



# State of Wisconsin Group Health Insurance Program Agreement

Plan Year 2024

Issued by the State of Wisconsin Department of Employee Trust Funds on behalf of the  
Group Insurance Board

*Release Date: August 01, 2023*

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This State of Wisconsin Group Health Insurance Program Agreement (AGREEMENT) is by and between the DEPARTMENT and the CONTRACTOR named in the CONTRACT. Non-substantive changes may be made to this AGREEMENT, the CONTRACT, their appendices, exhibits, and attachments by the DEPARTMENT without the need for a formal CONTRACT amendment. The DEPARTMENT will notify CONTRACTOR of all such non-substantive changes via email. Should there be a requirement for substantive change(s) (changes to the CONTRACT that affect the rights of either party), a CONTRACT amendment will be required.

## I. Definitions

Unless otherwise defined herein, any term needing definition shall have the definition found in the CERTIFICATE OF COVERAGE or in applicable Wisconsin law or federal law. As used in this AGREEMENT, the following terms are to be interpreted in accordance with these definitions:

**ACCESS PLAN** means the nationwide Preferred Provider Organization (PPO) Benefit Plan offering available to all Participants. Participants may use In-Network or Out-of-Network Providers for covered services.

**AGREEMENT** means this State of Wisconsin Group Health Insurance Program Agreement, which is part of the binding CONTRACT between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

**ANNUITANT**, when not otherwise specified, means an eligible retired EMPLOYEE of the State of Wisconsin or a participating LOCAL EMPLOYER who has been specified by the DEPARTMENT for enrollment in the HEALTH BENEFIT PROGRAM and is entitled to BENEFITS.

**BENEFITS** means those items and services identified in the CERTIFICATE OF COVERAGE and SCHEDULE OF BENEFITS.

**BOARD** means the Group Insurance Board.

**BUSINESS DAY** means each DAY except Saturday, Sunday, and official State of Wisconsin holidays, as listed under Wis. Stat. [§ 230.35\(4\)\(a\)](#); (see also: DAY).

**CERTIFICATE OF COVERAGE** means the document appended to this AGREEMENT (as updated as required by the DEPARTMENT), that specifies the UNIFORM BENEFITS and services applicable to PARTICIPANTS of the GROUP HEALTH INSURANCE PROGRAM.

**CONTINUANT** means any SUBSCRIBER enrolled under federal or STATE continuation provisions.

**CONTRACT** means the contract document signed by the CONTRACTOR and the DEPARTMENT, and includes all appendices, exhibits, attachments made a part thereof, and this AGREEMENT.

**CONTRACTOR** means the licensed insurer who is the legal signatory to the CONTRACT.

**DAY(S)** means calendar day(s) unless otherwise indicated.

**DEPARTMENT** means the State of Wisconsin Department of Employee Trust Funds.

**DEPENDENT** is defined in the CERTIFICATE OF COVERAGE.

**EMPLOYEE**

When not specified, EMPLOYEE(S) means STATE EMPLOYEE and LOCAL EMPLOYEE.

**STATE EMPLOYEE** means an eligible EMPLOYEE of the STATE as defined under [Wis. Stat. § 40.02 \(25\) \(a\), 1., 2., or \(b\), 1m., 2., 2g., or 8.](#)

**LOCAL EMPLOYEE** means an eligible EMPLOYEE as defined under [Wis. Stat. § 40.02 \(46\)](#) or [40.19 \(4\) \(a\)](#), of an EMPLOYER as defined under [Wis. Stat. § 40.02 \(28\)](#), other than the STATE, which has acted under [Wis. Stat. § 40.51 \(7\)](#), to make healthcare coverage available to its EMPLOYEES.

**EMPLOYER**

When not specified, EMPLOYER or EMPLOYERS means STATE EMPLOYER and LOCAL EMPLOYER.

**STATE EMPLOYER** means an eligible STATE agency as defined in [Wis. Stat. § 40.02 \(54\)](#).

**LOCAL EMPLOYER** means a Wisconsin Public Employer who has acted under [Wis. Stat. § 40.51 \(7\)](#), to participate in the HEALTH BENEFIT PROGRAM for its EMPLOYEES.

**HEALTH BENEFIT PROGRAM or GROUP HEALTH INSURANCE PROGRAM (GHIP)** means the program that provides group health BENEFITS to eligible STATE EMPLOYEES and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. The HEALTH BENEFIT PROGRAM is established, maintained, and administered by the BOARD.

**HIGH DEDUCTIBLE HEALTH PLAN (HDHP)** is defined in the CERTIFICATE OF COVERAGE and includes items and services specified in the SCHEDULE OF BENEFITS.

**HOSPITAL** is defined in the CERTIFICATE OF COVERAGE.

**IN-NETWORK** refers to a PROVIDER who has agreed in writing to provide, prescribe, or direct healthcare services, supplies, or other items covered under UNIFORM BENEFITS to PARTICIPANTS. The PROVIDER'S written participation agreement with a CONTRACTOR must be in force at the time such services, supplies, or other items covered under UNIFORM BENEFITS are provided to a PARTICIPANT. The CONTRACTOR agrees to give PARTICIPANTS lists of affiliated PROVIDERS. Some PROVIDERS require prior authorization by the CONTRACTOR in advance of the services being provided.

**INPATIENT** means a PARTICIPANT admitted as a bed patient to a healthcare facility or in twenty-four (24)-hour home care.

**OPEN ENROLLMENT** means the time period that occurs at least annually to allow:

- a) SUBSCRIBERS the opportunity to change CONTRACTORS and/or coverage; and
- b) eligible individuals the opportunity to enroll for coverage in the HEALTH BENEFIT PROGRAM.

**OUT-OF-NETWORK** refers to a PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the CONTRACTOR'S professional directory of PROVIDERS.

**PARTICIPANT** means the SUBSCRIBER or any of the SUBSCRIBER'S DEPENDENTS who have been specified by the DEPARTMENT for enrollment in the HEALTH BENEFIT PROGRAM and are entitled to BENEFITS.

**PHARMACY BENEFIT MANAGER (PBM)** is defined in the CERTIFICATE OF COVERAGE.

**PREMIUM(S)** means the rates shown in the HEALTH BENEFIT PROGRAM print and web materials published by the DEPARTMENT that includes the medical, pharmacy, and dental (when applicable) components, and administration fees required by the BOARD.

**PRIMARY CARE PROVIDER (PCP) or PRIMARY CARE CLINIC (PCC)** is defined in the CERTIFICATE OF COVERAGE.

**PROVIDER** is defined in the CERTIFICATE OF COVERAGE.

**QUARTERLY** means a period consisting of every consecutive three (3) months beginning in January of each calendar year.

