$72.86	\$85.84	\$95.37	\$63.59	\$177.93	\$105.52
All Ages	\$92.44	\$67.18	\$79.51	\$78.49	\$57.67	\$165.35	\$94.86
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$55.46	\$41.99	\$49.45	\$54.04	\$37.45	\$98.15	\$56.47
Ages 40-64	\$112.43	\$84.67	\$99.84	\$110.50	\$74.41	\$205.71	\$119.27
Ages 65+	\$96.10	\$72.56	\$85.32	\$94.95	\$63.41	\$177.82	\$105.24
All Ages	\$91.90	\$66.71	\$78.70	\$77.81	\$57.38	\$165.18	\$94.42
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$46.61	\$35.82	\$41.80	\$47.46	\$30.30	\$89.80	\$49.28
Ages 40-64	\$97.46	\$74.15	\$86.55	\$99.10	\$62.48	\$191.93	\$106.87
Ages 65+	\$85.27	\$64.94	\$75.66	\$86.68	\$54.80	\$167.90	\$96.28
All Ages	\$79.88	\$58.53	\$68.47	\$69.80	\$48.13	\$154.33	\$84.81
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$45.91	\$35.23	\$40.76	\$46.62	\$29.94	\$89.59	\$48.71
Ages 40-64	\$96.87	\$73.65	\$85.67	\$98.40	\$62.18	\$191.75	\$106.40
Ages 65+	\$84.92	\$64.64	\$75.14	\$86.26	\$54.62	\$167.79	\$96.00
All Ages	\$79.33	\$58.06	\$67.67	\$69.13	\$47.83	\$154.16	\$84.37

Exhibit 18B Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments SSI Dual Eligible Trilogy Health Insurance							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	3	-	-	1	9	13
Ages 40-64	-	-	-	-	5	6	11
Ages 65+	-	1	-	-	4	7	12
All Ages	-	4	-	-	10	22	36
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$53.86	\$40.28	\$48.19	\$52.58	\$35.51	\$96.06	\$78.53
Ages 40-64	\$110.72	\$82.87	\$98.42	\$108.90	\$72.41	\$203.59	\$143.96
Ages 65+	\$94.15	\$70.56	\$83.54	\$93.07	\$61.29	\$175.63	\$128.76
All Ages	\$0.00	\$47.85	\$0.00	\$0.00	\$64.27	\$150.70	\$115.27
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$53.16	\$39.69	\$47.15	\$51.74	\$35.15	\$95.85	\$78.22
Ages 40-64	\$110.13	\$82.37	\$97.54	\$108.20	\$72.11	\$203.41	\$143.73
Ages 65+	\$93.80	\$70.26	\$83.02	\$92.65	\$61.11	\$175.52	\$128.61
All Ages	\$0.00	\$47.33	\$0.00	\$0.00	\$64.01	\$150.53	\$115.03
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$44.31	\$33.52	\$39.50	\$45.16	\$28.00	\$87.50	\$70.47
Ages 40-64	\$95.16	\$71.85	\$84.25	\$96.80	\$60.18	\$189.63	\$130.79
Ages 65+	\$82.97	\$62.64	\$73.36	\$84.38	\$52.50	\$165.60	\$119.32
All Ages	\$0.00	\$40.80	\$0.00	\$0.00	\$53.89	\$140.20	\$105.18
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$43.61	\$32.93	\$38.46	\$44.32	\$27.64	\$87.29	\$70.16
Ages 40-64	\$94.57	\$71.35	\$83.37	\$96.10	\$59.88	\$189.45	\$130.55
Ages 65+	\$82.62	\$62.34	\$72.84	\$83.96	\$52.32	\$165.49	\$119.17
All Ages	\$0.00	\$40.28	\$0.00	\$0.00	\$53.63	\$140.03	\$104.95

Exhibit 18B							
Wisconsin Department of Health Services							
2017 SSI Capitation Rate Development							
Final Capitation Rates Including Access Payments							
SSI Dual Eligible							
Unitedhealthcare Community Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	50	303	26	22	224	405	1,030
Ages 40-64	71	334	30	29	315	867	1,646
Ages 65+	61	256	13	27	246	731	1,334
All Ages	182	893	69	78	785	2,003	4,010
2017 All Services Capitation Rate PMPM							
Ages 19-39	\$53.91	\$40.33	\$48.24	\$52.63	\$35.56	\$96.11	\$62.35
Ages 40-64	\$110.77	\$82.92	\$98.47	\$108.95	\$72.46	\$203.64	\$146.45
Ages 65+	\$94.20	\$70.61	\$83.59	\$93.12	\$61.34	\$175.68	\$128.14
All Ages	\$89.60	\$64.94	\$76.74	\$87.59	\$58.45	\$171.69	\$118.75
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 10B)							
Ages 19-39	\$53.21	\$39.74	\$47.20	\$51.79	\$35.20	\$95.90	\$61.93
Ages 40-64	\$110.18	\$82.42	\$97.59	\$108.25	\$72.16	\$203.46	\$146.14
Ages 65+	\$93.85	\$70.31	\$83.07	\$92.70	\$61.16	\$175.57	\$127.96
All Ages	\$89.06	\$64.47	\$75.87	\$86.94	\$58.17	\$171.53	\$118.46
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-39	\$44.36	\$33.57	\$39.55	\$45.21	\$28.05	\$87.55	\$54.52
Ages 40-64	\$95.21	\$71.90	\$84.30	\$96.85	\$60.23	\$189.68	\$133.38
Ages 65+	\$83.02	\$62.69	\$73.41	\$84.43	\$52.55	\$165.65	\$118.71
All Ages	\$77.15	\$56.25	\$65.39	\$77.99	\$48.64	\$160.26	\$108.24
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	\$43.66	\$32.98	\$38.51	\$44.37	\$27.69	\$87.34	\$54.11
Ages 40-64	\$94.62	\$71.40	\$83.42	\$96.15	\$59.93	\$189.50	\$133.07
Ages 65+	\$82.67	\$62.39	\$72.89	\$84.01	\$52.37	\$165.54	\$118.53
All Ages	\$76.61	\$55.78	\$64.51	\$77.34	\$48.36	\$160.10	\$107.95

C. MAPP Medicaid Only Rate Exhibits

Exhibit 18C							
Wisconsin Department of Health Services							
2017 SSI Capitation Rate Development							
Final Capitation Rates Including P4P and Access Payments							
MAPP Medicaid Only							
New HMOs							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
All Ages	28	47	16	28	55	85	259
2017 All Services Capitation Rate PMPM							
All Ages	\$1,094.70	\$1,148.90	\$1,160.33	\$1,169.35	\$1,214.20	\$1,192.51	\$1,174.14
2017 Medical & Dental Capitation Rate PMPM							
All Ages	\$1,091.21	\$1,145.41	\$1,156.84	\$1,165.86	\$1,210.71	\$1,189.02	\$1,170.65
2017 Medical & Chiropractic Capitation Rate PMPM							
All Ages	\$1,078.81	\$1,133.01	\$1,144.44	\$1,153.46	\$1,198.31	\$1,176.62	\$1,158.25
2017 Medical Capitation Rate PMPM (From Exhibit 6C)							
All Ages	\$1,075.32	\$1,129.52	\$1,140.95	\$1,149.97	\$1,194.82	\$1,173.13	\$1,154.76

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Anthem Blue Cross Blue Shield	
August 2016 Membership by Rate Cell	All Regions
All Ages	21
2017 All Services Capitation Rate PMPM	
All Ages	\$1,195.07
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,191.58
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,179.18
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,175.69

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Care Wisconsin Health Plan	
August 2016 Membership by Rate Cell	All Regions
All Ages	16
2017 All Services Capitation Rate PMPM	
All Ages	\$1,189.01
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,185.52
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,173.12
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,169.63

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Compcare	
August 2016 Membership by Rate Cell	All Regions
All Ages	3
2017 All Services Capitation Rate PMPM	
All Ages	\$1,137.20
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,133.71
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,121.31
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,117.82

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Group Health Coop Eau Claire	
August 2016 Membership by Rate Cell	All Regions
All Ages	17
2017 All Services Capitation Rate PMPM	
All Ages	\$1,126.99
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,123.50
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,111.10
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,107.61

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Independent Care (ICare)	
August 2016 Membership by Rate Cell	All Regions
All Ages	19
2017 All Services Capitation Rate PMPM	
All Ages	\$1,192.95
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,189.46
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,177.06
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,173.57

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only MHS Health Wisconsin	
August 2016 Membership by Rate Cell	All Regions
All Ages	17
2017 All Services Capitation Rate PMPM	
All Ages	\$1,150.66
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,147.17
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,134.77
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,131.28

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Molina Healthcare	
August 2016 Membership by Rate Cell	All Regions
All Ages	11
2017 All Services Capitation Rate PMPM	
All Ages	\$1,166.64
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,163.15
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,150.75
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,147.26

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Network Health Plan	
August 2016 Membership by Rate Cell	All Regions
All Ages	13
2017 All Services Capitation Rate PMPM	
All Ages	\$1,154.64
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,151.15
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,138.75
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,135.26

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Trilogy Health Insurance	
August 2016 Membership by Rate Cell	All Regions
All Ages	3
2017 All Services Capitation Rate PMPM	
All Ages	\$1,179.60
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,176.11
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,163.71
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,160.22

Exhibit 18C Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including P4P and Access Payments MAPP Medicaid Only Unitedhealthcare Community Plan	
August 2016 Membership by Rate Cell	All Regions
All Ages	139
2017 All Services Capitation Rate PMPM	
All Ages	\$1,183.60
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$1,180.11
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$1,167.71
2017 Medical Capitation Rate PMPM (From Exhibit 6C)	
All Ages	\$1,164.22

D. MAPP Dual Eligible Rate Exhibits

Exhibit 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible New HMOs							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
All Ages	104	260	101	166	472	1147	2,250
2017 All Services Capitation Rate PMPM							
All Ages	\$155.30	\$149.01	\$154.69	\$148.88	\$148.95	\$148.95	\$149.50
2017 Medical & Dental Capitation Rate PMPM							
All Ages	\$155.04	\$148.75	\$154.43	\$148.62	\$148.69	\$148.69	\$149.24
2017 Medical & Chiropractic Capitation Rate PMPM							
All Ages	\$138.01	\$131.72	\$137.40	\$131.59	\$131.66	\$131.66	\$132.21
2017 Medical Capitation Rate PMPM (From Exhibit 6D)							
All Ages	\$137.75	\$131.46	\$137.14	\$131.33	\$131.40	\$131.40	\$131.95

Exhibit 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Anthem Blue Cross Blue Shield	
August 2016 Membership by Rate Cell	All Regions
All Ages	40
2017 All Services Capitation Rate PMPM	
All Ages	\$149.03
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$148.77
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$131.74
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$131.48

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Care Wisconsin Health Plan	
August 2016 Membership by Rate Cell	All Regions
All Ages	17
2017 All Services Capitation Rate PMPM	
All Ages	\$149.00
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$148.74
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$131.71
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$131.45

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Compcare	
August 2016 Membership by Rate Cell	All Regions
All Ages	12
2017 All Services Capitation Rate PMPM	
All Ages	\$154.32
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$154.06
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$137.03
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$136.77

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Group Health Coop Eau Claire	
August 2016 Membership by Rate Cell	All Regions
All Ages	89
2017 All Services Capitation Rate PMPM	
All Ages	\$153.48
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$153.22
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$136.19
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$135.93

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Independent Care (ICare)	
August 2016 Membership by Rate Cell	All Regions
All Ages	681
2017 All Services Capitation Rate PMPM	
All Ages	\$148.92
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$148.66
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$131.63
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$131.37

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible MHS Health Wisconsin	
August 2016 Membership by Rate Cell	All Regions
All Ages	131
2017 All Services Capitation Rate PMPM	
All Ages	\$151.73
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$151.47
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$134.44
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$134.18

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Molina Healthcare	
August 2016 Membership by Rate Cell	All Regions
All Ages	86
2017 All Services Capitation Rate PMPM	
All Ages	\$149.03
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$148.77
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$131.74
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$131.48

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Network Health Plan	
August 2016 Membership by Rate Cell	All Regions
All Ages	96
2017 All Services Capitation Rate PMPM	
All Ages	\$151.27
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$151.01
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$133.98
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$133.72

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Trilogy Health Insurance	
August 2016 Membership by Rate Cell	All Regions
All Ages	6
2017 All Services Capitation Rate PMPM	
All Ages	\$148.97
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$148.71
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$131.68
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$131.42

Exhibitt 18D Wisconsin Department of Health Services 2017 SSI Capitation Rate Development Final Capitation Rates Including Access Payments MAPP Dual Eligible Unitedhealthcare Community Plan	
August 2016 Membership by Rate Cell	All Regions
All Ages	1,092
2017 All Services Capitation Rate PMPM	
All Ages	\$149.02
2017 Medical & Dental Capitation Rate PMPM	
All Ages	\$148.76
2017 Medical & Chiropractic Capitation Rate PMPM	
All Ages	\$131.73
2017 Medical Capitation Rate PMPM (From Exhibit 6D)	
All Ages	\$131.47

E. BadgerCare Plus Standard Rate Exhibits

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard New HMOs							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	3,993	5,445	3,405	5,271	3,555	8,873	30,542
Ages 1-14	42,058	55,686	34,374	56,647	39,137	94,112	322,014
Ages 15-20	10,182	12,531	8,025	12,723	9,479	21,676	74,616
Ages 21-44	18,995	23,866	15,593	23,204	16,372	39,331	137,361
Ages 45+	3,563	3,978	2,771	3,940	3,023	5,615	22,890
All Ages	78,791	101,506	64,168	101,785	71,566	169,607	587,423
2017 All Services Capitation Rate PMPM							
Age 0	\$476.57	\$428.92	\$446.14	\$444.53	\$464.08	\$496.37	\$463.45
Ages 1-14	\$118.48	\$120.11	\$128.15	\$123.10	\$139.42	\$144.69	\$130.81
Ages 15-20	\$160.26	\$155.87	\$165.43	\$160.11	\$176.52	\$184.36	\$169.12
Ages 21-44	\$244.19	\$228.04	\$241.25	\$235.30	\$250.95	\$264.56	\$246.19
Ages 45+	\$334.32	\$304.59	\$321.28	\$314.86	\$330.87	\$350.20	\$327.66
All Ages	\$182.09	\$173.70	\$185.51	\$177.37	\$194.06	\$202.76	\$187.62
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$474.16	\$427.07	\$443.56	\$442.95	\$463.05	\$496.09	\$462.04
Ages 1-14	\$116.89	\$118.89	\$126.45	\$122.06	\$138.74	\$144.50	\$129.89
Ages 15-20	\$157.41	\$153.68	\$162.38	\$158.25	\$175.31	\$184.03	\$167.47
Ages 21-44	\$237.63	\$223.00	\$234.24	\$231.02	\$248.16	\$263.79	\$242.33
Ages 45+	\$326.68	\$298.72	\$313.12	\$309.87	\$327.62	\$349.30	\$322.96
All Ages	\$178.83	\$171.24	\$182.02	\$175.31	\$192.70	\$202.39	\$185.75
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$476.37	\$428.78	\$445.96	\$444.39	\$463.94	\$496.25	\$463.30
Ages 1-14	\$100.44	\$108.16	\$112.91	\$110.83	\$127.49	\$134.13	\$118.07
Ages 15-20	\$143.34	\$144.65	\$151.13	\$148.61	\$165.32	\$174.45	\$157.13
Ages 21-44	\$232.29	\$220.22	\$230.58	\$226.72	\$243.29	\$257.17	\$237.49
Ages 45+	\$321.13	\$295.92	\$309.45	\$305.34	\$322.38	\$342.01	\$317.90
All Ages	\$166.80	\$163.57	\$172.44	\$166.77	\$183.94	\$193.64	\$176.69
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$473.96	\$426.93	\$443.38	\$442.81	\$462.91	\$495.97	\$461.90
Ages 1-14	\$98.85	\$106.94	\$111.21	\$109.79	\$126.81	\$133.94	\$117.15
Ages 15-20	\$140.49	\$142.46	\$148.08	\$146.75	\$164.11	\$174.12	\$155.47
Ages 21-44	\$225.73	\$215.18	\$223.57	\$222.44	\$240.50	\$256.40	\$233.64
Ages 45+	\$313.49	\$290.05	\$301.29	\$300.35	\$319.13	\$341.11	\$313.20
All Ages	\$163.54	\$161.12	\$168.96	\$164.71	\$182.58	\$193.27	\$174.82
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	2,446	3,340	2,134	3,186	2,289	6,466	19,861
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,472.62