**SCHEDULE(S) OF BENEFITS** means the document(s) appended to this AGREEMENT (as updated as may be required by the DEPARTMENT), that explains what medical services the HEALTH BENEFIT PROGRAM covers, and the cost PARTICIPANTS pay for such services.

**SECURE/SECURED/SECURELY** means the confidentiality, integrity, and availability of the DEPARTMENT'S data is of the highest priority and must be protected at all times.

**STATE** means the State of Wisconsin.

**SUBSCRIBER** means an EMPLOYEE, ANNUITANT, or their surviving DEPENDENT(S), who has been specified by the DEPARTMENT to the CONTRACTOR for enrollment in the GHIP and who is entitled to BENEFITS.

**UNIFORM BENEFITS** means the BENEFITS described in the CERTIFICATE OF COVERAGE and SCHEDULE OF BENEFITS.

## II. Statutory and Board Authority

### A. Statutory and Legal Authority

The HEALTH BENEFIT PROGRAM is established by Chapter 40, Subchapter IV of Wisconsin Statutes ([Wis. Stats. §40.51](#)). The DEPARTMENT administers the HEALTH BENEFIT PROGRAM on behalf of the BOARD. The CONTRACTOR must meet the minimum requirements of [Wis. Stats. Chapter 40](#) other applicable STATE and federal laws (both current as well as any new legislation passed during the term of the CONTRACT), the administrative rules of the DEPARTMENT, and the requirements in this AGREEMENT.

### B. Board Authority

[Wis. Stats. § 40.03 \(6\)\(a\)](#) provides authority for the BOARD to enter into contracts with health insurance companies licensed to do business in the STATE. The BOARD establishes OPEN ENROLLMENT periods at least once per year and reserves the right to change the BENEFITS period to a fiscal year or to some other schedule that it deems appropriate.

In cases where services or data provided by the CONTRACTOR are deemed to be inadequate by the BOARD, DEPARTMENT, or the BOARD'S consulting actuary, the BOARD may take any action up to and including limiting new enrollment into the benefit plan administered by the CONTRACTOR.

The BOARD will determine all policy for the HEALTH BENEFIT PROGRAM. If the CONTRACTOR requests, in writing, that the BOARD issue HEALTH BENEFIT PROGRAM policy determinations or operating guidelines required for proper performance of the CONTRACT, the DEPARTMENT will acknowledge receipt of the request in writing and respond to the request within a mutually agreed upon time frame.

The DEPARTMENT, on behalf of the BOARD, may designate a common vendor who will provide services related to the HEALTH BENEFITS PROGRAM as the DEPARTMENT deems appropriate.



## III. Program Administration

### A. Enrollment and Eligibility Maintenance

This section addresses the CONTRACTOR'S role in the enrollment process and maintaining eligibility files for PARTICIPANTS in the GROUP HEALTH INSURANCE PROGRAM (GHIP).

#### 1. Eligibility

- a. The DEPARTMENT maintains the primary record of eligibility for all PARTICIPANTS in the GHIP. Although the DEPARTMENT is responsible for eligibility determination and enrollment, the CONTRACTOR must maintain an enrollment/eligibility system to support the GHIP.
- b. The CONTRACTOR'S system(s) must be able to accommodate a HIPAA 834 file transfer from the DEPARTMENT, per the most recent *834 Overview Guide and 834 Companion Guide* issued by the DEPARTMENT.
- c. The CONTRACTOR must accept an enrollment file update daily, and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of receipt.
- d. The CONTRACTOR must resolve all enrollment discrepancies between the DEPARTMENT'S database and the CONTRACTOR'S database in addition to the exception report described below within one (1) BUSINESS DAY of being notified by the DEPARTMENT of such a discrepancy or identification by the CONTRACTOR.
- e. The CONTRACTOR must assist with a full file comparison (FFC) of enrollment data at the frequency directed by the DEPARTMENT by submitting a file to the DEPARTMENT containing current enrollment data. The DEPARTMENT will verify that data, compare that data with the DEPARTMENT'S data, and generate an exception report. The CONTRACTOR will be responsible for resolving differences between the DEPARTMENT'S data and the CONTRACTOR'S data, updating the CONTRACTOR'S data, and informing the DEPARTMENT of changes or clarifications as appropriate.
- f. The CONTRACTOR must maintain an exception report spreadsheet that includes the error details and final resolution, and submit it to the DEPARTMENT, at the frequency directed by the DEPARTMENT.
- g. CONTRACTOR delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY.
- h. The daily and full file comparison of the DEPARTMENT'S HIPAA 834 enrollment files must be fully tested and ready for GHIP operation no later than forty-five (45) calendar DAYS prior to the start of OPEN ENROLLMENT or another date as defined by the DEPARTMENT.

#### 2. Enrollment

- a. CONTRACTOR must participate in the annual OPEN ENROLLMENT offering. The OPEN ENROLLMENT period is scheduled for each fall prior to the covered program year, which begins January 1 unless otherwise specified by the BOARD.

- b. During the OPEN ENROLLMENT period, the CONTRACTOR will accept any SUBSCRIBER who transfers from one benefit plan to another without requiring evidence of insurability, waiting periods, or exclusions as defined in [Wis. Admin. Code INS §3.31 \(3\)](#), and any eligible EMPLOYEE or STATE retiree under [Wis. Stats. § 40.51 \(16\)](#) who enrolls.
- c. The CONTRACTOR will assist in the Coordination of Benefits (COB) for PARTICIPANTS enrolled in other coverage. The CONTRACTOR must collect from PARTICIPANTS COB information necessary to coordinate BENEFITS under [Wis. Admin. Code INS §3.40](#) and report this information to the DEPARTMENT as needed.
- d. The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the latter of either the receipt of the DEPARTMENT'S enrollment file or notification by Medicare for non-Medicare Advantage CONTRACTORS.

### 3. Errors

- a. Clerical errors made by the EMPLOYER, the DEPARTMENT, or the CONTRACTOR shall not invalidate the BENEFITS of a PARTICIPANT that are otherwise validly in force, continue BENEFITS otherwise validly terminated, or create eligibility for any BENEFITS where none otherwise existed under the HEALTH BENEFIT PROGRAM.
- b. Retroactive adjustments to PREMIUM or claims for coverage must be limited to no more than six (6) months of PREMIUMS paid, except in cases of fraud, material misrepresentation, resolution of BOARD appeal, or when required by Medicare.
- c. In cases where Medicare is the primary payer, retroactive adjustments to PREMIUM or claims for coverage not validly in force must correspond with the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six (6) months, and in accordance with the CERTIFICATE OF COVERAGE and SCHEDULE OF BENEFITS.
- d. No retroactive PREMIUM refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation.
- e. If the CONTRACTOR, its PROVIDER, or subcontractor sends wrong or misleading information to PARTICIPANTS, the DEPARTMENT may require the CONTRACTOR to send corrections to PARTICIPANTS by mail at the CONTRACTOR'S expense.

### 4. Identification (ID) Cards

- a. The CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the effective date of coverage, and the emergency room and office visit copayment amounts, if applicable.
- b. The CONTRACTOR must issue new ID cards upon enrollment and following BENEFITS changes that impact the information printed on the ID cards.

- c. The CONTRACTOR must issue the ID cards and a welcome packet to newly-enrolled PARTICIPANTS. The CONTRACTOR must issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, or at least ten (10) BUSINESS DAYS prior to the effective date of coverage.
- d. The CONTRACTOR must notify the DEPARTMENT Program Manager of any delays with issuing the ID cards. The CONTRACTOR must send a written notice to the DEPARTMENT Program Manager following the OPEN ENROLLMENT period regarding any anticipated delays in mailing ID cards for the following enrollment year, as well as a confirmation email indicating the date(s) that ID cards were mailed.
- e. ID cards generated by enrollment files received by the CONTRACTOR between the first DAY of the OPEN ENROLLMENT period and December 5 must be mailed by December 15 each year. ID cards generated by enrollment files specific to the OPEN ENROLLMENT period and received by the CONTRACTOR between December 6 and December 31 must be mailed within ten (10) BUSINESS DAYS.
- f. The CONTRACTOR must provide replacement cards upon request at no cost to the PARTICIPANT. The CONTRACTOR must also have a process to make available to the PARTICIPANT a temporary, printable ID card.

#### 5. Enrollment and Eligibility Information for PARTICIPANTS

- a. The CONTRACTOR must provide the following information, at a minimum, to PARTICIPANTS upon enrollment:
  - i. Information about PARTICIPANT responsibilities and plan requirements, including prior authorizations and referrals.
  - ii. Directions on how to access the HEALTH BENEFIT PROGRAM PROVIDER directory on the CONTRACTOR'S website and directions on how to request a printed copy of the PROVIDER directory.
  - iii. Directions on how to change the PARTICIPANT'S PRIMARY CARE PROVIDER or PRIMARY CARE CLINIC
  - iv. The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line number, list of telehealth services, and website address.
- b. The CONTRACTOR will assist in distributing the federally required Summary of Benefits and Coverage (SBC) to non-Medicare PARTICIPANTS in a manner similar to the OPEN ENROLLMENT materials mailing process described in [Section III.E.1. OPEN ENROLLMENT Materials](#).
- c. In accordance with federal guidelines, the CONTRACTOR must issue or notify members how to receive 1095-B forms. The CONTRACTOR must submit a written notification to the DEPARTMENT Program Manager indicating the date(s) 1095-B forms were issued to PARTICIPANTS or when the web notice was posted, as required by federal law.

## 6. Coverage Termination and Continuation

- a. A PARTICIPANT who ceases to meet the definition of EMPLOYEE, ANNUITANT, or DEPENDENT may elect to continue GHIP coverage as required by STATE and federal law. The CONTRACTOR must bill the continuing PARTICIPANT directly for the required PREMIUM.
- b. The CONTRACTOR must provide the SUBSCRIBER, upon the SUBSCRIBER'S request, written notification of how to enroll in a conversion policy set forth in [Wis. Stat. § 632.897](#), and/or a Marketplace plan, in the event of termination of employment.
- c. Upon discovery, the CONTRACTOR must report to the DEPARTMENT any qualifying event that makes a PARTICIPANT ineligible for BENEFITS.
- d. Upon the DEPARTMENT'S request, the CONTRACTOR must provide GHIP-related information to the DEPARTMENT, including aggregate claim amounts or other documentation.

## B. PREMIUM

This section addresses the CONTRACTOR'S and DEPARTMENT'S responsibilities related to processing PREMIUMS, as well as services that may be included or excluded from PREMIUMS.

### 1. Services Included in PREMIUM

- a. PREMIUMS paid to the CONTRACTOR by the DEPARTMENT are intended to pay for all services rendered by the CONTRACTOR to the DEPARTMENT. The CONTRACTOR may not charge an additional fee for any services described within this AGREEMENT.
- b. The CONTRACTOR may not invoice the DEPARTMENT or PARTICIPANTS for any services that are outside the scope of this AGREEMENT pursuant to CONTRACTOR'S role under this AGREEMENT without prior, written consent of the DEPARTMENT.

### 2. PREMIUM Payments from the DEPARTMENT

- a. By the end of each month, the DEPARTMENT pay CONTRACTOR for that month's PREMIUM based on the number of enrolled SUBSCRIBERS per the DEPARTMENT'S records. The DEPARTMENT will deduct the pharmacy premium, dental premium, if applicable, and other fees required by the BOARD.
- b. The CONTRACTOR must support ACH payments of PREMIUM by the DEPARTMENT.
- c. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

### 3. Direct Pay PREMIUMS

- a. The CONTRACTOR must collect PREMIUMS directly from certain SUBSCRIBERS identified by the DEPARTMENT. No later than the second Wednesday of the month following CONTRACTOR'S receipt of the PREMIUMS, the CONTRACTOR must credit the DEPARTMENT for the applicable portion of PREMIUMS billed and received by the CONTRACTOR. When coverage is continued, the CONTRACTOR must bill the CONTINUANT directly for required PREMIUMS.

- b. The CONTRACTOR must allow SUBSCRIBERS to submit direct pay PREMIUM payments via electronic funds transfer (EFT). Direct pay PREMIUMS may also be submitted to the CONTRACTOR via mail. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the CONTRACTOR, and approved by the DEPARTMENT, the healthcare coverage must be canceled by the CONTRACTOR. The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving written notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first.

#### 4. PREMIUM Payments for Surviving DEPENDENTS

- a. PREMIUMS for surviving DEPENDENTS (except those specified in section 4.b. below) must be paid first by deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System. If the annuity is insufficient to allow PREMIUM deductions, then PREMIUMS will be paid directly to the CONTRACTOR by the surviving DEPENDENT.
- b. PREMIUMS for surviving DEPENDENTS of a law enforcement officer who dies in the line of duty must be paid by the fallen officer's EMPLOYER until the DEPENDENT is no longer eligible for coverage as required under [Wis. Stats. §66.0137 \(5\)](#).