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Anthem Blue Cross Blue Shield							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	12	444	16	135	685	1,347	2,639
Ages 1-14	73	2,499	86	961	7,529	13,993	25,141
Ages 15-20	20	477	21	203	1,989	3,531	6,241
Ages 21-44	48	1,344	47	471	3,414	6,393	11,717
Ages 45+	8	140	9	78	698	988	1,921
All Ages	161	4,904	179	1,848	14,315	26,252	47,659
2017 All Services Capitation Rate PMPM							
Age 0	\$512.49	\$447.39	\$462.40	\$462.36	\$465.42	\$494.98	\$477.51
Ages 1-14	\$154.40	\$137.07	\$144.41	\$140.52	\$140.58	\$141.34	\$140.71
Ages 15-20	\$196.18	\$164.84	\$181.69	\$170.94	\$175.54	\$177.13	\$175.56
Ages 21-44	\$280.11	\$249.35	\$257.51	\$243.76	\$261.75	\$268.08	\$263.12
Ages 45+	\$370.24	\$310.88	\$337.54	\$332.69	\$337.58	\$360.94	\$347.59
All Ages	\$234.48	\$203.60	\$216.61	\$201.80	\$199.49	\$203.43	\$202.35
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$510.08	\$445.54	\$459.82	\$460.78	\$464.39	\$494.70	\$476.68
Ages 1-14	\$152.81	\$135.85	\$142.71	\$139.48	\$139.90	\$141.15	\$140.22
Ages 15-20	\$193.33	\$162.65	\$178.64	\$169.08	\$174.33	\$176.80	\$174.74
Ages 21-44	\$273.55	\$244.31	\$250.50	\$239.48	\$258.96	\$267.31	\$261.08
Ages 45+	\$362.60	\$305.01	\$329.38	\$327.70	\$334.33	\$360.04	\$345.24
All Ages	\$230.89	\$201.05	\$212.96	\$199.63	\$198.09	\$203.05	\$201.35
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$512.29	\$447.25	\$462.22	\$462.22	\$465.28	\$494.86	\$477.38
Ages 1-14	\$136.36	\$125.12	\$129.17	\$128.25	\$128.65	\$130.78	\$129.49
Ages 15-20	\$179.26	\$153.62	\$167.39	\$159.44	\$164.34	\$167.22	\$165.05
Ages 21-44	\$268.21	\$241.53	\$246.84	\$235.18	\$254.09	\$260.69	\$255.52
Ages 45+	\$357.05	\$302.21	\$325.71	\$323.17	\$329.09	\$352.75	\$339.16
All Ages	\$219.98	\$194.02	\$204.20	\$191.55	\$189.41	\$194.35	\$192.85
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$509.88	\$445.40	\$459.64	\$460.64	\$464.25	\$494.58	\$476.55
Ages 1-14	\$134.77	\$123.90	\$127.47	\$127.21	\$127.97	\$130.59	\$129.01
Ages 15-20	\$176.41	\$151.43	\$164.34	\$157.58	\$163.13	\$166.89	\$164.23
Ages 21-44	\$261.65	\$236.49	\$239.83	\$230.90	\$251.30	\$259.92	\$253.48
Ages 45+	\$349.41	\$296.34	\$317.55	\$318.18	\$325.84	\$351.85	\$336.82
All Ages	\$216.39	\$191.47	\$200.55	\$189.39	\$188.01	\$193.97	\$191.85
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	5	195	3	62	440	1,032	1,737
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,445.09

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Childrens Comm Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	1	267	-	95	1,224	3,753	5,340
Ages 1-14	-	1,668	-	1,409	17,272	48,996	69,345
Ages 15-20	-	336	-	267	4,055	10,880	15,538
Ages 21-44	-	711	-	432	6,444	18,308	25,895
Ages 45+	-	114	-	92	1,231	2,689	4,126
All Ages	1	3,096	-	2,295	30,226	84,626	120,244
2017 All Services Capitation Rate PMPM							
Age 0	\$503.99	\$438.89	\$453.90	\$453.86	\$456.92	\$486.48	\$476.75
Ages 1-14	\$145.90	\$127.24	\$135.91	\$127.67	\$135.25	\$136.82	\$136.01
Ages 15-20	\$187.68	\$163.17	\$173.19	\$179.80	\$175.56	\$177.39	\$176.65
Ages 21-44	\$271.61	\$212.16	\$249.01	\$259.38	\$248.17	\$261.09	\$256.50
Ages 45+	\$361.74	\$293.13	\$329.04	\$357.90	\$327.80	\$338.11	\$334.23
All Ages	\$503.99	\$183.63	\$0.00	\$181.26	\$185.60	\$190.82	\$189.14
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$501.58	\$437.04	\$451.32	\$452.28	\$455.89	\$486.20	\$476.19
Ages 1-14	\$144.31	\$126.02	\$134.21	\$126.63	\$134.57	\$136.63	\$135.66
Ages 15-20	\$184.83	\$160.98	\$170.14	\$177.94	\$174.35	\$177.06	\$176.02
Ages 21-44	\$265.05	\$207.12	\$242.00	\$255.10	\$245.38	\$260.32	\$255.05
Ages 45+	\$354.10	\$287.26	\$320.88	\$352.91	\$324.55	\$337.21	\$332.40
All Ages	\$501.58	\$181.20	\$0.00	\$179.33	\$184.28	\$190.46	\$188.46
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$503.79	\$438.75	\$453.72	\$453.72	\$456.78	\$486.36	\$476.62
Ages 1-14	\$127.86	\$115.29	\$120.67	\$115.40	\$123.32	\$126.26	\$125.04
Ages 15-20	\$170.76	\$151.95	\$158.89	\$168.30	\$164.36	\$167.48	\$166.34
Ages 21-44	\$259.71	\$204.34	\$238.34	\$250.80	\$240.51	\$253.70	\$249.01
Ages 45+	\$348.55	\$284.46	\$317.21	\$348.38	\$319.31	\$329.92	\$325.91
All Ages	\$503.79	\$173.84	\$0.00	\$170.39	\$175.30	\$181.57	\$179.58
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$501.38	\$436.90	\$451.14	\$452.14	\$455.75	\$486.08	\$476.07
Ages 1-14	\$126.27	\$114.07	\$118.97	\$114.36	\$122.64	\$126.07	\$124.69
Ages 15-20	\$167.91	\$149.76	\$155.84	\$166.44	\$163.15	\$167.15	\$165.72
Ages 21-44	\$253.15	\$199.30	\$231.33	\$246.52	\$237.72	\$252.93	\$247.57
Ages 45+	\$340.91	\$278.59	\$309.05	\$343.39	\$316.06	\$329.02	\$324.08
All Ages	\$501.38	\$171.42	\$0.00	\$168.46	\$173.98	\$181.21	\$178.90
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	3	144	4	163	789	2,667	3,770
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,530.89

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Compcare							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	529	-	205	152	-	-	886
Ages 1-14	5,631	4	2,261	1,697	2	-	9,595
Ages 15-20	1,428	-	534	357	-	-	2,319
Ages 21-44	2,702	2	1,112	673	1	-	4,490
Ages 45+	441	-	182	119	-	-	742
All Ages	10,731	6	4,294	2,998	3	-	18,032
2017 All Services Capitation Rate PMPM							
Age 0	\$475.40	\$410.30	\$425.31	\$425.27	\$428.33	\$457.89	\$455.21
Ages 1-14	\$115.68	\$101.49	\$104.31	\$104.77	\$103.67	\$106.21	\$111.06
Ages 15-20	\$159.52	\$137.25	\$145.65	\$138.26	\$140.77	\$145.88	\$153.05
Ages 21-44	\$239.70	\$209.42	\$212.63	\$200.07	\$215.20	\$226.08	\$227.04
Ages 45+	\$326.87	\$285.97	\$301.97	\$277.60	\$295.12	\$311.72	\$312.86
All Ages	\$179.15	\$137.47	\$161.20	\$153.26	\$140.85	\$0.00	\$170.55
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$472.99	\$408.45	\$422.73	\$423.69	\$427.30	\$457.61	\$452.90
Ages 1-14	\$114.09	\$100.27	\$102.61	\$103.73	\$102.99	\$106.02	\$109.54
Ages 15-20	\$156.67	\$135.06	\$142.60	\$136.40	\$139.56	\$145.55	\$150.31
Ages 21-44	\$233.14	\$204.38	\$205.62	\$195.79	\$212.41	\$225.31	\$220.71
Ages 45+	\$319.23	\$280.10	\$293.81	\$272.61	\$291.87	\$310.82	\$305.52
All Ages	\$175.86	\$134.97	\$157.65	\$151.21	\$139.46	\$0.00	\$167.40
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$475.20	\$410.16	\$425.13	\$425.13	\$428.19	\$457.77	\$455.03
Ages 1-14	\$97.64	\$89.54	\$89.07	\$92.50	\$91.74	\$95.65	\$94.71
Ages 15-20	\$142.60	\$126.03	\$131.35	\$126.76	\$129.57	\$135.97	\$137.57
Ages 21-44	\$227.80	\$201.60	\$201.96	\$191.49	\$207.54	\$218.69	\$215.94
Ages 45+	\$313.68	\$277.30	\$290.14	\$268.08	\$286.63	\$303.53	\$300.59
All Ages	\$163.89	\$126.89	\$148.13	\$142.64	\$130.34	\$0.00	\$156.58
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$472.79	\$408.31	\$422.55	\$423.55	\$427.16	\$457.49	\$452.72
Ages 1-14	\$96.05	\$88.32	\$87.37	\$91.46	\$91.06	\$95.46	\$93.19
Ages 15-20	\$139.75	\$123.84	\$128.30	\$124.90	\$128.36	\$135.64	\$134.83
Ages 21-44	\$221.24	\$196.56	\$194.95	\$187.21	\$204.75	\$217.92	\$209.61
Ages 45+	\$306.04	\$271.43	\$281.98	\$263.09	\$283.38	\$302.63	\$293.25
All Ages	\$160.59	\$124.40	\$144.57	\$140.59	\$128.96	\$0.00	\$153.43
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	353	0	141	121	0	1	616
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$6,076.87

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Dean Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	-	47	1,833	-	-	1,880
Ages 1-14	1	3	467	20,285	-	-	20,756
Ages 15-20	-	1	77	4,457	-	-	4,535
Ages 21-44	1	1	246	8,217	-	-	8,465
Ages 45+	-	1	37	1,351	-	-	1,389
All Ages	2	6	874	36,143	-	-	37,025
2017 All Services Capitation Rate PMPM							
Age 0	\$490.67	\$425.57	\$440.58	\$440.54	\$443.60	\$473.16	\$440.54
Ages 1-14	\$132.58	\$116.76	\$127.97	\$118.53	\$118.94	\$121.48	\$118.74
Ages 15-20	\$174.36	\$152.52	\$174.80	\$159.29	\$156.04	\$161.15	\$159.55
Ages 21-44	\$258.29	\$224.69	\$270.14	\$235.13	\$230.47	\$241.35	\$236.15
Ages 45+	\$348.42	\$301.24	\$315.72	\$311.63	\$310.39	\$326.99	\$311.73
All Ages	\$195.44	\$171.46	\$196.87	\$173.61	\$0.00	\$0.00	\$174.16
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$488.26	\$423.72	\$438.00	\$438.96	\$442.57	\$472.88	\$438.94
Ages 1-14	\$130.99	\$115.54	\$126.27	\$117.49	\$118.26	\$121.29	\$117.69
Ages 15-20	\$171.51	\$150.33	\$171.75	\$157.43	\$154.83	\$160.82	\$157.67
Ages 21-44	\$251.73	\$219.65	\$263.13	\$230.85	\$227.68	\$240.58	\$231.79
Ages 45+	\$340.78	\$295.37	\$307.56	\$306.64	\$307.14	\$326.09	\$306.66
All Ages	\$191.36	\$168.66	\$193.24	\$171.56	\$0.00	\$0.00	\$172.07
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$490.47	\$425.43	\$440.40	\$440.40	\$443.46	\$473.04	\$440.40
Ages 1-14	\$114.54	\$104.81	\$112.73	\$106.26	\$107.01	\$110.92	\$106.41
Ages 15-20	\$157.44	\$141.30	\$160.50	\$147.79	\$144.84	\$151.24	\$148.00
Ages 21-44	\$246.39	\$216.87	\$259.47	\$226.55	\$222.81	\$233.96	\$227.51
Ages 45+	\$335.23	\$292.57	\$303.89	\$302.11	\$301.90	\$318.80	\$302.15
All Ages	\$180.47	\$160.86	\$183.95	\$163.00	\$0.00	\$0.00	\$163.49
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$488.06	\$423.58	\$437.82	\$438.82	\$442.43	\$472.76	\$438.80
Ages 1-14	\$112.95	\$103.59	\$111.03	\$105.22	\$106.33	\$110.73	\$105.35
Ages 15-20	\$154.59	\$139.11	\$157.45	\$145.93	\$143.63	\$150.91	\$146.12
Ages 21-44	\$239.83	\$211.83	\$252.46	\$222.27	\$220.02	\$233.19	\$223.15
Ages 45+	\$327.59	\$286.70	\$295.73	\$297.12	\$298.65	\$317.90	\$297.08
All Ages	\$176.39	\$158.07	\$180.32	\$160.94	\$0.00	\$0.00	\$161.40
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	1	5	24	1,139	1	2	1,172
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,081.30