#### 5. SUBSCRIBER Nonpayment of PREMIUMS

- a. As required by federal law, if timely payment of PREMIUMS is made by the CONTINUANT in an amount that is not significantly less than the amount due, that amount is deemed to satisfy the CONTRACTOR'S requirement for the amount due. However, the CONTRACTOR may notify the CONTINUANT of the amount of the deficiency and grant a reasonable time period for payment of that amount, no less than thirty (30) calendar DAYS after the notice is mailed.
- b. The CONTRACTOR must notify the DEPARTMENT within one (1) month of the effective date of termination of coverage due to non-payment of PREMIUM. PREMIUM refunds to the CONTRACTOR are limited to one (1) month following the termination date.

#### 6. LOCAL EMPLOYER Group Program Participation

- a. The CONTRACTOR must provide coverage for local PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.
- b. The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the HEALTH BENEFIT PROGRAM.
- c. Local governments seeking to participate in the HEALTH BENEFIT PROGRAM may be subject to group underwriting and may be assessed a surcharge based on their risk, which is passed on to the CONTRACTOR at 80% and DEPARTMENT'S PBM at 20%.

### C. Rate Setting

This section addresses the annual process for establishing PREMIUM rates, including prohibited fees and allocation of a quality credit.

## 1. Annual Rate Bidding Process

- a. Rates may be revised by the BOARD annually prior to OPEN ENROLLMENT, effective on each succeeding January 1 following the effective date of the CONTRACT.
- b. The CONTRACTOR must submit rate bid(s) for the benefit year beginning January 1 following the effective date of the CONTRACT as directed by the DEPARTMENT. The CONTRACTOR'S sealed bids are submitted in the format specified by the DEPARTMENT. The bid will be reviewed for reasonableness, considering plan utilization, experience, and other relevant factors.
- c. Bids are subject to negotiation by the BOARD. The BOARD reserves the right to reject any rate, limit new enrollment, or take other action as appropriate if the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.
- d. The CONTRACTOR must submit statistical report(s) showing utilization and claims data on the CONTRACTOR'S plan as a whole if community rated, or specifically the STATE and LOCAL EMPLOYEES and DEPENDENTS covered thereunder if experience rated. If the plan is community rated, then the CONTRACTOR should provide the percentage the STATE and LOCAL EMPLOYEE groups represent of the total covered community.
- e. The BOARD will require each CONTRACTOR to provide an explanation of rate methodology and the rate calculation developed by the CONTRACTOR'S actuary or consultant along with supporting documentation deemed necessary by the BOARD'S consulting actuary.
- f. The BOARD reserves the right to reject any CONTRACTOR'S bid when the BOARD believes it is not in the best interests of the HEALTH BENEFIT PROGRAM. The BOARD reserves the right to reopen the bid process after final bids are submitted when the BOARD determines that it is in the best interests of the HEALTH BENEFIT PROGRAM.
- g. CONTRACTOR'S rates must be uniform statewide for each separate plan. CONTRACTORS may submit different rates which result from separate plans with mutually exclusive provider networks. Each network will be separately held to the Provider Access standards described in [Section III.F. Provider Access](#).
- h. The STATE and local groups must be separately rated in accordance with generally accepted actuarial principles. The local group is to be rated as a single entity for each plan. CONTRACTOR must provide rates for each of the plan design options for the local group.
- i. The CONTRACTOR must submit to the DEPARTMENT (or its designee) statistical report(s) showing financial and utilization data that includes claims and enrollment information annually as required by the DEPARTMENT.
- j. The DEPARTMENT reserves the right to audit, at the expense of the CONTRACTOR, the financial and utilization data, and other data the CONTRACTOR uses to support its bid. A bid based on data which an audit later determines is unsupported is subject to re-opening and renegotiating downward.

- k. Rate adjustments, if any, required for a benefit mandated by applicable STATE or federal law will occur on January 1 after the next benefit period begins unless otherwise mutually agreed to by the CONTRACTOR and the DEPARTMENT in writing.
- l. CONTRACTOR'S rates may not exceed the calculated rate in the utilization data submission without written justification.
- m. The CONTRACTOR must provide coverage and rates for the following PREMIUM categories allowed by the BOARD:
  - i. Individual (EMPLOYEE Only);
  - ii. Family (EMPLOYEE Plus Eligible DEPENDENTS); and
  - iii. Family rates (regular coverage) must be 2.5 times the individual rate.
- n. The CONTRACTOR must provide coverage and rates for the following HEALTH BENEFIT PROGRAM options:
  - i. Program Option 01 (STATE \$250 deductible health plan and HDHP);
  - ii. Program Option 02/12 (Local Traditional Plan);
  - iii. Program Option 04/14 (Local Deductible Plan);
  - iv. Program Option 06/16 (Local Health Plan);
  - v. Program Option 07/17 (Local HDHP); and
  - vi. Program Option 08 (Local Annuitant Health Program - LAHP).
- o. The CONTRACTOR must offer the following Medicare coordinated coverage for the program options allowed by the BOARD:
  - i. Individual: Individual rates must be justified by experience and may not exceed the calculated rate in the utilization data submission without written justification. Rates may not exceed 50% of the individual rate for regular, non-Medicare coverage, unless the BOARD'S consulting actuary determines that percentage to be lower.
  - ii. Family 2 (all PARTICIPANTS under Medicare): Medicare Family 2 eligible rates must be twice the individual Medicare coordinated rate.
  - iii. Family 1 (at least 1 under Medicare, at least 1 other not under Medicare): Medicare Family 1 rates must be the sum of the individual rate for regular coverage and the individual rate for Medicare-eligible coverage. Any administrative fees may only be assessed once for this family PREMIUM rate.
- p. The CONTRACTOR must provide rates for Graduate Assistants, regardless of geographic area of operation, as follows:
  - i. Individual: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate.
  - ii. Family: Family rate must be within a range of 65% to 75% of the family regular coverage rate.
- q. Local Program Option rates are based on the relative value of these plans to the Traditional Plan (Program Option 02/12). The ratio is to be determined annually by the BOARD'S consulting actuary.

- r. Local Traditional Program Option rates must be no greater than 1.5 times the rate for the STATE program unless the local group is sufficiently large that the rate is justified by experience, as determined by the BOARD'S consulting actuary.
- s. The BOARD will consider rate proposals outside of these standards if the variation is supported by evidence of demographic differences other than age or sex or is required by federal or STATE HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the BOARD upward or downward to the nearest within-range percentage to conform to these requirements.
- t. The BOARD will assess administration fees to cover expenses of the DEPARTMENT. This charge is added by the BOARD to the rates quoted by each CONTRACTOR and is collected prior to transmittal of the PREMIUMS to the CONTRACTOR.
- u. The CONTRACTOR will have the option of accepting adjusted and/or negotiated rates or withdrawing from the HEALTH BENEFIT PROGRAM. CONTRACTOR must notify the DEPARTMENT of withdrawal from the HEALTH BENEFIT PROGRAM before final bid offers are due.