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Group Health Coop Eau Claire							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	999	1	568	181	-	-	1,749
Ages 1-14	10,407	-	5,489	1,682	2	-	17,580
Ages 15-20	2,496	-	1,138	342	-	1	3,977
Ages 21-44	4,776	-	2,568	743	2	-	8,089
Ages 45+	844	-	377	131	-	-	1,352
All Ages	19,522	1	10,140	3,079	4	1	32,747
2017 All Services Capitation Rate PMPM							
Age 0	\$480.95	\$415.85	\$430.86	\$430.82	\$433.88	\$463.44	\$459.46
Ages 1-14	\$122.53	\$107.04	\$110.50	\$105.04	\$109.22	\$111.76	\$117.10
Ages 15-20	\$161.94	\$142.80	\$153.21	\$135.46	\$146.32	\$151.43	\$157.16
Ages 21-44	\$239.58	\$214.97	\$221.64	\$209.44	\$220.75	\$231.63	\$231.11
Ages 45+	\$320.71	\$291.52	\$306.76	\$256.79	\$300.67	\$317.27	\$310.63
All Ages	\$183.11	\$415.85	\$168.68	\$159.22	\$164.99	\$151.43	\$176.40
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$478.54	\$414.00	\$428.28	\$429.24	\$432.85	\$463.16	\$457.08
Ages 1-14	\$120.94	\$105.82	\$108.80	\$104.00	\$108.54	\$111.57	\$115.53
Ages 15-20	\$159.09	\$140.61	\$150.16	\$133.60	\$145.11	\$151.10	\$154.34
Ages 21-44	\$233.02	\$209.93	\$214.63	\$205.16	\$217.96	\$230.86	\$224.62
Ages 45+	\$313.07	\$285.65	\$298.60	\$251.80	\$297.42	\$316.37	\$303.10
All Ages	\$179.84	\$414.00	\$165.20	\$157.11	\$163.25	\$151.10	\$173.17
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$480.75	\$415.71	\$430.68	\$430.68	\$433.74	\$463.32	\$459.27
Ages 1-14	\$104.49	\$95.09	\$95.26	\$92.77	\$97.29	\$101.20	\$100.49
Ages 15-20	\$145.02	\$131.58	\$138.91	\$123.96	\$135.12	\$141.52	\$141.46
Ages 21-44	\$227.68	\$207.15	\$210.97	\$200.86	\$213.09	\$224.24	\$219.91
Ages 45+	\$307.52	\$282.85	\$294.93	\$247.27	\$292.18	\$309.08	\$298.17
All Ages	\$167.84	\$415.71	\$155.68	\$148.76	\$155.19	\$141.52	\$162.29
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$478.34	\$413.86	\$428.10	\$429.10	\$432.71	\$463.04	\$456.89
Ages 1-14	\$102.90	\$93.87	\$93.56	\$91.73	\$96.61	\$101.01	\$98.91
Ages 15-20	\$142.17	\$129.39	\$135.86	\$122.10	\$133.91	\$141.19	\$138.64
Ages 21-44	\$221.12	\$202.11	\$203.96	\$196.58	\$210.30	\$223.47	\$213.42
Ages 45+	\$299.88	\$276.98	\$286.77	\$242.28	\$288.93	\$308.18	\$290.64
All Ages	\$164.57	\$413.86	\$152.19	\$146.64	\$153.46	\$141.19	\$159.06
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	576	2	328	107	0	0	1,013
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$6,105.35

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Group Health Coop SC WI							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	1	-	203	-	-	204
Ages 1-14	-	1	-	2,070	-	-	2,071
Ages 15-20	-	-	-	518	-	-	518
Ages 21-44	-	-	-	840	-	-	840
Ages 45+	-	-	-	150	-	-	150
All Ages	-	2	-	3,781	-	-	3,783
2017 All Services Capitation Rate PMPM							
Age 0	\$480.67	\$415.57	\$430.58	\$430.54	\$433.60	\$463.16	\$430.47
Ages 1-14	\$122.58	\$106.76	\$112.59	\$109.57	\$108.94	\$111.48	\$109.57
Ages 15-20	\$164.36	\$142.52	\$149.87	\$131.92	\$146.04	\$151.15	\$131.92
Ages 21-44	\$248.29	\$214.69	\$225.69	\$223.91	\$220.47	\$231.35	\$223.91
Ages 45+	\$338.42	\$291.24	\$305.72	\$302.14	\$300.39	\$316.99	\$302.14
All Ages	\$0.00	\$261.17	\$0.00	\$162.91	\$0.00	\$0.00	\$162.96
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$478.26	\$413.72	\$428.00	\$428.96	\$432.57	\$462.88	\$428.89
Ages 1-14	\$120.99	\$105.54	\$110.89	\$108.53	\$108.26	\$111.29	\$108.53
Ages 15-20	\$161.51	\$140.33	\$146.82	\$130.06	\$144.83	\$150.82	\$130.06
Ages 21-44	\$241.73	\$209.65	\$218.68	\$219.63	\$217.68	\$230.58	\$219.63
Ages 45+	\$330.78	\$285.37	\$297.56	\$297.15	\$297.14	\$316.09	\$297.15
All Ages	\$0.00	\$259.63	\$0.00	\$160.85	\$0.00	\$0.00	\$160.90
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$480.47	\$415.43	\$430.40	\$430.40	\$433.46	\$463.04	\$430.33
Ages 1-14	\$104.54	\$94.81	\$97.35	\$97.30	\$97.01	\$100.92	\$97.30
Ages 15-20	\$147.44	\$131.30	\$135.57	\$120.42	\$134.84	\$141.24	\$120.42
Ages 21-44	\$236.39	\$206.87	\$215.02	\$215.33	\$212.81	\$223.96	\$215.33
Ages 45+	\$325.23	\$282.57	\$293.89	\$292.62	\$291.90	\$308.80	\$292.62
All Ages	\$0.00	\$255.12	\$0.00	\$152.32	\$0.00	\$0.00	\$152.38
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$478.06	\$413.58	\$427.82	\$428.82	\$432.43	\$462.76	\$428.75
Ages 1-14	\$102.95	\$93.59	\$95.65	\$96.26	\$96.33	\$100.73	\$96.26
Ages 15-20	\$144.59	\$129.11	\$132.52	\$118.56	\$133.63	\$140.91	\$118.56
Ages 21-44	\$229.83	\$201.83	\$208.01	\$211.05	\$210.02	\$223.19	\$211.05
Ages 45+	\$317.59	\$276.70	\$285.73	\$287.63	\$288.65	\$307.90	\$287.63
All Ages	\$0.00	\$253.59	\$0.00	\$150.26	\$0.00	\$0.00	\$150.32
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	0	0	0	0	0	0	0
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$0.00

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Gundersen Lutheran Health							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	-	721	24	-	-	745
Ages 1-14	-	-	7,478	278	-	-	7,756
Ages 15-20	-	-	1,741	57	-	-	1,798
Ages 21-44	-	-	3,322	156	-	-	3,478
Ages 45+	-	-	621	27	-	-	648
All Ages	-	-	13,883	542	-	-	14,425
2017 All Services Capitation Rate PMPM							
Age 0	\$512.16	\$447.06	\$462.07	\$462.03	\$465.09	\$494.65	\$462.07
Ages 1-14	\$154.07	\$138.25	\$145.30	\$142.46	\$140.43	\$142.97	\$145.20
Ages 15-20	\$195.85	\$174.01	\$178.58	\$177.61	\$177.53	\$182.64	\$178.55
Ages 21-44	\$279.78	\$246.18	\$253.72	\$221.56	\$251.96	\$262.84	\$252.28
Ages 45+	\$369.91	\$322.73	\$313.95	\$332.36	\$331.88	\$348.48	\$314.72
All Ages	\$0.00	\$0.00	\$199.41	\$192.53	\$0.00	\$0.00	\$199.15
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$509.75	\$445.21	\$459.49	\$460.45	\$464.06	\$494.37	\$459.52
Ages 1-14	\$152.48	\$137.03	\$143.60	\$141.42	\$139.75	\$142.78	\$143.52
Ages 15-20	\$193.00	\$171.82	\$175.53	\$175.75	\$176.32	\$182.31	\$175.54
Ages 21-44	\$273.22	\$241.14	\$246.71	\$217.28	\$249.17	\$262.07	\$245.39
Ages 45+	\$362.27	\$316.86	\$305.79	\$327.37	\$328.63	\$347.58	\$306.69
All Ages	\$0.00	\$0.00	\$195.94	\$190.25	\$0.00	\$0.00	\$195.72
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$511.96	\$446.92	\$461.89	\$461.89	\$464.95	\$494.53	\$461.89
Ages 1-14	\$136.03	\$126.30	\$130.06	\$130.19	\$128.50	\$132.41	\$130.06
Ages 15-20	\$178.93	\$162.79	\$164.28	\$166.11	\$166.33	\$172.73	\$164.34
Ages 21-44	\$267.88	\$238.36	\$243.05	\$212.98	\$244.30	\$255.45	\$241.70
Ages 45+	\$356.72	\$314.06	\$302.12	\$322.84	\$323.39	\$340.29	\$302.98
All Ages	\$0.00	\$0.00	\$186.32	\$182.08	\$0.00	\$0.00	\$186.16
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$509.55	\$445.07	\$459.31	\$460.31	\$463.92	\$494.25	\$459.34
Ages 1-14	\$134.44	\$125.08	\$128.36	\$129.15	\$127.82	\$132.22	\$128.39
Ages 15-20	\$176.08	\$160.60	\$161.23	\$164.25	\$165.12	\$172.40	\$161.33
Ages 21-44	\$261.32	\$233.32	\$236.04	\$208.70	\$241.51	\$254.68	\$234.81
Ages 45+	\$349.08	\$308.19	\$293.96	\$317.85	\$320.14	\$339.39	\$294.96
All Ages	\$0.00	\$0.00	\$182.84	\$179.80	\$0.00	\$0.00	\$182.73
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	0	1	487	15	0	0	503
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,451.49

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Health Tradition Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	-	432	9	-	-	441
Ages 1-14	-	-	4,131	67	-	-	4,198
Ages 15-20	-	-	916	12	-	-	928
Ages 21-44	-	-	1,701	37	-	-	1,738
Ages 45+	-	-	323	5	-	-	328
All Ages	-	-	7,503	130	-	-	7,633
2017 All Services Capitation Rate PMPM							
Age 0	\$472.13	\$407.03	\$422.04	\$422.00	\$425.06	\$454.62	\$422.04
Ages 1-14	\$114.04	\$98.22	\$98.61	\$89.54	\$100.40	\$102.94	\$98.47
Ages 15-20	\$155.82	\$133.98	\$131.09	\$137.58	\$137.50	\$142.61	\$131.17
Ages 21-44	\$239.75	\$206.15	\$209.71	\$212.77	\$211.93	\$222.81	\$209.78
Ages 45+	\$329.88	\$282.70	\$300.47	\$292.33	\$291.85	\$308.45	\$300.35
All Ages	\$0.00	\$0.00	\$155.07	\$159.86	\$0.00	\$0.00	\$155.16
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$469.72	\$405.18	\$419.46	\$420.42	\$424.03	\$454.34	\$419.48
Ages 1-14	\$112.45	\$97.00	\$96.91	\$88.50	\$99.72	\$102.75	\$96.78
Ages 15-20	\$152.97	\$131.79	\$128.04	\$135.72	\$136.29	\$142.28	\$128.14
Ages 21-44	\$233.19	\$201.11	\$202.70	\$208.49	\$209.14	\$222.04	\$202.82
Ages 45+	\$322.24	\$276.83	\$292.31	\$287.34	\$288.60	\$307.55	\$292.23
All Ages	\$0.00	\$0.00	\$151.68	\$157.64	\$0.00	\$0.00	\$151.78
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$471.93	\$406.89	\$421.86	\$421.86	\$424.92	\$454.50	\$421.86
Ages 1-14	\$96.00	\$86.27	\$83.37	\$77.27	\$88.47	\$92.38	\$83.27
Ages 15-20	\$138.90	\$122.76	\$116.79	\$126.08	\$126.30	\$132.70	\$116.91
Ages 21-44	\$227.85	\$198.33	\$199.04	\$204.19	\$204.27	\$215.42	\$199.15
Ages 45+	\$316.69	\$274.03	\$288.64	\$282.81	\$283.36	\$300.26	\$288.55
All Ages	\$0.00	\$0.00	\$142.00	\$149.66	\$0.00	\$0.00	\$142.13
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$469.52	\$405.04	\$419.28	\$420.28	\$423.89	\$454.22	\$419.30
Ages 1-14	\$94.41	\$85.05	\$81.67	\$76.23	\$87.79	\$92.19	\$81.58
Ages 15-20	\$136.05	\$120.57	\$113.74	\$124.22	\$125.09	\$132.37	\$113.88
Ages 21-44	\$221.29	\$193.29	\$192.03	\$199.91	\$201.48	\$214.65	\$192.20
Ages 45+	\$309.05	\$268.16	\$280.48	\$277.82	\$280.11	\$299.36	\$280.44
All Ages	\$0.00	\$0.00	\$138.60	\$147.43	\$0.00	\$0.00	\$138.75
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	0	0	221	3	0	1	225
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,460.44

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Independent Care (ICare)							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	158	2	21	110	246	537
Ages 1-14	-	797	9	98	509	1,217	2,630
Ages 15-20	-	180	2	17	127	327	653
Ages 21-44	-	421	4	45	256	751	1,477
Ages 45+	-	54	-	8	30	104	196
All Ages	-	1,610	17	189	1,032	2,645	5,493
2017 All Services Capitation Rate PMPM							
Age 0	\$545.49	\$480.39	\$495.40	\$495.36	\$498.42	\$527.98	\$506.53
Ages 1-14	\$187.40	\$171.58	\$177.41	\$173.93	\$173.76	\$176.30	\$174.29
Ages 15-20	\$229.18	\$207.34	\$214.69	\$210.94	\$210.86	\$215.97	\$212.46
Ages 21-44	\$313.11	\$279.51	\$290.51	\$286.13	\$285.29	\$296.17	\$289.21
Ages 45+	\$403.24	\$356.06	\$370.54	\$365.69	\$365.21	\$381.81	\$371.52
All Ages	\$0.00	\$240.29	\$245.82	\$247.80	\$246.16	\$256.03	\$249.25
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$543.08	\$478.54	\$492.82	\$493.78	\$497.39	\$527.70	\$505.57
Ages 1-14	\$185.81	\$170.36	\$175.71	\$172.89	\$173.08	\$176.11	\$173.66
Ages 15-20	\$226.33	\$205.15	\$211.64	\$209.08	\$209.65	\$215.64	\$211.40
Ages 21-44	\$306.55	\$274.47	\$283.50	\$281.85	\$282.50	\$295.40	\$286.75
Ages 45+	\$395.60	\$350.19	\$362.38	\$360.70	\$361.96	\$380.91	\$368.72
All Ages	\$0.00	\$237.75	\$242.61	\$245.69	\$244.78	\$255.62	\$247.96
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$545.29	\$480.25	\$495.22	\$495.22	\$498.28	\$527.86	\$506.39
Ages 1-14	\$169.36	\$159.63	\$162.17	\$161.66	\$161.83	\$165.74	\$162.97
Ages 15-20	\$212.26	\$196.12	\$200.39	\$199.44	\$199.66	\$206.06	\$201.89
Ages 21-44	\$301.21	\$271.69	\$279.84	\$277.55	\$277.63	\$288.78	\$281.61
Ages 45+	\$390.05	\$347.39	\$358.71	\$356.17	\$356.72	\$373.62	\$363.09
All Ages	\$0.00	\$230.77	\$233.54	\$237.95	\$236.74	\$247.51	\$240.21
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$542.88	\$478.40	\$492.64	\$493.64	\$497.25	\$527.58	\$505.44
Ages 1-14	\$167.77	\$158.41	\$160.47	\$160.62	\$161.15	\$165.55	\$162.33
Ages 15-20	\$209.41	\$193.93	\$197.34	\$197.58	\$198.45	\$205.73	\$200.82
Ages 21-44	\$294.65	\$266.65	\$272.83	\$273.27	\$274.84	\$288.01	\$279.15
Ages 45+	\$382.41	\$341.52	\$350.55	\$351.18	\$353.47	\$372.72	\$360.30
All Ages	\$0.00	\$228.23	\$230.32	\$235.83	\$235.36	\$247.10	\$238.93
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	0	84	0	8	58	149	299
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,314.47

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Mercy Care Insurance Company							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	-	1	590	1	-	592
Ages 1-14	-	3	-	6,377	8	3	6,391
Ages 15-20	-	-	-	1,696	1	-	1,697
Ages 21-44	-	2	-	2,961	3	-	2,966
Ages 45+	-	-	-	413	2	-	415
All Ages	-	5	1	12,037	15	3	12,061
2017 All Services Capitation Rate PMPM							
Age 0	\$475.91	\$410.81	\$425.82	\$425.78	\$428.84	\$458.40	\$425.79
Ages 1-14	\$117.82	\$102.00	\$107.83	\$100.35	\$104.18	\$106.72	\$100.36
Ages 15-20	\$159.60	\$137.76	\$145.11	\$139.35	\$141.28	\$146.39	\$139.35
Ages 21-44	\$243.53	\$209.93	\$220.93	\$212.91	\$215.71	\$226.59	\$212.91
Ages 45+	\$333.66	\$286.48	\$300.96	\$304.47	\$295.63	\$312.23	\$304.43
All Ages	\$0.00	\$145.17	\$425.82	\$156.49	\$176.13	\$106.72	\$156.52
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$473.50	\$408.96	\$423.24	\$424.20	\$427.81	\$458.12	\$424.20
Ages 1-14	\$116.23	\$100.78	\$106.13	\$99.31	\$103.50	\$106.53	\$99.32
Ages 15-20	\$156.75	\$135.57	\$142.06	\$137.49	\$140.07	\$146.06	\$137.49
Ages 21-44	\$236.97	\$204.89	\$213.92	\$208.63	\$212.92	\$225.82	\$208.63
Ages 45+	\$326.02	\$280.61	\$292.80	\$299.48	\$292.38	\$311.33	\$299.45
All Ages	\$0.00	\$142.42	\$423.24	\$154.37	\$174.63	\$106.53	\$154.40
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$475.71	\$410.67	\$425.64	\$425.64	\$428.70	\$458.28	\$425.65
Ages 1-14	\$99.78	\$90.05	\$92.59	\$88.08	\$92.25	\$96.16	\$88.09
Ages 15-20	\$142.68	\$126.54	\$130.81	\$127.85	\$130.08	\$136.48	\$127.85
Ages 21-44	\$231.63	\$202.11	\$210.26	\$204.33	\$208.05	\$219.20	\$204.33
Ages 45+	\$320.47	\$277.81	\$289.13	\$294.95	\$287.14	\$304.04	\$294.91
All Ages	\$0.00	\$134.87	\$425.64	\$145.92	\$166.35	\$96.16	\$145.96
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$473.30	\$408.82	\$423.06	\$424.06	\$427.67	\$458.00	\$424.06
Ages 1-14	\$98.19	\$88.83	\$90.89	\$87.04	\$91.57	\$95.97	\$87.05
Ages 15-20	\$139.83	\$124.35	\$127.76	\$125.99	\$128.87	\$136.15	\$125.99
Ages 21-44	\$225.07	\$197.07	\$203.25	\$200.05	\$205.26	\$218.43	\$200.05
Ages 45+	\$312.83	\$271.94	\$280.97	\$289.96	\$283.89	\$303.14	\$289.93
All Ages	\$0.00	\$132.13	\$423.06	\$143.81	\$164.84	\$95.97	\$143.84
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	1	1	0	376	0	2	380
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,078.75

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard MHS Health Wisconsin							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	175	420	89	189	104	263	1,240
Ages 1-14	1,595	5,897	1,087	2,911	573	1,274	13,337
Ages 15-20	382	1,402	225	725	156	350	3,240
Ages 21-44	740	2,296	478	1,140	290	731	5,675
Ages 45+	107	394	80	193	48	101	923
All Ages	2,999	10,409	1,959	5,158	1,171	2,719	24,415
2017 All Services Capitation Rate PMPM							
Age 0	\$500.20	\$435.10	\$450.11	\$450.07	\$453.13	\$482.69	\$459.25
Ages 1-14	\$131.39	\$123.78	\$120.78	\$124.29	\$124.84	\$127.48	\$124.96
Ages 15-20	\$172.22	\$160.11	\$145.76	\$158.55	\$152.11	\$176.31	\$161.56
Ages 21-44	\$268.80	\$228.88	\$235.18	\$244.66	\$220.73	\$218.61	\$236.05
Ages 45+	\$323.69	\$303.95	\$310.84	\$334.59	\$319.92	\$300.14	\$313.66
All Ages	\$198.88	\$171.24	\$174.29	\$175.52	\$189.37	\$199.04	\$179.75
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$497.79	\$433.25	\$447.53	\$448.49	\$452.10	\$482.41	\$457.71
Ages 1-14	\$129.80	\$122.56	\$119.08	\$123.25	\$124.16	\$127.29	\$123.81
Ages 15-20	\$169.37	\$157.92	\$142.71	\$156.69	\$150.90	\$175.98	\$159.55
Ages 21-44	\$262.24	\$223.84	\$228.17	\$240.38	\$217.94	\$217.84	\$231.46
Ages 45+	\$316.05	\$298.08	\$302.68	\$329.60	\$316.67	\$299.24	\$308.25
All Ages	\$195.64	\$168.84	\$170.83	\$173.48	\$187.96	\$198.64	\$177.51
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$500.00	\$434.96	\$449.93	\$449.93	\$452.99	\$482.57	\$459.11
Ages 1-14	\$113.35	\$111.83	\$105.54	\$112.02	\$112.91	\$116.92	\$112.07
Ages 15-20	\$155.30	\$148.89	\$131.46	\$147.05	\$140.91	\$166.40	\$149.53
Ages 21-44	\$256.90	\$221.06	\$224.51	\$236.08	\$213.07	\$211.22	\$227.37
Ages 45+	\$310.50	\$295.28	\$299.01	\$325.07	\$311.43	\$291.95	\$304.07
All Ages	\$183.71	\$160.90	\$161.09	\$164.72	\$179.79	\$190.51	\$168.73
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$497.59	\$433.11	\$447.35	\$448.35	\$451.96	\$482.29	\$457.57
Ages 1-14	\$111.76	\$110.61	\$103.84	\$110.98	\$112.23	\$116.73	\$110.93
Ages 15-20	\$152.45	\$146.70	\$128.41	\$145.19	\$139.70	\$166.07	\$147.53
Ages 21-44	\$250.34	\$216.02	\$217.50	\$231.80	\$210.28	\$210.45	\$222.78
Ages 45+	\$302.86	\$289.41	\$290.85	\$320.08	\$308.18	\$291.05	\$298.66
All Ages	\$180.47	\$158.50	\$157.64	\$162.68	\$178.38	\$190.11	\$166.49
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	144	321	101	124	48	142	880
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,362.45

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Molina Healthcare							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	55	351	37	83	674	1,745	2,945
Ages 1-14	343	2,976	284	634	8,824	19,998	33,059
Ages 15-20	62	643	51	133	1,950	4,258	7,097
Ages 21-44	181	1,411	137	281	3,514	8,075	13,599
Ages 45+	14	214	16	25	532	941	1,742
All Ages	655	5,595	525	1,156	15,494	35,017	58,442
2017 All Services Capitation Rate PMPM							
Age 0	\$505.47	\$440.37	\$455.38	\$455.34	\$458.40	\$487.96	\$474.52
Ages 1-14	\$135.03	\$129.33	\$134.09	\$131.12	\$127.30	\$131.17	\$130.04
Ages 15-20	\$189.16	\$160.13	\$174.67	\$183.58	\$159.80	\$169.90	\$166.70
Ages 21-44	\$248.07	\$220.48	\$250.66	\$243.51	\$226.53	\$233.70	\$231.04
Ages 45+	\$363.22	\$279.75	\$330.52	\$325.67	\$298.58	\$317.54	\$307.71
All Ages	\$207.37	\$181.12	\$197.08	\$191.96	\$174.18	\$182.31	\$180.65
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$503.06	\$438.52	\$452.80	\$453.76	\$457.37	\$487.68	\$473.78
Ages 1-14	\$133.44	\$128.11	\$132.39	\$130.08	\$126.62	\$130.98	\$129.58
Ages 15-20	\$186.31	\$157.94	\$171.62	\$181.72	\$158.59	\$169.57	\$165.89
Ages 21-44	\$241.51	\$215.44	\$243.65	\$239.23	\$223.74	\$232.93	\$229.09
Ages 45+	\$355.58	\$273.88	\$322.36	\$320.68	\$295.33	\$316.64	\$305.30
All Ages	\$204.09	\$178.61	\$193.61	\$189.92	\$172.85	\$181.95	\$179.73
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$505.27	\$440.23	\$455.20	\$455.20	\$458.26	\$487.84	\$474.39
Ages 1-14	\$116.99	\$117.38	\$118.85	\$118.85	\$115.37	\$120.61	\$118.83
Ages 15-20	\$172.24	\$148.91	\$160.37	\$172.08	\$148.60	\$159.99	\$156.19
Ages 21-44	\$236.17	\$212.66	\$239.99	\$234.93	\$218.87	\$226.31	\$223.42
Ages 45+	\$350.03	\$271.08	\$318.69	\$316.15	\$290.09	\$309.35	\$299.28
All Ages	\$192.74	\$171.16	\$184.29	\$181.61	\$163.94	\$173.15	\$171.00
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$502.86	\$438.38	\$452.62	\$453.62	\$457.23	\$487.56	\$473.65
Ages 1-14	\$115.40	\$116.16	\$117.15	\$117.81	\$114.69	\$120.42	\$118.38
Ages 15-20	\$169.39	\$146.72	\$157.32	\$170.22	\$147.39	\$159.66	\$155.38
Ages 21-44	\$229.61	\$207.62	\$232.98	\$230.65	\$216.08	\$225.54	\$221.47
Ages 45+	\$342.39	\$265.21	\$310.53	\$311.16	\$286.84	\$308.45	\$296.87
All Ages	\$189.46	\$168.65	\$180.81	\$179.56	\$162.61	\$172.78	\$170.08
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	33	228	22	44	570	1,581	2,478
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,495.42

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Network Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	123	716	118	100	140	214	1,411
Ages 1-14	1,300	8,337	1,210	1,261	634	1,021	13,763
Ages 15-20	254	2,072	307	277	132	245	3,287
Ages 21-44	585	3,312	558	460	330	608	5,853
Ages 45+	90	636	92	68	27	57	970
All Ages	2,352	15,073	2,285	2,166	1,263	2,145	25,284
2017 All Services Capitation Rate PMPM							
Age 0	\$498.93	\$433.83	\$448.84	\$448.80	\$451.86	\$481.42	\$450.83
Ages 1-14	\$132.60	\$123.24	\$128.94	\$125.51	\$125.15	\$125.95	\$125.12
Ages 15-20	\$182.73	\$165.11	\$156.55	\$164.67	\$148.90	\$152.51	\$164.04
Ages 21-44	\$258.34	\$227.78	\$231.14	\$236.79	\$208.77	\$207.91	\$228.73
Ages 45+	\$324.70	\$300.49	\$311.34	\$350.56	\$318.65	\$335.25	\$309.82
All Ages	\$195.80	\$174.20	\$181.47	\$176.14	\$189.83	\$193.24	\$179.43
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$496.52	\$431.98	\$446.26	\$447.22	\$450.83	\$481.14	\$449.21
Ages 1-14	\$131.01	\$122.02	\$127.24	\$124.47	\$124.47	\$125.76	\$123.94
Ages 15-20	\$179.88	\$162.92	\$153.50	\$162.81	\$147.69	\$152.18	\$161.93
Ages 21-44	\$251.78	\$222.74	\$224.13	\$232.51	\$205.98	\$207.14	\$223.98
Ages 45+	\$317.06	\$294.62	\$303.18	\$345.57	\$315.40	\$334.35	\$304.00
All Ages	\$192.56	\$171.78	\$177.99	\$174.16	\$188.45	\$192.84	\$177.10
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$498.73	\$433.69	\$448.66	\$448.66	\$451.72	\$481.30	\$450.68
Ages 1-14	\$114.56	\$111.29	\$113.70	\$113.24	\$113.22	\$115.39	\$112.38
Ages 15-20	\$165.81	\$153.89	\$142.25	\$153.17	\$137.70	\$142.60	\$152.17
Ages 21-44	\$246.44	\$219.96	\$220.47	\$228.21	\$201.11	\$200.52	\$220.22
Ages 45+	\$311.51	\$291.82	\$299.51	\$341.04	\$310.16	\$327.06	\$300.41
All Ages	\$180.52	\$163.96	\$168.39	\$165.40	\$180.47	\$184.76	\$168.61
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$496.32	\$431.84	\$446.08	\$447.08	\$450.69	\$481.02	\$449.06
Ages 1-14	\$112.97	\$110.07	\$112.00	\$112.20	\$112.54	\$115.20	\$111.20
Ages 15-20	\$162.96	\$151.70	\$139.20	\$151.31	\$136.49	\$142.27	\$150.06
Ages 21-44	\$239.88	\$214.92	\$213.46	\$223.93	\$198.32	\$199.75	\$215.47
Ages 45+	\$303.87	\$285.95	\$291.35	\$336.05	\$306.91	\$326.16	\$294.58
All Ages	\$177.29	\$161.54	\$164.90	\$163.42	\$179.09	\$184.36	\$166.28
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	100	490	104	63	71	126	954
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,200.44

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Physicians Plus Insurance Co							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	-	-	445	-	-	445
Ages 1-14	-	-	-	4,217	-	-	4,217
Ages 15-20	-	-	-	857	-	1	858
Ages 21-44	-	-	-	1,602	-	-	1,602
Ages 45+	-	-	-	286	-	-	286
All Ages	-	-	-	7,407	-	1	7,408
2017 All Services Capitation Rate PMPM							
Age 0	\$510.01	\$444.91	\$459.92	\$459.88	\$462.94	\$492.50	\$459.88
Ages 1-14	\$151.92	\$136.10	\$141.93	\$139.15	\$138.28	\$140.82	\$139.15
Ages 15-20	\$193.70	\$171.86	\$179.21	\$160.40	\$175.38	\$180.49	\$160.42
Ages 21-44	\$277.63	\$244.03	\$255.03	\$251.34	\$249.81	\$260.69	\$251.34
Ages 45+	\$367.76	\$320.58	\$335.06	\$307.40	\$329.73	\$346.33	\$307.40
All Ages	\$0.00	\$0.00	\$0.00	\$191.64	\$0.00	\$180.49	\$191.64
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$507.60	\$443.06	\$457.34	\$458.30	\$461.91	\$492.22	\$458.30
Ages 1-14	\$150.33	\$134.88	\$140.23	\$138.11	\$137.60	\$140.63	\$138.11
Ages 15-20	\$190.85	\$169.67	\$176.16	\$158.54	\$174.17	\$180.16	\$158.57
Ages 21-44	\$271.07	\$238.99	\$248.02	\$247.06	\$247.02	\$259.92	\$247.06
Ages 45+	\$360.12	\$314.71	\$326.90	\$302.41	\$326.48	\$345.43	\$302.41
All Ages	\$0.00	\$0.00	\$0.00	\$189.62	\$0.00	\$180.16	\$189.62
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$509.81	\$444.77	\$459.74	\$459.74	\$462.80	\$492.38	\$459.74
Ages 1-14	\$133.88	\$124.15	\$126.69	\$126.88	\$126.35	\$130.26	\$126.88
Ages 15-20	\$176.78	\$160.64	\$164.91	\$148.90	\$164.18	\$170.58	\$148.93
Ages 21-44	\$265.73	\$236.21	\$244.36	\$242.76	\$242.15	\$253.30	\$242.76
Ages 45+	\$354.57	\$311.91	\$323.23	\$297.88	\$321.24	\$338.14	\$297.88
All Ages	\$0.00	\$0.00	\$0.00	\$181.09	\$0.00	\$170.58	\$181.09
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$507.40	\$442.92	\$457.16	\$458.16	\$461.77	\$492.10	\$458.16
Ages 1-14	\$132.29	\$122.93	\$124.99	\$125.84	\$125.67	\$130.07	\$125.84
Ages 15-20	\$173.93	\$158.45	\$161.86	\$147.04	\$162.97	\$170.25	\$147.07
Ages 21-44	\$259.17	\$231.17	\$237.35	\$238.48	\$239.36	\$252.53	\$238.48
Ages 45+	\$346.93	\$306.04	\$315.07	\$292.89	\$317.99	\$337.24	\$292.89
All Ages	\$0.00	\$0.00	\$0.00	\$179.07	\$0.00	\$170.25	\$179.07
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	0	0	0	287	0	0	287
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,072.17