## 2. Prohibited Fees

The CONTRACTOR is prohibited from including in their premium bid or rates:

- a. The cost to handle any claims paid outside of UNIFORM BENEFITS.
- b. The cost to administer any optional health and wellness benefit(s) beyond UNIFORM BENEFITS, except as approved by the DEPARTMENT.
- c. Any fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

## 3. Quality

- a. The CONTRACTOR must collect Healthcare Effectiveness Data and Information Set (HEDIS) measures and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as specified by the National Committee for Quality Assurance (NCQA) guidelines. Upon request by the DEPARTMENT, the CONTRACTOR must provide information about subcontractors used to audit the HEDIS results and administer the CAHPS survey.
- b. The CONTRACTOR must submit to the DEPARTMENT audited HEDIS data results annually for the previous calendar year for its contracted membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. The results must include integration of the prescription drug data from the PBM. If CONTRACTOR uses a vended solution to produce HEDIS results, CONTRACTOR must utilize a vendor certified by NCQA.
- c. The CONTRACTOR must submit to the DEPARTMENT the results of its annual CAHPS survey to the DEPARTMENT. Results must be based on responses for its contracted membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. The survey must be conducted by a certified CAHPS survey vendor. Results must utilize the current version of the CAHPS survey as specified by the NCQA guidelines at the time the survey is administered. Results must be for



each standard NCQA composite. Results must be submitted annually and in a file format as specified by the DEPARTMENT.

- d. The DEPARTMENT will utilize the supplied HEDIS and CAHPS data for the calculation of the quality credit, which is a financial incentive to encourage quality improvement built into the rate setting process. Quality measures for the quality credit will be established annually by the DEPARTMENT in cooperation with CONTRACTORS.

## D. Data and Information Security

This section addresses requirements regarding the process of protecting data used in the course of administering the services described in this AGREEMENT from unauthorized access and data corruption.

### 1. Information Systems

- a. The CONTRACTOR'S systems must have the capability of adapting to any future changes that become necessary as a result of modifications to the STATE and Local programs and their requirements. The CONTRACTOR'S systems must be scalable and flexible so they can be adapted as needed, within negotiated timeframes, as requirements may change.
- b. The CONTRACTOR shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM during the term of the CONTRACT without specific, prior written notice of at least one hundred eighty (180) calendar DAYS to the DEPARTMENT. Examples of a major system change include a new platform for enrollment, claims payment or data submission system. This does not apply to any program fixes, modifications, or enhancements. If the CONTRACTOR has plans to migrate to a different data or web platform, the DEPARTMENT must be notified no less than one hundred eighty (180) calendar DAYS in advance of the migration.
- c. The CONTRACTOR must transmit data SECURELY using current industry standard SECURE transmission protocols (e.g., sFTP/SSH or SSL/TLS). This may require software on desktops or an automated system that collects files from the CONTRACTOR'S repository and SECURELY transmits data.
- d. All related hardware, software, firmware, protocols, methods, policies, procedures, standards, and guidelines that govern, store, or transport the data must be implemented in manners consistent with current industry standards, such as, but not limited to the Health Insurance Portability and Accountability Act (HIPAA), Genetic Information Nondiscrimination Act (GINA), National Institute of Standards and Technology (NIST) 800-53, and Center for Internet Security (CIS) Critical Security Controls to ensure the protection of all DEPARTMENT data.
- e. The CONTRACTOR'S staff must be trained and follow SECURE computing best practices. Wireless networks must be protected using strong encryption and password policies. Connectivity to all networks, wired or wireless, must be protected from unwanted/unknown connections.
- f. All data backups must be handled or transmitted SECURELY. Offsite storage must be audited for compliance (i.e., physical security, all used tapes are accounted for). A business recovery plan must be documented and tested annually, at a minimum, by the CONTRACTOR, and submitted to the DEPARTMENT within sixty (60) calendar DAYS following the end of each calendar year.

## 2. Information Systems Security Audit

- a. The CONTRACTOR and its authorized subcontractors are subject to the audit provisions outlined in Section 6.0 of the Department Terms and Conditions. Clarification of those provisions, specific to the HEALTH BENEFIT PROGRAM, are outlined in this section.
- b. Upon request from the DEPARTMENT, the CONTRACTOR must furnish the DEPARTMENT with a copy of an independent service auditor's report.
- c. The DEPARTMENT'S preferred annual attestation is an SSAE No. 18 (SOC 2, Type 2) audit report. SOC 2, Type 2 requirements are outlined in Section 6.2 and Section 28.0(3) of the Department Terms and Conditions.
- d. The SOC 2, Type 2 audit must include all programs under the CONTRACT and be conducted at the CONTRACTOR'S expense.
- e. The CONTRACTOR must determine which of the five SOC 2, Type 2 Trust Services Criteria (TSC) are applicable to the CONTRACTOR'S overall book of business. The DEPARTMENT does not require a specific number or configuration of TSCs. The five TSCs are:
  - i. Security
  - ii. Availability
  - iii. Processing Integrity
  - iv. Confidentiality
  - v. Privacy
- f. If the CONTRACTOR'S SSAE 18 (SOC 2, Type 2) audit covers less than twelve (12) months of a calendar year, the CONTRACTOR will provide a bridge letter to the DEPARTMENT, stating whether processes and controls have changed since the SSAE 18 (SOC 2, Type 2) audit.
- g. The CONTRACTOR may submit one or more of the following documents to the DEPARTMENT in lieu of a SOC 2, Type 2 audit report:
  - i. Independent attestation of certification, including but not limited to:
    - HITRUST Certification; or
    - International Standards Organization (ISO) / International Electrotechnical Commission (IEC) 27001 Certification; or
    - NIST 800-53 compliance or certification/accreditation; or
    - CIS Critical Security Controls for Effective Cyber Defense compliance; or
    - HIPAA Security Rule - 45 CFR Part 155 and Subparts A and C of Part 164.
  - ii. Information Security Plan scope statement; or
  - iii. An alternate submission, comprised of one or more documents, previously submitted and mutually agreed upon between the CONTRACTOR and the DEPARTMENT.
- h. If the CONTRACTOR is unable to produce one of the above documents, the CONTRACTOR may satisfy the requirement by providing the assurances to the requirements outlined in Section 28.0(h) of the Department Terms and Conditions.

- i. The DEPARTMENT reserves the right to require the CONTRACTOR to provide more than one of the documents outlined above.
- j. The CONTRACTOR must submit a letter of attestation indicating the CONTRACTOR'S receipt of management's assertion of control compliance from the CONTRACTOR'S subcontractors, as outlined in Section 6.2 of the Department Terms and Conditions.

### 3. Data Integration and Technical Requirements

- a. The DEPARTMENT'S systems identify PARTICIPANT records using an eight (8)-digit member ID. This member ID is transmitted to and must be stored by the CONTRACTOR to communicate information about PARTICIPANTS. The CONTRACTOR must support use of the DEPARTMENT'S member ID in all interfaces that contain PARTICIPANT data. Further, the CONTRACTOR must supply member ID values on any communication or data transmission that refers to individual PARTICIPANTS, including but not limited to HIPAA 834 file transfers, reports, data extracts, and invoices. Given the ubiquitous and central nature of the member ID in the DEPARTMENT'S systems, it is strongly preferred that the member ID is stored in the CONTRACTOR'S system directly, thereby facilitating ad hoc queries, data integrity, and referential integrity within the CONTRACTOR'S system. Any costs incurred by the DEPARTMENT because of CONTRACTOR'S failure to comply with this requirement will be paid by the CONTRACTOR.
- b. The CONTRACTOR must follow the DEPARTMENT'S SECURE file transfer protocols (sFTP) using the DEPARTMENT'S sFTP site to submit and retrieve files from the DEPARTMENT or provide another acceptable means for the SECURE, electronic exchange of files between the CONTRACTOR and the DEPARTMENT, as approved by the DEPARTMENT.

### 4. Data Integration and Use

- a. The CONTRACTOR must provide all data and other information related to this AGREEMENT as needed in the file format specified by the DEPARTMENT. The CONTRACTOR shall place no restraints on the use of the data; provided that the DEPARTMENT will not disclose to third parties any data received from the CONTRACTOR that constitutes a trade secret as defined under Wisconsin law.
- b. The CONTRACTOR must provide data at the request of the DEPARTMENT, to a DEPARTMENT designee for purposes of assisting in the implementation and management of disease management programs or other programs desired by the BOARD.
- c. Using the most recent file and data specifications provided by the DEPARTMENT, the CONTRACTOR must fully incorporate available pharmacy claims data into data reporting, including, but not limited to:
  - i. HEDIS data;
  - ii. Wisconsin Health Information Organization (WHIO) claims data;
  - iii. Information requested on the DEPARTMENT'S disease management program survey;
  - iv. Catastrophic claims data; and
  - v. Other data as required by the DEPARTMENT. Where appropriate, such as for the catastrophic claims data report, the CONTRACTOR must separate out pharmacy claims from the DEPARTMENT'S PBM from any pharmacy claims that are paid by the CONTRACTOR.

- d. The CONTRACTOR agrees to use the identification (ID) numbers established by the DEPARTMENT for both the group and the SUBSCRIBER. ID numbers must not correlate to Social Security numbers. Social Security numbers must be incorporated into the PARTICIPANT'S data file and may be used for identification purposes only and not disclosed and used for any other purpose, unless the parties have agreed upon a different identification system. The CONTRACTOR must keep a record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit, unique member ID number that is assigned by the DEPARTMENT. Any costs incurred by the DEPARTMENT because of CONTRACTOR'S failure to comply with this requirement will be paid by the CONTRACTOR.
- e. In addition to data transfers to the DEPARTMENT'S data warehouse, the CONTRACTOR'S data transfers must include, but will not be limited to:
  - i. Pharmacy Claims Data – The CONTRACTOR must be able to accept and accommodate a daily file from the DEPARTMENT'S PBM for the CONTRACTOR'S PARTICIPANTS and integrate the data as required later in this section. The file must be in a file format compliant with the most recent Pharmacy Data Specifications provided by the DEPARTMENT in consultation with the PBM.
  - ii. Wellness and Chronic Condition Management Data – The CONTRACTOR must be able to accept and accommodate a monthly file from the DEPARTMENT'S wellness and chronic condition management vendor that includes data for the CONTRACTOR'S PARTICIPANTS and integrate that data into the CONTRACTOR'S medical management program. This data may include results from biometric screenings, health assessments, and unique PARTICIPANT information regarding enrollment in health coaching and/or chronic condition management programs. The file format must comply with the most recent Wellness Data Specifications as provided by the DEPARTMENT.
  - iii. WHIO Data – The CONTRACTOR must submit all claims (except Medicaid) data to WHIO for the CONTRACTOR'S commercial and Medicare covered lives residing in Wisconsin at a minimum. CONTRACTOR must submit claims to WHIO in a manner compliant with WHIO requirements.
- f. For data transfers between vendors of STATE and Local programs not specified in this AGREEMENT, the CONTRACTOR must establish vendor to vendor data transfers within ninety (90) calendar DAYS of written notification from the DEPARTMENT to do so. Such data must be accurate, complete, and timely. The CONTRACTOR must not place restrictions on the use of the data provided to the STATE and Local program vendors.
- g. Health information provided by the CONTRACTOR to the DEPARTMENT must be de-identified, unless authorized by the PARTICIPANT for the purpose of appeal, issue resolution, or fraud investigation.

## 5. Data Warehouse File Requirements

- a. The CONTRACTOR must comply with the DEPARTMENT'S specifications for submission of the required data in the formats attached to this AGREEMENT, and as updated by the DEPARTMENT. To comply with the data submission requirements, the CONTRACTOR must follow the specified data file layout and formatting of all data elements within the specified data

file layout and the DEPARTMENT'S specifications for data filtering and extraction. All file formats are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM. The DEPARTMENT will notify the CONTRACTOR of file format changes as soon as practicable.

- b. Data submitted by the CONTRACTOR to the DEPARTMENT'S data warehouse must include all of the following:
  - i. Data on payments for BENEFITS provided to PARTICIPANTS under this AGREEMENT. Payment data must include claim payments made or denied, capitation or per-member payments, administrative payments, and payments made after coordinating responsibility with third parties.
  - ii. Data on other financial transactions associated with claim payments, including charged amount, allowed amount, per-claim rebates, discounts, payments made by third-party insurance, including Medicare, and charges to PARTICIPANTS as co-payments, coinsurance, and deductibles.
  - iii. Data on the PROVIDERS of BENEFITS provided under this AGREEMENT.
  - iv. Data for all claims processed for PARTICIPANTS, as specified by the DEPARTMENT.
  - v. Data for all IN-NETWORK PROVIDERS including subcontracted PROVIDERS, as specified by the DEPARTMENT.
  - vi. Other data, as specified by the DEPARTMENT.
  