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Security Health Plan of Wisconsin							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	1,440	20	890	-	-	-	2,350
Ages 1-14	15,790	192	9,314	4	-	6	25,306
Ages 15-20	4,030	37	2,404	-	-	1	6,472
Ages 21-44	6,892	96	4,125	1	-	1	11,115
Ages 45+	1,515	16	808	1	-	-	2,340
All Ages	29,667	361	17,541	6	-	8	47,583
2017 All Services Capitation Rate PMPM							
Age 0	\$489.80	\$424.70	\$439.71	\$439.67	\$442.73	\$472.29	\$470.28
Ages 1-14	\$135.44	\$110.20	\$127.80	\$118.24	\$118.07	\$120.61	\$132.43
Ages 15-20	\$179.54	\$151.65	\$168.28	\$155.25	\$155.17	\$160.28	\$175.20
Ages 21-44	\$271.50	\$225.49	\$244.34	\$230.44	\$229.60	\$240.48	\$261.02
Ages 45+	\$357.26	\$300.37	\$330.78	\$310.00	\$309.52	\$326.12	\$347.71
All Ages	\$201.57	\$170.96	\$185.93	\$168.90	\$0.00	\$140.55	\$195.56
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$487.39	\$422.85	\$437.13	\$438.09	\$441.70	\$472.01	\$467.81
Ages 1-14	\$133.85	\$108.98	\$126.10	\$117.20	\$117.39	\$120.42	\$130.80
Ages 15-20	\$176.69	\$149.46	\$165.23	\$153.39	\$153.96	\$159.95	\$172.27
Ages 21-44	\$264.94	\$220.45	\$237.33	\$226.16	\$226.81	\$239.71	\$254.30
Ages 45+	\$349.62	\$294.50	\$322.62	\$305.01	\$306.27	\$325.22	\$339.90
All Ages	\$198.30	\$168.38	\$182.45	\$166.66	\$0.00	\$140.27	\$192.22
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$489.60	\$424.56	\$439.53	\$439.53	\$442.59	\$472.17	\$470.08
Ages 1-14	\$117.40	\$98.25	\$112.56	\$105.97	\$106.14	\$110.05	\$115.47
Ages 15-20	\$162.62	\$140.43	\$153.98	\$143.75	\$143.97	\$150.37	\$159.28
Ages 21-44	\$259.60	\$217.67	\$233.67	\$221.86	\$221.94	\$233.09	\$249.61
Ages 45+	\$344.07	\$291.70	\$318.95	\$300.48	\$301.03	\$317.93	\$335.02
All Ages	\$186.22	\$160.98	\$172.81	\$157.70	\$0.00	\$130.47	\$181.07
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$487.19	\$422.71	\$436.95	\$437.95	\$441.56	\$471.89	\$467.61
Ages 1-14	\$115.81	\$97.03	\$110.86	\$104.93	\$105.46	\$109.86	\$113.84
Ages 15-20	\$159.77	\$138.24	\$150.93	\$141.89	\$142.76	\$150.04	\$156.36
Ages 21-44	\$253.04	\$212.63	\$226.66	\$217.58	\$219.15	\$232.32	\$242.90
Ages 45+	\$336.43	\$285.83	\$310.79	\$295.49	\$297.78	\$317.03	\$327.21
All Ages	\$182.95	\$158.41	\$169.34	\$155.47	\$0.00	\$130.19	\$177.74
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	780	16	532	5	1	1	1,335
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$6,156.82

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Trilogy Health Insurance							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	6	76	2	5	75	185	349
Ages 1-14	25	435	34	39	443	1,200	2,176
Ages 15-20	8	100	3	13	118	312	554
Ages 21-44	14	243	11	19	230	604	1,121
Ages 45+	3	25	-	4	27	79	138
All Ages	56	879	50	80	893	2,380	4,338
2017 All Services Capitation Rate PMPM							
Age 0	\$531.11	\$466.01	\$481.02	\$480.98	\$484.04	\$513.60	\$496.53
Ages 1-14	\$173.02	\$157.20	\$163.03	\$159.55	\$159.38	\$161.92	\$160.56
Ages 15-20	\$214.80	\$192.96	\$200.31	\$196.56	\$196.48	\$201.59	\$199.01
Ages 21-44	\$298.73	\$265.13	\$276.13	\$271.75	\$270.91	\$281.79	\$275.93
Ages 45+	\$388.86	\$341.68	\$356.16	\$351.31	\$350.83	\$367.43	\$359.52
All Ages	\$260.35	\$223.05	\$202.87	\$221.89	\$226.06	\$231.70	\$228.64
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$528.70	\$464.16	\$478.44	\$479.40	\$483.01	\$513.32	\$495.68
Ages 1-14	\$171.43	\$155.98	\$161.33	\$158.51	\$158.70	\$161.73	\$160.01
Ages 15-20	\$211.95	\$190.77	\$197.26	\$194.70	\$195.27	\$201.26	\$198.07
Ages 21-44	\$292.17	\$260.09	\$269.12	\$267.47	\$268.12	\$281.02	\$273.63
Ages 45+	\$381.22	\$335.81	\$348.00	\$346.32	\$347.58	\$366.53	\$356.99
All Ages	\$256.92	\$220.48	\$199.88	\$219.72	\$224.66	\$231.31	\$227.50
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$530.91	\$465.87	\$480.84	\$480.84	\$483.90	\$513.48	\$496.40
Ages 1-14	\$154.98	\$145.25	\$147.79	\$147.28	\$147.45	\$151.36	\$149.26
Ages 15-20	\$197.88	\$181.74	\$186.01	\$185.06	\$185.28	\$191.68	\$188.43
Ages 21-44	\$286.83	\$257.31	\$265.46	\$263.17	\$263.25	\$274.40	\$268.28
Ages 45+	\$375.67	\$333.01	\$344.33	\$341.79	\$342.34	\$359.24	\$351.03
All Ages	\$246.17	\$213.44	\$189.29	\$211.52	\$216.42	\$222.92	\$219.36
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$528.50	\$464.02	\$478.26	\$479.26	\$482.87	\$513.20	\$495.55
Ages 1-14	\$153.39	\$144.03	\$146.09	\$146.24	\$146.77	\$151.17	\$148.70
Ages 15-20	\$195.03	\$179.55	\$182.96	\$183.20	\$184.07	\$191.35	\$187.49
Ages 21-44	\$280.27	\$252.27	\$258.45	\$258.89	\$260.46	\$273.63	\$265.98
Ages 45+	\$368.03	\$327.14	\$336.17	\$336.80	\$339.09	\$358.34	\$348.51
All Ages	\$242.75	\$210.87	\$186.31	\$209.34	\$215.02	\$222.53	\$218.22
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	1	24	0	1	30	119	175
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,482.25

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Unitedhealthcare Community Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	653	2,979	260	391	542	1,120	5,945
Ages 1-14	6,893	32,788	2,465	4,743	3,341	6,403	56,633
Ages 15-20	1,502	7,264	580	1,072	951	1,770	13,139
Ages 21-44	3,056	13,992	1,242	2,042	1,888	3,860	26,080
Ages 45+	541	2,381	219	393	428	655	4,617
All Ages	12,645	59,404	4,766	8,641	7,150	13,808	106,414
2017 All Services Capitation Rate PMPM							
Age 0	\$501.31	\$436.21	\$451.22	\$451.18	\$454.24	\$483.80	\$455.61
Ages 1-14	\$141.13	\$128.79	\$129.00	\$127.02	\$132.68	\$138.18	\$131.44
Ages 15-20	\$175.92	\$163.71	\$162.95	\$168.20	\$172.10	\$181.18	\$168.40
Ages 21-44	\$256.81	\$240.33	\$252.56	\$251.50	\$252.32	\$272.37	\$249.33
Ages 45+	\$377.33	\$320.40	\$336.73	\$333.42	\$333.57	\$368.22	\$336.96
All Ages	\$201.93	\$182.43	\$192.45	\$185.60	\$205.92	\$220.15	\$191.92
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$498.90	\$434.36	\$448.64	\$449.60	\$453.21	\$483.52	\$454.06
Ages 1-14	\$139.54	\$127.57	\$127.30	\$125.98	\$132.00	\$137.99	\$130.32
Ages 15-20	\$173.07	\$161.52	\$159.90	\$166.34	\$170.89	\$180.85	\$166.44
Ages 21-44	\$250.25	\$235.29	\$245.55	\$247.22	\$249.53	\$271.60	\$244.87
Ages 45+	\$369.69	\$314.53	\$328.57	\$328.43	\$330.32	\$367.32	\$331.80
All Ages	\$198.68	\$179.97	\$188.86	\$183.49	\$204.43	\$219.74	\$189.68
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$501.11	\$436.07	\$451.04	\$451.04	\$454.10	\$483.68	\$455.47
Ages 1-14	\$123.09	\$116.84	\$113.76	\$114.75	\$120.75	\$127.62	\$118.74
Ages 15-20	\$159.00	\$152.49	\$148.65	\$156.70	\$160.90	\$171.27	\$156.55
Ages 21-44	\$244.91	\$232.51	\$241.89	\$242.92	\$244.66	\$264.98	\$240.91
Ages 45+	\$364.14	\$311.73	\$324.90	\$323.90	\$325.08	\$360.03	\$327.62
All Ages	\$186.63	\$172.26	\$179.50	\$174.97	\$196.31	\$211.52	\$181.22
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$498.70	\$434.22	\$448.46	\$449.46	\$453.07	\$483.40	\$453.91
Ages 1-14	\$121.50	\$115.62	\$112.06	\$113.71	\$120.07	\$127.43	\$117.62
Ages 15-20	\$156.15	\$150.30	\$145.60	\$154.84	\$159.69	\$170.94	\$154.59
Ages 21-44	\$238.35	\$227.47	\$234.88	\$238.64	\$241.87	\$264.21	\$236.45
Ages 45+	\$356.50	\$305.86	\$316.74	\$318.91	\$321.83	\$359.13	\$322.46
All Ages	\$183.39	\$169.81	\$175.90	\$172.86	\$194.82	\$211.11	\$178.98
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	449	1,827	163	266	280	643	3,628
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,237.39

Exhibit 21A Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS, P4P, and Access Payments BadgerCare Plus Standard Unity Healthplans Insurance							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	12	17	815	-	-	844
Ages 1-14	-	86	59	7,914	-	1	8,060
Ages 15-20	-	19	26	1,720	-	-	1,765
Ages 21-44	-	35	42	3,084	-	-	3,161
Ages 45+	-	3	7	596	-	1	607
All Ages	-	155	151	14,129	-	2	14,437
2017 All Services Capitation Rate PMPM							
Age 0	\$516.87	\$451.77	\$466.78	\$466.74	\$469.80	\$499.36	\$466.53
Ages 1-14	\$158.78	\$141.40	\$148.79	\$154.88	\$145.14	\$147.68	\$154.69
Ages 15-20	\$200.56	\$178.72	\$186.07	\$190.95	\$182.24	\$187.35	\$190.75
Ages 21-44	\$284.49	\$250.89	\$261.89	\$249.87	\$256.67	\$267.55	\$250.04
Ages 45+	\$374.62	\$327.44	\$341.92	\$332.51	\$336.59	\$353.19	\$332.63
All Ages	\$0.00	\$198.33	\$231.42	\$205.49	\$0.00	\$250.44	\$205.69
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	\$514.46	\$449.92	\$464.20	\$465.16	\$468.77	\$499.08	\$464.92
Ages 1-14	\$157.19	\$140.18	\$147.09	\$153.84	\$144.46	\$147.49	\$153.64
Ages 15-20	\$197.71	\$176.53	\$183.02	\$189.09	\$181.03	\$187.02	\$188.87
Ages 21-44	\$277.93	\$245.85	\$254.88	\$245.59	\$253.88	\$266.78	\$245.72
Ages 45+	\$366.98	\$321.57	\$333.76	\$327.52	\$333.34	\$352.29	\$327.60
All Ages	\$0.00	\$195.99	\$227.61	\$203.44	\$0.00	\$249.89	\$203.62
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	\$516.67	\$451.63	\$466.60	\$466.60	\$469.66	\$499.24	\$466.39
Ages 1-14	\$140.74	\$129.45	\$133.55	\$142.61	\$133.21	\$137.12	\$142.40
Ages 15-20	\$183.64	\$167.50	\$171.77	\$179.45	\$171.04	\$177.44	\$179.21
Ages 21-44	\$272.59	\$243.07	\$251.22	\$241.29	\$249.01	\$260.16	\$241.44
Ages 45+	\$361.43	\$318.77	\$330.09	\$322.99	\$328.10	\$345.00	\$323.09
All Ages	\$0.00	\$188.38	\$219.47	\$194.93	\$0.00	\$241.06	\$195.12
2017 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	\$514.26	\$449.78	\$464.02	\$465.02	\$468.63	\$498.96	\$464.78
Ages 1-14	\$139.15	\$128.23	\$131.85	\$141.57	\$132.53	\$136.93	\$141.36
Ages 15-20	\$180.79	\$165.31	\$168.72	\$177.59	\$169.83	\$177.11	\$177.33
Ages 21-44	\$266.03	\$238.03	\$244.21	\$237.01	\$246.22	\$259.39	\$237.12
Ages 45+	\$353.79	\$312.90	\$321.93	\$318.00	\$324.85	\$344.10	\$318.06
All Ages	\$0.00	\$186.04	\$215.66	\$192.89	\$0.00	\$240.52	\$193.06
2017 Maternity Kick Payment Base Period Deliveries (November 2014 - October 2015)							
All Ages	0	2	4	402	1	0	409
2017 Maternity Kick Payment (From Exhibit 9)							
All Ages	\$6,666.88	\$4,732.50	\$5,464.65	\$5,072.17	\$5,214.67	\$5,694.41	\$5,074.70