- c. Data submitted by the CONTRACTOR to the DEPARTMENT'S data warehouse must meet all the following requirements:
  - i. The CONTRACTOR must submit, in the most recent file format specified by the DEPARTMENT, all claims processed for PARTICIPANTS.
  - ii. The CONTRACTOR must submit, in the most recent file format specified by the DEPARTMENT, the specified data for all IN-NETWORK PROVIDERS including subcontracted PROVIDERS.
  - iii. The claim adjustment data the CONTRACTOR submits must follow the logic the DEPARTMENT'S data warehouse vendor defines in the data specifications.
  - iv. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file.
  - v. On all files, the CONTRACTOR must supply the 10-digit National Provider Identifier (NPI) as issued by the US Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System (NPPES), if applicable.
  
- d. The CONTRACTOR must establish and maintain a SECURE data transfer with the DEPARTMENT'S data warehouse. The CONTRACTOR must follow the data transmission instructions provided by the DEPARTMENT'S data warehouse vendor, which must include industry-standard electronic transmission methods via SECURE Internet technology.
  
- e. The CONTRACTOR must submit the required data monthly, or other frequency agreed upon by the CONTRACTOR and the DEPARTMENT. Specifically:
  - i. All data for claims paid in the previous month must be submitted in the correct file layout to the DEPARTMENT'S data warehouse. The data must be submitted to the data warehouse vendor on the date approved by the DEPARTMENT.

- ii. All network provider enrollment data for the previous month must be submitted to the DEPARTMENT'S data warehouse in the correct file layout. The data must be submitted to the data warehouse vendor on the date approved by the DEPARTMENT.
- f. The CONTRACTOR must communicate any delays in submitting the required program data to the DEPARTMENT'S data warehouse vendor via email to the DEPARTMENT Program Manager or designee and the designated data warehouse vendor as soon as the delay is known, but at least one (1) BUSINESS DAY before the scheduled transfer as described above.
- g. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR must resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse vendor or the DEPARTMENT and resubmit the data to the data warehouse.
- h. The DEPARTMENT will charge the CONTRACTOR a penalty as described in [Section IV.C. Penalty Assessments](#) and [Section IV.K. Data Warehouse Performance Standards](#) for each data file submitted after the deadlines established above. For files that are delayed by no more than five (5) calendar DAYS and for which CONTRACTOR provided the DEPARTMENT with notice of delay at least one (1) BUSINESS DAY prior to the scheduled transfer date, the penalty will be waived.
- i. The CONTRACTOR must submit documentation on its data files including a data dictionary. The data files must use the valid values specified in the CONTRACTOR'S data dictionary.
- j. The CONTRACTOR must designate a CONTRACTOR employee as a data steward who is knowledgeable of its data and systems that generate it. The data steward must attend data submission planning or status meetings scheduled by the DEPARTMENT'S data warehouse vendor on the DEPARTMENT'S behalf and will be the key point of contact for the DEPARTMENT'S data warehouse vendor on the submission of CONTRACTOR'S data and the correction of data errors should they occur.

#### 6. Data Warehouse File Submission Quality

- a. The quality of CONTRACTOR'S data submissions will be assessed by the DEPARTMENT'S data warehouse vendor for timeliness, validity, and completeness. If the DEPARTMENT'S data warehouse vendor determines that the data submitted by CONTRACTOR fails to meet the DEPARTMENT'S data warehouse vendor's thresholds for data quality, the CONTRACTOR must cooperate with the DEPARTMENT'S data warehouse vendor in submitting corrected data.
- b. As needed, the DEPARTMENT, in consultation with its data warehouse vendor and the CONTRACTOR, will develop a data improvement plan which will identify specific areas for the CONTRACTOR to improve the quality and completeness of its data submission, along with goals and timelines for improvement.
- c. The CONTRACTOR shall pay the financial penalties described in [Section IV.C. Penalty Assessments](#) and [Section IV.K. Data Warehouse Performance Standards](#) for failure to submit data in accordance with this AGREEMENT, and which are assessed by the DEPARTMENT'S data warehouse vendor on behalf of the DEPARTMENT. Charges or penalties that are the direct result of the CONTRACTOR'S failure to meet the DEPARTMENT'S data submission requirements, timelines, or other requirements in this AGREEMENT that impact the DEPARTMENT'S data

warehouse vendor will either be invoiced to the CONTRACTOR and due within thirty (30) calendar DAYS or deducted from a future payment(s) owed the CONTRACTOR.

- d. During the onboarding of a new CONTRACTOR, the CONTRACTOR will have two (2) chances to submit acceptable data as described in subsection III.D.6.a. above to the DEPARTMENT'S data warehouse. The DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the second submission not accepted by the DEPARTMENT'S data warehouse vendor. During the ongoing operation of the DEPARTMENT'S data warehouse, if the DEPARTMENT'S data warehouse vendor notifies the CONTRACTOR of an error on its initial data submission, as described in subsection III.D.6.a. above, the CONTRACTOR will have one opportunity to submit a corrected data file. If the CONTRACTOR requires additional submissions to correct identified errors, the DEPARTMENT will charge the CONTRACTOR a penalty as described in [Section IV.C. Penalty Assessments](#) and [Section IV.K. Data Warehouse Performance Standards](#) for each data file submitted after the first corrected submission not accepted by the DEPARTMENT'S data warehouse vendor.
- e. The penalties discussed in [Section III.D. Data and Information Security](#) and specified in [Section IV. Performance Standards and Penalties](#) do not apply to the penalty maximum described in [Section IV.C. Penalty Assessments](#). See [Section IV. Performance Standards and Penalties](#) for data warehouse deliverable and penalty details.

## E. Communications

This section addresses requirements related to CONTRACTOR'S communications with PARTICIPANTS.

All CONTRACTOR communications materials that are specific to the HEALTH BENEFIT PROGRAM and provided to PARTICIPANTS and EMPLOYERS must include a notice indicating CONTRACTOR is a contracted business partner of the DEPARTMENT. Notice may be accomplished by including the DEPARTMENT'S logo on letters, e-mails, and other communications materials or by including a statement indicating that CONTRACTOR has been contracted by the DEPARTMENT.