F. BadgerCare Plus Childless Adults (CLA) Rate Exhibits

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
New HMOs							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	7,202	10,078	6,742	11,233	8,265	25,357	68,877
Ages 45+	8,202	8,814	6,022	8,824	6,944	16,249	55,055
All Ages	15,404	18,892	12,764	20,057	15,209	41,606	123,932
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$213.74	\$207.51	\$208.71	\$229.78	\$219.27	\$217.60
Ages 45+	\$419.25	\$396.33	\$383.92	\$387.26	\$426.62	\$407.57	\$404.07
All Ages	\$329.10	\$298.93	\$290.74	\$287.26	\$319.65	\$292.81	\$300.44
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$210.39	\$203.93	\$206.11	\$228.00	\$218.66	\$215.55
Ages 45+	\$414.50	\$391.52	\$378.80	\$383.54	\$424.06	\$406.70	\$400.86
All Ages	\$325.02	\$294.90	\$286.43	\$284.17	\$317.52	\$292.10	\$297.87
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$207.31	\$198.30	\$202.25	\$221.81	\$211.62	\$209.89
Ages 45+	\$403.05	\$385.80	\$368.84	\$376.67	\$413.57	\$395.03	\$391.28
All Ages	\$315.84	\$290.58	\$278.76	\$278.99	\$309.36	\$283.25	\$290.47
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$203.96	\$194.72	\$199.65	\$220.03	\$211.01	\$207.84
Ages 45+	\$398.30	\$380.99	\$363.72	\$372.95	\$411.01	\$394.16	\$388.06
All Ages	\$311.77	\$286.55	\$274.45	\$275.89	\$307.23	\$282.54	\$287.90

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Anthem Blue Cross Blue Shield							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	52	1,298	69	715	1,754	4,228	8,116
Ages 45+	33	951	32	541	1,656	2,899	6,112
All Ages	85	2,249	101	1,256	3,410	7,127	14,228
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$206.84	\$207.51	\$218.74	\$235.65	\$220.57	\$221.40
Ages 45+	\$419.25	\$364.29	\$383.92	\$377.31	\$427.46	\$389.78	\$395.05
All Ages	\$301.29	\$273.42	\$263.40	\$287.04	\$328.80	\$289.40	\$295.99
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$203.49	\$203.93	\$216.14	\$233.87	\$219.96	\$219.88
Ages 45+	\$414.50	\$359.48	\$378.80	\$373.59	\$424.90	\$388.91	\$392.81
All Ages	\$297.42	\$269.45	\$259.33	\$283.96	\$326.64	\$288.68	\$294.17
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$200.41	\$198.30	\$212.28	\$227.68	\$212.92	\$213.95
Ages 45+	\$403.05	\$353.76	\$368.84	\$366.72	\$414.41	\$377.24	\$382.82
All Ages	\$288.94	\$265.25	\$252.33	\$278.80	\$318.36	\$279.76	\$286.49
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$197.06	\$194.72	\$209.68	\$225.90	\$212.31	\$212.43
Ages 45+	\$398.30	\$348.95	\$363.72	\$363.00	\$411.85	\$376.37	\$380.59
All Ages	\$285.07	\$261.29	\$248.26	\$275.72	\$316.20	\$279.04	\$284.67

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Childrens Comm Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	474	-	109	1,447	4,803	6,833
Ages 45+	-	274	-	60	1,024	2,301	3,659
All Ages	-	748	-	169	2,471	7,104	10,492
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$200.14	\$207.51	\$215.26	\$240.39	\$227.93	\$228.44
Ages 45+	\$419.25	\$352.17	\$383.92	\$387.26	\$444.33	\$416.46	\$418.97
All Ages	\$0.00	\$255.83	\$0.00	\$276.33	\$324.90	\$289.00	\$294.88
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$196.79	\$203.93	\$212.66	\$238.61	\$227.32	\$227.36
Ages 45+	\$414.50	\$347.36	\$378.80	\$383.54	\$441.77	\$415.59	\$417.28
All Ages	\$0.00	\$251.95	\$0.00	\$273.33	\$322.80	\$288.30	\$293.59
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$193.71	\$198.30	\$208.80	\$232.42	\$220.28	\$220.82
Ages 45+	\$403.05	\$341.64	\$368.84	\$376.67	\$431.28	\$403.92	\$406.47
All Ages	\$0.00	\$247.90	\$0.00	\$268.40	\$314.83	\$279.76	\$285.57
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$190.36	\$194.72	\$206.20	\$230.64	\$219.67	\$219.74
Ages 45+	\$398.30	\$336.83	\$363.72	\$372.95	\$428.72	\$403.05	\$404.78
All Ages	\$0.00	\$244.01	\$0.00	\$265.40	\$312.73	\$279.07	\$284.27

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Compcare							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	1,031	1	509	434	-	-	1,975
Ages 45+	1,017	-	457	416	-	-	1,890
All Ages	2,048	1	966	850	-	-	3,865
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$212.43	\$213.74	\$203.92	\$208.30	\$229.78	\$219.27	\$209.33
Ages 45+	\$406.99	\$396.33	\$379.82	\$337.92	\$426.62	\$407.57	\$385.22
All Ages	\$309.05	\$213.74	\$287.14	\$271.74	\$0.00	\$0.00	\$295.34
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$209.12	\$210.39	\$200.34	\$205.70	\$228.00	\$218.66	\$206.11
Ages 45+	\$402.24	\$391.52	\$374.70	\$334.20	\$424.06	\$406.70	\$380.60
All Ages	\$305.02	\$210.39	\$282.83	\$268.59	\$0.00	\$0.00	\$291.44
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$202.53	\$207.31	\$194.71	\$201.84	\$221.81	\$211.62	\$200.37
Ages 45+	\$390.79	\$385.80	\$364.74	\$327.33	\$413.57	\$395.03	\$370.52
All Ages	\$296.02	\$207.31	\$275.15	\$263.26	\$0.00	\$0.00	\$283.57
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$199.22	\$203.96	\$191.13	\$199.24	\$220.03	\$211.01	\$197.14
Ages 45+	\$386.04	\$380.99	\$359.62	\$323.61	\$411.01	\$394.16	\$365.91
All Ages	\$291.99	\$203.96	\$270.84	\$260.11	\$0.00	\$0.00	\$279.67

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Dean Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	1	30	2,268	-	1	2,300
Ages 45+	-	-	41	2,101	-	-	2,142
All Ages	-	1	71	4,369	-	1	4,442
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$213.74	\$207.51	\$221.82	\$229.78	\$219.27	\$221.63
Ages 45+	\$419.25	\$396.33	\$383.92	\$386.11	\$426.62	\$407.57	\$386.07
All Ages	\$0.00	\$213.74	\$309.38	\$300.83	\$0.00	\$219.27	\$300.92
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$210.39	\$203.93	\$219.22	\$228.00	\$218.66	\$219.02
Ages 45+	\$414.50	\$391.52	\$378.80	\$382.39	\$424.06	\$406.70	\$382.32
All Ages	\$0.00	\$210.39	\$304.91	\$297.69	\$0.00	\$218.66	\$297.76
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$207.31	\$198.30	\$215.36	\$221.81	\$211.62	\$215.13
Ages 45+	\$403.05	\$385.80	\$368.84	\$375.52	\$413.57	\$395.03	\$375.39
All Ages	\$0.00	\$207.31	\$296.78	\$292.38	\$0.00	\$211.62	\$292.41
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$203.96	\$194.72	\$212.76	\$220.03	\$211.01	\$212.52
Ages 45+	\$398.30	\$380.99	\$363.72	\$371.80	\$411.01	\$394.16	\$371.65
All Ages	\$0.00	\$203.96	\$292.31	\$289.24	\$0.00	\$211.01	\$289.25

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Group Health Coop Eau Claire							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	1,685	-	1,157	476	-	-	3,318
Ages 45+	1,898	-	925	396	-	-	3,219
All Ages	3,583	-	2,082	872	-	-	6,537
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$228.40	\$213.74	\$214.10	\$197.24	\$229.78	\$219.27	\$218.94
Ages 45+	\$399.64	\$396.33	\$399.59	\$337.92	\$426.62	\$407.57	\$392.03
All Ages	\$319.11	\$0.00	\$296.51	\$261.13	\$0.00	\$0.00	\$304.18
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$225.09	\$210.39	\$210.52	\$194.64	\$228.00	\$218.66	\$215.64
Ages 45+	\$394.89	\$391.52	\$394.47	\$334.20	\$424.06	\$406.70	\$387.30
All Ages	\$315.04	\$0.00	\$292.25	\$258.02	\$0.00	\$0.00	\$300.17
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$218.50	\$207.31	\$204.89	\$190.78	\$221.81	\$211.62	\$209.78
Ages 45+	\$383.44	\$385.80	\$384.51	\$327.33	\$413.57	\$395.03	\$376.84
All Ages	\$305.87	\$0.00	\$284.69	\$252.79	\$0.00	\$0.00	\$292.05
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$215.19	\$203.96	\$201.31	\$188.18	\$220.03	\$211.01	\$206.48
Ages 45+	\$378.69	\$380.99	\$379.39	\$323.61	\$411.01	\$394.16	\$372.12
All Ages	\$301.80	\$0.00	\$280.43	\$249.68	\$0.00	\$0.00	\$288.04

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Group Health Coop SC WI							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	-	1	1,367	-	-	1,368
Ages 45+	-	-	-	655	-	-	655
All Ages	-	-	1	2,022	-	-	2,023
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$213.74	\$207.51	\$188.03	\$229.78	\$219.27	\$188.04
Ages 45+	\$419.25	\$396.33	\$383.92	\$353.22	\$426.62	\$407.57	\$353.22
All Ages	\$0.00	\$0.00	\$207.51	\$241.54	\$0.00	\$0.00	\$241.52
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$210.39	\$203.93	\$185.43	\$228.00	\$218.66	\$185.44
Ages 45+	\$414.50	\$391.52	\$378.80	\$349.50	\$424.06	\$406.70	\$349.50
All Ages	\$0.00	\$0.00	\$203.93	\$238.58	\$0.00	\$0.00	\$238.56
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$207.31	\$198.30	\$181.57	\$221.81	\$211.62	\$181.58
Ages 45+	\$403.05	\$385.80	\$368.84	\$342.63	\$413.57	\$395.03	\$342.63
All Ages	\$0.00	\$0.00	\$198.30	\$233.74	\$0.00	\$0.00	\$233.73
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$203.96	\$194.72	\$178.97	\$220.03	\$211.01	\$178.98
Ages 45+	\$398.30	\$380.99	\$363.72	\$338.91	\$411.01	\$394.16	\$338.91
All Ages	\$0.00	\$0.00	\$194.72	\$230.78	\$0.00	\$0.00	\$230.76

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Gundersen Lutheran Health							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	-	1,190	87	-	-	1,277
Ages 45+	-	-	1,156	79	-	-	1,235
All Ages	-	-	2,346	166	-	-	2,512
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$213.74	\$217.10	\$208.71	\$229.78	\$219.27	\$216.53
Ages 45+	\$419.25	\$396.33	\$374.97	\$318.03	\$426.62	\$407.57	\$371.33
All Ages	\$0.00	\$0.00	\$294.89	\$260.74	\$0.00	\$0.00	\$292.63
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$210.39	\$213.52	\$206.11	\$228.00	\$218.66	\$213.02
Ages 45+	\$414.50	\$391.52	\$369.85	\$314.31	\$424.06	\$406.70	\$366.30
All Ages	\$0.00	\$0.00	\$290.55	\$257.60	\$0.00	\$0.00	\$288.37
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$207.31	\$207.89	\$202.25	\$221.81	\$211.62	\$207.51
Ages 45+	\$403.05	\$385.80	\$359.89	\$307.44	\$413.57	\$395.03	\$356.53
All Ages	\$0.00	\$0.00	\$282.79	\$252.31	\$0.00	\$0.00	\$280.77
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$203.96	\$204.31	\$199.65	\$220.03	\$211.01	\$203.99
Ages 45+	\$398.30	\$380.99	\$354.77	\$303.72	\$411.01	\$394.16	\$351.50
All Ages	\$0.00	\$0.00	\$278.45	\$249.18	\$0.00	\$0.00	\$276.52

Exhibit 21B Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates including CDPS and P4P BadgerCare Plus Childless Adults Health Tradition Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	-	646	4	-	-	650
Ages 45+	-	-	541	4	-	-	545
All Ages	-	-	1,187	8	-	-	1,195
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$213.74	\$214.70	\$208.71	\$229.78	\$219.27	\$214.66
Ages 45+	\$419.25	\$396.33	\$375.71	\$387.26	\$426.62	\$407.57	\$375.79
All Ages	\$0.00	\$0.00	\$288.08	\$297.99	\$0.00	\$0.00	\$288.15
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$210.39	\$211.12	\$206.11	\$228.00	\$218.66	\$211.09
Ages 45+	\$414.50	\$391.52	\$370.59	\$383.54	\$424.06	\$406.70	\$370.69
All Ages	\$0.00	\$0.00	\$283.80	\$294.83	\$0.00	\$0.00	\$283.88
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$207.31	\$205.49	\$202.25	\$221.81	\$211.62	\$205.47
Ages 45+	\$403.05	\$385.80	\$360.63	\$376.67	\$413.57	\$395.03	\$360.75
All Ages	\$0.00	\$0.00	\$276.20	\$289.46	\$0.00	\$0.00	\$276.29
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$203.96	\$201.91	\$199.65	\$220.03	\$211.01	\$201.90
Ages 45+	\$398.30	\$380.99	\$355.51	\$372.95	\$411.01	\$394.16	\$355.64
All Ages	\$0.00	\$0.00	\$271.92	\$286.30	\$0.00	\$0.00	\$272.01

Exhibit 21B Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates including CDPS and P4P BadgerCare Plus Childless Adults Independent Care (ICare)							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	628	19	52	531	2,335	3,565
Ages 45+	-	410	4	38	428	1,692	2,572
All Ages	-	1,038	23	90	959	4,027	6,137
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$200.56	\$207.51	\$208.71	\$209.02	\$234.20	\$224.01
Ages 45+	\$419.25	\$372.88	\$383.92	\$387.26	\$403.43	\$426.17	\$413.25
All Ages	\$0.00	\$268.62	\$238.19	\$284.10	\$295.78	\$314.86	\$303.32
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$197.21	\$203.93	\$206.11	\$207.24	\$233.59	\$222.70
Ages 45+	\$414.50	\$368.07	\$378.80	\$383.54	\$400.87	\$425.30	\$411.42
All Ages	\$0.00	\$264.70	\$234.34	\$281.02	\$293.66	\$314.14	\$301.79
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$194.13	\$198.30	\$202.25	\$201.05	\$226.55	\$216.54
Ages 45+	\$403.05	\$362.35	\$368.84	\$376.67	\$390.38	\$413.63	\$400.97
All Ages	\$0.00	\$260.58	\$227.96	\$275.89	\$285.55	\$305.15	\$293.83
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$190.78	\$194.72	\$199.65	\$199.27	\$225.94	\$215.22
Ages 45+	\$398.30	\$357.54	\$363.72	\$372.95	\$387.82	\$412.76	\$399.14
All Ages	\$0.00	\$256.65	\$224.11	\$272.82	\$283.42	\$304.44	\$292.30

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Mercy Care Insurance Company							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	1	-	1,182	-	-	1,183
Ages 45+	-	-	-	1,095	-	-	1,095
All Ages	-	1	-	2,277	-	-	2,278
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$213.74	\$207.51	\$223.04	\$229.78	\$219.27	\$223.03
Ages 45+	\$419.25	\$396.33	\$383.92	\$395.29	\$426.62	\$407.57	\$395.29
All Ages	\$0.00	\$213.74	\$0.00	\$305.87	\$0.00	\$0.00	\$305.83
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$210.39	\$203.93	\$220.44	\$228.00	\$218.66	\$220.43
Ages 45+	\$414.50	\$391.52	\$378.80	\$391.57	\$424.06	\$406.70	\$391.57
All Ages	\$0.00	\$210.39	\$0.00	\$302.74	\$0.00	\$0.00	\$302.70
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$207.31	\$198.30	\$216.58	\$221.81	\$211.62	\$216.57
Ages 45+	\$403.05	\$385.80	\$368.84	\$384.70	\$413.57	\$395.03	\$384.70
All Ages	\$0.00	\$207.31	\$0.00	\$297.43	\$0.00	\$0.00	\$297.39
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$203.96	\$194.72	\$213.98	\$220.03	\$211.01	\$213.97
Ages 45+	\$398.30	\$380.99	\$363.72	\$380.98	\$411.01	\$394.16	\$380.98
All Ages	\$0.00	\$203.96	\$0.00	\$294.29	\$0.00	\$0.00	\$294.25

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
MHS Health Wisconsin							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	403	968	308	555	519	1,947	4,700
Ages 45+	373	753	228	413	330	1,044	3,141
All Ages	776	1,721	536	968	849	2,991	7,841
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$221.40	\$217.09	\$195.13	\$200.93	\$202.93	\$200.87	\$205.83
Ages 45+	\$413.53	\$405.71	\$379.07	\$381.14	\$410.18	\$403.93	\$401.35
All Ages	\$313.75	\$299.62	\$273.37	\$277.82	\$283.49	\$271.75	\$284.15
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$218.09	\$213.74	\$191.55	\$198.33	\$201.15	\$200.26	\$203.86
Ages 45+	\$408.78	\$400.90	\$373.95	\$377.42	\$407.62	\$403.06	\$398.22
All Ages	\$309.75	\$295.63	\$269.14	\$274.74	\$281.40	\$271.05	\$281.72
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$211.50	\$210.66	\$185.92	\$194.47	\$194.96	\$193.22	\$198.24
Ages 45+	\$397.33	\$395.18	\$363.99	\$370.55	\$397.13	\$391.39	\$388.88
All Ages	\$300.82	\$291.39	\$261.67	\$269.60	\$273.54	\$262.39	\$274.61
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$208.19	\$207.31	\$182.34	\$191.87	\$193.18	\$192.61	\$196.28
Ages 45+	\$392.58	\$390.37	\$358.87	\$366.83	\$394.57	\$390.52	\$385.74
All Ages	\$296.82	\$287.41	\$257.43	\$266.52	\$271.46	\$261.69	\$272.17

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Molina Healthcare							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	175	837	139	199	1,073	3,203	5,626
Ages 45+	121	644	85	175	682	1,657	3,364
All Ages	296	1,481	224	374	1,755	4,860	8,990
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$203.90	\$202.44	\$185.74	\$202.98	\$200.44	\$209.10	\$205.50
Ages 45+	\$347.35	\$352.56	\$288.42	\$399.12	\$386.99	\$374.02	\$370.72
All Ages	\$262.54	\$267.72	\$224.70	\$294.76	\$272.93	\$265.33	\$267.33
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$200.59	\$199.09	\$182.16	\$200.38	\$198.66	\$208.49	\$204.03
Ages 45+	\$342.60	\$347.75	\$283.30	\$395.40	\$384.43	\$373.15	\$368.36
All Ages	\$258.64	\$263.73	\$220.54	\$291.63	\$270.85	\$264.63	\$265.52
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$194.00	\$196.01	\$176.53	\$196.52	\$192.47	\$201.45	\$197.91
Ages 45+	\$331.15	\$342.03	\$273.34	\$388.53	\$373.94	\$361.48	\$358.37
All Ages	\$250.06	\$259.51	\$213.27	\$286.36	\$262.99	\$256.01	\$257.95
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$190.69	\$192.66	\$172.95	\$193.92	\$190.69	\$200.84	\$196.44
Ages 45+	\$326.40	\$337.22	\$268.22	\$384.81	\$371.38	\$360.61	\$356.01
All Ages	\$246.17	\$255.52	\$209.10	\$283.24	\$260.91	\$255.31	\$256.15

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Network Health Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	350	1,339	328	362	467	1,762	4,608
Ages 45+	323	1,238	307	230	307	872	3,277
All Ages	673	2,577	635	592	774	2,634	7,885
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$203.03	\$205.37	\$167.57	\$166.53	\$219.85	\$179.67	\$191.09
Ages 45+	\$417.62	\$393.99	\$359.30	\$398.74	\$394.16	\$368.36	\$386.60
All Ages	\$306.02	\$295.98	\$260.26	\$256.75	\$288.99	\$242.14	\$272.34
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$199.72	\$202.02	\$163.99	\$163.93	\$218.07	\$179.06	\$188.99
Ages 45+	\$412.87	\$389.18	\$354.18	\$395.02	\$391.60	\$367.49	\$383.10
All Ages	\$302.02	\$291.93	\$255.94	\$253.71	\$286.90	\$241.44	\$269.66
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$193.13	\$198.94	\$158.36	\$160.07	\$211.88	\$172.02	\$183.57
Ages 45+	\$401.42	\$383.46	\$344.22	\$388.15	\$381.11	\$355.82	\$374.31
All Ages	\$293.10	\$287.58	\$248.22	\$248.68	\$279.00	\$232.87	\$262.84
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$189.82	\$195.59	\$154.78	\$157.47	\$210.10	\$171.41	\$181.48
Ages 45+	\$396.67	\$378.65	\$339.10	\$384.43	\$378.55	\$354.95	\$370.81
All Ages	\$289.10	\$283.53	\$243.89	\$245.65	\$276.91	\$232.17	\$260.16

Exhibit 21B Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates including CDPS and P4P BadgerCare Plus Childless Adults Physicians Plus Insurance Co							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	1	-	-	1,781	-	-	1,782
Ages 45+	-	-	-	1,044	-	-	1,044
All Ages	1	-	-	2,825	-	-	2,826
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$213.74	\$207.51	\$191.51	\$229.78	\$219.27	\$191.53
Ages 45+	\$419.25	\$396.33	\$383.92	\$389.17	\$426.62	\$407.57	\$389.17
All Ages	\$226.43	\$0.00	\$0.00	\$264.56	\$0.00	\$0.00	\$264.54
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$210.39	\$203.93	\$188.91	\$228.00	\$218.66	\$188.93
Ages 45+	\$414.50	\$391.52	\$378.80	\$385.45	\$424.06	\$406.70	\$385.45
All Ages	\$223.12	\$0.00	\$0.00	\$261.54	\$0.00	\$0.00	\$261.53
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$207.31	\$198.30	\$185.05	\$221.81	\$211.62	\$185.07
Ages 45+	\$403.05	\$385.80	\$368.84	\$378.58	\$413.57	\$395.03	\$378.58
All Ages	\$216.53	\$0.00	\$0.00	\$256.57	\$0.00	\$0.00	\$256.56
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$203.96	\$194.72	\$182.45	\$220.03	\$211.01	\$182.47
Ages 45+	\$398.30	\$380.99	\$363.72	\$374.86	\$411.01	\$394.16	\$374.86
All Ages	\$213.22	\$0.00	\$0.00	\$253.56	\$0.00	\$0.00	\$253.54

Exhibit 21B Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates including CDPS and P4P BadgerCare Plus Childless Adults Security Health Plan of Wisconsin							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	2,249	43	1,572	1	-	-	3,865
Ages 45+	3,219	52	1,681	-	-	-	4,952
All Ages	5,468	95	3,253	1	-	-	8,817
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$244.36	\$213.74	\$214.90	\$208.71	\$229.78	\$219.27	\$232.03
Ages 45+	\$441.31	\$396.33	\$394.74	\$387.26	\$426.62	\$407.57	\$425.03
All Ages	\$360.30	\$313.68	\$307.83	\$208.71	\$0.00	\$0.00	\$340.43
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$241.05	\$210.39	\$211.32	\$206.11	\$228.00	\$218.66	\$228.61
Ages 45+	\$436.56	\$391.52	\$389.62	\$383.54	\$424.06	\$406.70	\$420.15
All Ages	\$356.15	\$309.53	\$303.46	\$206.11	\$0.00	\$0.00	\$336.19
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$234.46	\$207.31	\$205.69	\$202.25	\$221.81	\$211.62	\$222.45
Ages 45+	\$425.11	\$385.80	\$379.66	\$376.67	\$413.57	\$395.03	\$409.27
All Ages	\$346.70	\$305.01	\$295.59	\$202.25	\$0.00	\$0.00	\$327.37
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$231.15	\$203.96	\$202.11	\$199.65	\$220.03	\$211.01	\$219.03
Ages 45+	\$420.36	\$380.99	\$374.54	\$372.95	\$411.01	\$394.16	\$404.39
All Ages	\$342.54	\$300.86	\$291.21	\$199.65	\$0.00	\$0.00	\$323.14

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Trilogy Health Insurance							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	9	328	23	28	356	1,614	2,358
Ages 45+	3	130	11	12	177	721	1,054
All Ages	12	458	34	40	533	2,335	3,412
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$154.54	\$207.51	\$208.71	\$164.34	\$176.42	\$172.43
Ages 45+	\$419.25	\$341.23	\$383.92	\$387.26	\$416.92	\$355.42	\$364.84
All Ages	\$274.64	\$207.53	\$264.58	\$262.28	\$248.22	\$231.69	\$231.87
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$151.19	\$203.93	\$206.11	\$162.56	\$175.81	\$171.20
Ages 45+	\$414.50	\$336.42	\$378.80	\$383.54	\$414.36	\$354.55	\$363.11
All Ages	\$270.97	\$203.77	\$260.51	\$259.34	\$246.18	\$231.00	\$230.48
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$148.11	\$198.30	\$202.25	\$156.37	\$168.77	\$164.89
Ages 45+	\$403.05	\$330.70	\$368.84	\$376.67	\$403.87	\$342.88	\$352.45
All Ages	\$263.16	\$199.94	\$253.47	\$254.58	\$238.56	\$222.53	\$222.83
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$144.76	\$194.72	\$199.65	\$154.59	\$168.16	\$163.66
Ages 45+	\$398.30	\$325.89	\$363.72	\$372.95	\$401.31	\$342.01	\$350.72
All Ages	\$259.49	\$196.17	\$249.40	\$251.64	\$236.52	\$221.84	\$221.45

Exhibit 21B							
Wisconsin Department of Health Services							
2017 BadgerCare Plus Capitation Rate Development							
Final Capitation Rates including CDPS and P4P							
BadgerCare Plus Childless Adults							
Unitedhealthcare Community Plan							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	1,247	4,156	747	1,007	2,118	5,464	14,739
Ages 45+	1,215	4,361	552	896	2,340	5,063	14,427
All Ages	2,462	8,517	1,299	1,903	4,458	10,527	29,166
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$214.40	\$228.38	\$189.34	\$224.48	\$257.54	\$242.21	\$234.27
Ages 45+	\$410.26	\$415.48	\$385.41	\$410.98	\$441.37	\$433.44	\$424.11
All Ages	\$311.06	\$324.18	\$272.66	\$312.29	\$354.03	\$334.18	\$328.18
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$211.09	\$225.03	\$185.76	\$221.88	\$255.76	\$241.60	\$232.20
Ages 45+	\$405.51	\$410.67	\$380.29	\$407.26	\$438.81	\$432.57	\$421.11
All Ages	\$307.04	\$320.08	\$268.42	\$309.16	\$351.84	\$333.45	\$325.65
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$204.50	\$221.95	\$180.13	\$218.02	\$249.57	\$234.56	\$226.73
Ages 45+	\$394.06	\$404.95	\$370.33	\$400.39	\$428.32	\$420.90	\$411.81
All Ages	\$298.05	\$315.65	\$260.95	\$303.89	\$343.40	\$324.18	\$318.28
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$201.19	\$218.60	\$176.55	\$215.42	\$247.79	\$233.95	\$224.66
Ages 45+	\$389.31	\$400.14	\$365.21	\$396.67	\$425.76	\$420.03	\$408.81
All Ages	\$294.03	\$311.55	\$256.72	\$300.76	\$341.21	\$323.45	\$315.75

Exhibit 21B Wisconsin Department of Health Services 2017 BadgerCare Plus Capitation Rate Development Final Capitation Rates including CDPS and P4P BadgerCare Plus Childless Adults Unity Healthplans Insurance							
August 2016 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	4	4	606	-	-	614
Ages 45+	-	1	2	669	-	-	672
All Ages	-	5	6	1,275	-	-	1,286
2017 All Services Capitation Rate PMPM							
Ages 19-44	\$226.43	\$213.74	\$207.51	\$233.08	\$229.78	\$219.27	\$232.79
Ages 45+	\$419.25	\$396.33	\$383.92	\$448.84	\$426.62	\$407.57	\$448.57
All Ages	\$0.00	\$250.26	\$266.31	\$346.29	\$0.00	\$0.00	\$345.54
2017 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	\$223.12	\$210.39	\$203.93	\$230.48	\$228.00	\$218.66	\$230.18
Ages 45+	\$414.50	\$391.52	\$378.80	\$445.12	\$424.06	\$406.70	\$444.84
All Ages	\$0.00	\$246.62	\$262.22	\$343.10	\$0.00	\$0.00	\$342.35
2017 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	\$216.53	\$207.31	\$198.30	\$226.62	\$221.81	\$211.62	\$226.31
Ages 45+	\$403.05	\$385.80	\$368.84	\$438.25	\$413.57	\$395.03	\$437.97
All Ages	\$0.00	\$243.01	\$255.15	\$337.66	\$0.00	\$0.00	\$336.91
2017 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	\$213.22	\$203.96	\$194.72	\$224.02	\$220.03	\$211.01	\$223.70
Ages 45+	\$398.30	\$380.99	\$363.72	\$434.53	\$411.01	\$394.16	\$434.24
All Ages	\$0.00	\$239.37	\$251.05	\$334.48	\$0.00	\$0.00	\$333.72

DIVISION OF MEDICAID SERVICES

1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Scott Walker
Governor



State of Wisconsin
Department of Health Services

Linda Seemeyer
Secretary

Telephone: 608-266-8922
Fax: 608-266-1086
TTY: 711

July 13, 2018

Mr. David J. Kautter
Acting Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Preliminary Calculations (Letters 5066C) for Managed Care Organizations that Provide Medicaid Services

Dear Commissioner Kautter:

The Wisconsin Department of Health Services (DHS), Division of Medicaid Services (DMS) oversees the administration of the Medicaid program in Wisconsin. Medicaid provides health care coverage for more than 1.2 million low-income residents of Wisconsin. The programs cover half of all children in Wisconsin and helps provide care for two-thirds of Wisconsin nursing home residents. Most Medicaid services are currently delivered through managed care health plans under contract with the Department.

We take seriously our responsibility to assist those that rely upon Medicaid for their health care needs. As such, the more resources we have available, the more we are able to assist members of our programs. It was, thus, disappointing to see the Letter 5066Cs that you sent to our Medicaid managed care organizations regarding your agency's calculations for the Health Insurance Providers Fee for Fee Year 2018.

As a Defendant in the matter, you are aware that Wisconsin, along with five other States, challenged the Health Insurance Providers Fee (HIPF) as reimbursed by the states to the Medicaid managed care contracts. On March 5, 2018, the United States District Court for the Northern District of Texas ruled that "[i]n the ACA [(Affordable Care Act)], Congress expressly exempted states from paying the HIPF." *Id.* at *2 (citing ACA § 9010(c)(2)(B) (2010); 26 C.F.R. § 57.2(b)(2)(ii)(B)). *Texas et al. v. United States et al.*, No. 7:15-cv-00151, 2018 WL 1478250 (N.D. Tex. Mar. 5, 2018).

By burdening our Medicaid MCOs with the imposition of the HIPF, you burden Wisconsin and the members that rely upon the program and services. As the court found, "[s]ince the HIPF is a non-deductible tax, ASOP 49 effectively required states to pay MCOs the full amount of the HIPF in their capitation rates, because an AAA actuary could no longer certify the capitation rate as actuarially sound unless it did so." *Id.* at *5 (footnote omitted). Therefore, if you impose the HIPF on our Medicaid MCOs, you impose the HIPF on Wisconsin and harm

both the members of the Medicaid program and the taxpayers of the state who contribute to the state share of Medicaid costs. Apart from the direct harm, imposition of the HIPF against MCOs that will be reimbursed by Wisconsin Medicaid fails to recognize that “[t]he ACA explicitly excludes states from the definition of ‘covered entities,’ thereby exempting them from paying the HIPF.” *Id.* (citing ACA § 9010(c)(2)(B)).

Given these circumstances, the IRS inclusion of contracts for Medicaid in calculating HIPF allocations fails to account for the express language of Congress, and also for the court’s ruling (which involves your agency as a Defendant), as well as the needs of Medicaid members. In as much as the ACA is designed to help more Americans with their health care needs, the efforts of the IRS are presently imposing a direct harm upon the Medicaid program that assists those most in need.

As you know, the calculations performed by the IRS for the 2018 Fee Year are a ratio-based distribution of a predetermined liability of \$14,300,000,000. By whatever measure, the result of your calculations still yields \$14,300,000,000 into the Federal Treasury. Your present methodology of calculations functions as a federal tax upon Medicaid despite IRS discretion to honor the clear language of Congress and appropriately exempt Medicaid and CHIP contracts from consideration.

Given the undeniable exemption from the HIPF provided by Congress, the ruling of the court, and considering the negative impact your calculations are having upon Medicaid and CHIP, the Internal Revenue Service should not calculate the HIPF in the manner currently being employed. Accordingly, IRS should not include premiums for public health care programs for the six States involved in the lawsuit (Texas, Indiana, Kansas, Louisiana, Nebraska, and Wisconsin) in its calculations for the HIPF for Fee Year 2018, or any other year.

The final notice that the IRS will provide to MCOs on or before August 31, 2018 should be appropriately amended to exclude from calculations and allocated amounts all premiums for public health care programs in Texas, Indiana, Kansas, Louisiana, Nebraska, and Wisconsin.

In advance, we thank you for your time and attention to correcting this.

Sincerely,

A handwritten signature in black ink, appearing to read "Heather K. Smith". The signature is fluid and cursive, with the first name being the most prominent.

Heather K. Smith

Wisconsin Medicaid Director

From: Anderson, Gina M - DHS **On Behalf Of** Smith, Heather K - DHS

Sent: Tuesday, July 10, 2018 2:52 PM

To: DHS DL Encounter Data Technical Work Group Conference Call; DHS DL HMO Contract Administrator Meeting

Cc: Miller, Fratney L - DHS; Lillethun, Chad W - DHS; Nerad, Benjamin M - DHS; Currans-Henry, Rachel H - DHS; Tufto, Matthew A - DHS; Cummings, Grant R - DHS; Katz, Marci - DHS (Marci S Katz Assoc); Hoeft, Bryan J - DHS; Wagner, Makalah - DHS

Subject: DOJ Request: Health Insurance Provider Fee Follow- up

Greetings,

The Department of Health Services, Division of Medicaid services would like you to be aware of your right to challenge the IRS preliminary calculation the Health Insurance Provider Fee, and would like to draw your attention to the deadline for doing so, which is July 15.

Because of the State of Wisconsin's legal strategy at use in current litigation, the Wisconsin Department of Justice is requesting that HMOs serving Medicaid clients avail themselves of this process and request that the IRS exclude the value of Medicaid premiums from the calculation of premiums upon which the HIPF is calculated.

IRS guidance is attached, but the error correction report process simply requires each HMO to submit to the IRS:

- 1) a new Form 8396 that subtracts the amount of premiums attributable to Medicaid, and has a check mark in the "Corrected Form" box on the form, and
- 2) a brief cover letter indicating: "This Corrected Form 8963 does not include Medicaid premiums in light of the decision in *Texas et al. v. United States et al.*, issued by the Northern District of Texas on March 5, 2018".

If DHS/DMS can be of any assistance to you, please let us know.

Thank you,
Heather K. Smith
Medicaid Director

Part III – Administrative, Procedural, and Miscellaneous

Health Insurance Providers Fee; Procedural and Administrative Guidance

Notice 2013-76

Purpose

This notice provides guidance on the health insurance providers fee related to (1) the time and manner for submitting Form 8963, “Report of Health Insurance Provider Information,” (2) the time and manner for notifying covered entities of their preliminary fee calculation, (3) the time and manner for submitting a corrected Form 8963 for the error correction process, and (4) the time for notifying covered entities of their final fee calculation.

Background

Section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care

A0482

**Exhibit C
(Email attachment)**

Act or ACA), imposes an annual fee on covered entities engaged in the business of providing health insurance for United States health risks.

The Health Insurance Providers Fee Regulations in 26 CFR Part 57, issued on November 29, 2013, provide the method by which each covered entity's annual fee is calculated. Those regulations provide that the Internal Revenue Service (IRS) will issue additional guidance in the Internal Revenue Bulletin relating to the reporting and fee determination processes. This notice provides that guidance.

Section 57.3(a)(1) provides that each covered entity, including each controlled group that is treated as a single covered entity, must report its net premiums written for health insurance of United States health risks during the data year to the IRS by April 15th of the fee year on Form 8963 in accordance with the instructions for the form. Section 57.2(g) defines fee year as the calendar year in which the fee must be paid to the government, and § 57.2(d) defines data year as the calendar year immediately before the fee year.

Section 57.3(a)(2) authorizes the IRS to provide rules in guidance published in the Internal Revenue Bulletin for the manner of reporting by a covered entity under this section, including rules for reporting by a designated entity on behalf of a controlled group that is treated as a single covered entity. Section 57.2(c)(1) defines controlled group as a group of two or more persons, including at least one person that is a covered entity, that is treated as a single employer under § 52(a), 52(b), 414(m), or 414(o). Section 57.2(c)(2) provides that a controlled group is treated as a single covered entity for purposes of the fee. Section 57.2(e)(1) defines a designated entity as the person

A0483

**Exhibit C
(Email attachment)**

within the controlled group that is designated to act on behalf of the controlled group regarding the fee with respect to filing Form 8963, receiving IRS communications about the fee for the group, filing a corrected Form 8963 for the group, if applicable, and paying the fee for the group to the government.

Section 57.3(a)(3) provides that, pursuant to section 9010(g)(4), the information reported on each Form 8963 will be open for public inspection or available upon request.

Section 57.5 provides that, for each fee year, the IRS will make a preliminary fee calculation for each covered entity and will notify each covered entity of this calculation by the date prescribed in guidance published in the Internal Revenue Bulletin. Section 57.5(a) provides that the notification will include (1) the covered entity's allocated fee; (2) the covered entity's net premiums written for health insurance of United States health risks; (3) the covered entity's net premiums written for health insurance of United States health risks taken into account after application of § 57.4(a)(4); (4) the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and (5) instructions for how to submit a corrected Form 8963 to correct any errors through the error correction process. Section 57.6(a)

requires each covered entity to review the preliminary fee calculation and submit a corrected Form 8963 if there are any errors. Section 57.6(b) provides that the IRS will

specify in other guidance published in the Internal Revenue Bulletin the time and manner by which a covered entity must submit a corrected Form 8963.

Section 57.7(b) requires the IRS to send each covered entity its final fee calculation no later than August 31st of each fee year. Section 57.7(d) requires each covered entity to pay its fee by September 30th of each fee year.

Time and manner for submitting Form 8963

In accordance with § 57.3(a)(1), each covered entity (or, in the case of a controlled group, each designated entity) must file its Form 8963 by April 15th of each fee year. The Form 8963 must be filed in accordance with the instructions to the form. The form and the instructions will be electronically available at www.irs.gov.

Time and manner for notifying covered entities of their preliminary fee calculation

The IRS will mail each covered entity (or, in the case of a controlled group, each designated entity) a notice of its preliminary fee calculation by June 15th of each fee year. The notice of preliminary fee calculation will include all of the information required by § 57.5(a).

Time and manner for submitting an error correction report

If the covered entity believes that the notice of preliminary fee calculation contains one or more errors in the mathematical calculation of the fee, the net premiums written data, the net premiums written after taking into account the application of § 57.4(a)(4), or any other error, the covered entity (or, in the case of a controlled group, the designated entity) must provide a corrected report to the IRS by July 15th of each fee year. The covered entity will make an error correction report by completing in full a new Form 8963 and checking the "Corrected Report" box on the form. The corrected Form 8963 will replace the original Form 8963. Therefore, the corrected report must

contain all of the information required by the form's instructions. In the case of a controlled group, if the notice of preliminary fee calculation contains one or more errors, the corrected Form 8963 must include all of the information required by the form's instructions for the entire controlled group, including members that do not have corrections. Additionally, a covered entity may include attachments with the corrected Form 8963 if any corrected item requires further explanation.

The IRS will validate the data submitted on the corrected Form 8963 to ensure accuracy and completeness. Section 9010(b)(3) authorizes the IRS to use any other source of information to determine each covered entity's net premiums written for health insurance of United States health risks in addition to the information reported by each covered entity. Section 57.4(b)(1) provides that other sources of information that the IRS may use to determine net premiums written include the Supplemental Health Care Exhibit, which supplements the annual statement filed with the National Association of Insurance Commissioners (NAIC) pursuant to State law, the annual statement itself or the Accident and Health Policy Experience filed with the NAIC, the Medical Loss Ratio Annual Reporting Form filed with the Center for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services, or any similar statements filed with the NAIC, with any State government, or with the Federal government pursuant to applicable State or Federal requirements. To the extent any covered entity's preliminary fee calculation changes as a result of the error correction process, the final fee calculation for one or more covered entities may differ from the preliminary fee calculations that those entities previously

A0486

**Exhibit C
(Email attachment)**

received. Any such changes will be reflected in each covered entity's final fee calculation.

Notification and Payment of Final Fee Calculation

In accordance with § 57.7(b), the IRS will notify each covered entity (or each designated entity of a controlled group that is treated as a single covered entity) of its final fee calculation on or before August 31st of each fee year. In accordance with § 57.7(d), each covered entity (or designated entity, if applicable) must pay this fee by September 30th of each fee year.

Disclosure

The information submitted on both original and corrected Forms 8963 is not confidential. Although, generally, tax returns and return information are confidential, as required by § 6103, in accordance with § 57.3(a)(3), the information on Form 8963 is not subject to § 6103. All information on Form 8963 will be open for public inspection or available upon request. Do not include personal information other than that requested on Form 8963.

Drafting Information

The principal author of this notice is Charles J. Langley, Jr. of the Office of Associate Chief Counsel (Passthroughs & Special Industries). For further information regarding this notice, please contact Mr. Langley at (202) 317-6855 (not a toll-free call).

A0487

**Exhibit C
(Email attachment)**

3. I was not retained or specially employed to provide expert testimony in this matter, nor do my regular duties as an employee of FSSA regularly involve giving expert testimony in cases. I am not receiving any additional compensation.
4. Indiana provides a significant portion of its Medicaid and CHIP health care coverage through managed care arrangements. To do this, Indiana enters into contracts with MCEs, whereby the MCEs agree to deliver healthcare services in exchange for a fixed monthly payment, known as a “capitation payment” or “capitation rate.”
5. In my position as Medicaid Director for FSSA I am aware of all the MCEs that contract with FSSA. I and my Office are responsible for Medicaid and CHIP capitation rate development and contract negotiations. Through this rate development process, my Office is made aware of which MCEs remit a Health Insurance Providers Fee (HIPF) to the Internal Revenue Service.
6. I am aware that the Affordable Care Act exempts governments from the HIPF. *See* ACA § 9010(c)(2)(B). However, to date, to the best of my knowledge the IRS has not excluded Indiana Medicaid and CHIP program premiums reported by Indiana’s MCEs from HIPF liability. Three of the MCEs that currently contract with FSSA remit a HIPF for their Indiana Medicaid and CHIP program premiums.
7. Because the IRS has historically included Indiana’s MCEs’ Medicaid and CHIP premiums in its calculation of HIPF liability, the premiums that Indiana has paid for Medicaid and CHIP have resulted in HIPF liability for Indiana.
8. In previous years, FSSA has reimbursed its MCEs for the amount of the HIPF attributable to Indiana’s Medicaid and CHIP premiums. FSSA reimbursed affected entities for the HIPF because federal regulations, which Indiana has

successfully challenged in federal court, purported to require FSSA to reimburse MCEs' HIPF liability, as part of paying the ordinary capitation rates.

9. Indiana has reimbursed its MCEs for HIPF liability in the prior HIPF years of 2014, 2015, and 2016. There was a statutory moratorium on the HIPF for 2017. But the HIPF is being imposed for fee year 2018.
10. I am aware that the Indiana Attorney General sent a letter to IRS that objected to the inclusion of the Medicaid and CHIP premiums of its MCEs in the IRS's calculation of the overall 2018 HIPF liability for Indiana's MCEs. To date, to the best of my knowledge neither the Indiana Attorney General nor FSSA has received a response from the IRS.
11. In order for its Medicaid and CHIP contracts with its MCEs to be actuarially sound, FSSA has determined that it must reimburse the Indiana MCEs for the HIPF that they are expected to pay to the IRS no later than October 1, 2018.
12. As determined by Congress, and as affirmed by standards of practice within managed medical care, actuarial soundness is required in Medicaid and CHIP managed care rate setting.
13. I have reviewed the capitation rate structure for Indiana's Medicaid and CHIP contracts. For 2018, even if FSSA were not legally required to reimburse the HIPF, FSSA's contracted actuaries have advised that Indiana's Medicaid and CHIP capitation rates cannot be actuarially sound unless FSSA reimburses the HIPF liability incurred by Indiana's Medicaid and CHIP MCEs.
14. FSSA's contracted actuaries have advised that for Indiana's capitation rates for 2018 to be actuarially sound, as required by 42 U.S.C. § 1396b, the 2018 HIPF liability must be added to the capitation rates negotiated with the MCEs.
15. My opinions have been developed in my official capacity as Medicaid Director

for FSSA. All of the facts and data utilized by me in preparing my opinions and the information contained herein are the type and kinds of data that professionals within my fields of expertise typically rely upon. Any information and documents I consulted were kept in the regular course of business, and many were public records in Indiana. They were created by personnel, with knowledge of the act, event, condition, opinion, diagnosis, or information recorded made the record, or transmitted the information to be included in the record or document. Finally, these documents were created at or near the time of the act, event, condition, or information recorded.

16. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 14th day of September, 2018.

Allison Taylor

Allison Taylor, JD
Medicaid Director
Indiana Family and Social Services
Administration