### 1. OPEN ENROLLMENT Informational / Marketing Materials

- a. The CONTRACTOR is required to prepare informational materials in a form and with content acceptable to the BOARD, as determined by the DEPARTMENT, and clearly indicate any changes from the previous year's materials when submitting draft materials to the DEPARTMENT for review and approval.
- b. The CONTRACTOR must issue written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the OPEN ENROLLMENT period identifying those PROVIDERS (individual and groups or clinics, HOSPITALS, and other facilities) that will not be IN-NETWORK for the upcoming benefit period and include any specific language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. This notification cannot be combined with informational materials sent to non-PARTICIPANTS. The CONTRACTOR must send a written confirmation to the DEPARTMENT Program Manager indicating the date(s) this written notice was issued.

- c. The CONTRACTOR must submit the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the annual OPEN ENROLLMENT period:
  - i. CONTRACTOR contact information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number (if applicable), and website address.
  - ii. Content for the CONTRACTOR'S plan description page, including available features.
  - iii. Information for PARTICIPANTS to access the CONTRACTOR'S PROVIDER directory on its web site, including a link to the PROVIDER directory.
- d. The CONTRACTOR must submit all informational materials intended for distribution to PARTICIPANTS during the annual OPEN ENROLLMENT period to the DEPARTMENT for review and approval prior to distribution by the CONTRACTOR. For guidelines on vendor-produced materials pertaining to the GHIP, please consult the ETF Health Plan Account Manager Administration Manual.
- e. The CONTRACTOR must submit one (1) digital copy of all OPEN ENROLLMENT materials in final format to the DEPARTMENT at least two (2) weeks prior to the start of the OPEN ENROLLMENT period.

## 2. Other Informational / Marketing Materials

- a. Prior to the CONTRACTOR distributing materials and communications specified by the DEPARTMENT to PARTICIPANTS, such materials and communications must be pre-approved by the DEPARTMENT. This includes written and electronic communication to potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM, such as marketing, informational, letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and Summary of Benefits and Coverage.
- b. The CONTRACTOR must certify on a QUARTERLY basis that all materials and communications as described above were submitted to the DEPARTMENT for approval prior to the CONTRACTOR distributing such to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM.
- c. The CONTRACTOR must ensure that its marketing and communication materials are culturally sensitive and professional in content, appearance, and design. At the request of the DEPARTMENT, the CONTRACTOR must replace images or artwork on its dedicated website, web-portal, or promotional materials within seven (7) BUSINESS DAYS of the CONTRACTOR'S receipt of the DEPARTMENT'S request. The DEPARTMENT reserves the right to require removal of any objectionable content sooner. For guidelines on vendor-produced materials pertaining to the GHIP, please consult the ETF Health Plan Account Manager Administration Manual.
- d. The CONTRACTOR must include in its publications information for PARTICIPANTS regarding the CONTRACTOR'S language translation services and options for filing complaints related to discrimination, as specified by the DEPARTMENT.



- e. The CONTRACTOR'S costs for developing and distributing communications to PARTICIPANTS in order to correct an error in previous CONTRACTOR communication(s) that was the result of a CONTRACTOR error will be at the cost of the CONTRACTOR.
- f. The DEPARTMENT reserves the right to require the CONTRACTOR to provide notification to PARTICIPANTS as directed.

### 3. CONTRACTOR Web Content and Web-Portal

- a. The CONTRACTOR must host and maintain a customized website providing dedicated HEALTH BENEFIT PROGRAM web content (that may be provided via a microsite that meets all criteria below), and a web-portal dedicated to PARTICIPANTS. Web content will provide basic HEALTH BENEFIT PROGRAM information. The CONTRACTOR'S web-portal will be used to present and track PARTICIPANT level information, such as claim status and BENEFIT accumulation.
- b. The CONTRACTOR must submit the web content and web-portal design to the DEPARTMENT'S Program Manager for review as directed by the DEPARTMENT. The DEPARTMENT must approve the web content prior to CONTRACTOR publishing the content.
- c. The CONTRACTOR'S website and web-portal must be available via the three (3) most recent versions of each of the popular browsers available in the market, which include Microsoft Edge, Mozilla Firefox, Google Chrome, and Apple Safari. Ongoing adoption and support of future browser versions and other browsers that gain significant market share is required.
- d. The CONTRACTOR'S web-portal must be simple, intuitive, and easy to use and navigate. The CONTRACTOR'S web-portal must be able to render effectively on any mobile device, which includes smartphones and tablets.
- e. The CONTRACTOR'S website and web-portal must have mobile capabilities. At a minimum the mobile capabilities must allow the PARTICIPANT to access HEALTH BENEFIT PROGRAM information.
- f. The CONTRACTOR'S website and web-portal must use SSL/TLS for end-to-end encryption for all connections between the user devices and the website/web-portal with the use of browsers or smartphone applications (apps).
- g. The CONTRACTOR'S web-portal must be SECURED with a minimum of SHA2-256 (or similar system such as SHA-256 as approved by the DEPARTMENT) bit EV certificates to provide the latest in encryption and cryptography.
- h. The web-portal must disable SSL/TLS negotiations which are using non-SECURE protocols and weak ciphers.
- i. The CONTRACTOR must provide the DEPARTMENT reports on the current security safeguards enabled for the website and web-portal, upon the DEPARTMENT'S request.
- j. After CONTRACTOR'S initial website and web-portal implementation, the CONTRACTOR must grant the DEPARTMENT access to the website and web-portal test environment for the

DEPARTMENT'S review and approval no less than four (4) weeks prior to the subsequent annual launch dates for each, and for each new major iteration of the website and web-portal.

- k. The CONTRACTOR must submit to the DEPARTMENT for review and approval the updated website content for the upcoming OPEN ENROLLMENT period. The DEPARTMENT will annually communicate to the CONTRACTOR the due date for this submission. After the DEPARTMENT'S approval of the web content, the CONTRACTOR must launch the updated web content at least two (2) weeks prior to the annual OPEN ENROLLMENT period.
- l. The CONTRACTOR must obtain prior approval from the DEPARTMENT Program Manager for the inclusion of any links on the CONTRACTOR'S website pages that include HEALTH BENEFIT PROGRAM information or on the web-portal to external (governmental and non-governmental) websites/portals or website pages.
- m. The CONTRACTOR will notify the DEPARTMENT Program Manager of any substantial changes being made to the CONTRACTOR'S website prior to the implementation of such changes. A substantial change in this case is a change that may affect a PARTICIPANT'S ability to find HEALTH BENEFIT PROGRAM information on the website.
- n. Basic information must be available on the CONTRACTOR'S website without requiring login credentials, including:
  - i. General information about the HEALTH BENEFIT PROGRAM and other programs offered by the BOARD;
  - ii. Directions on how to access the HEALTH BENEFIT PROGRAM PROVIDER directory and Summary of Benefits and Coverage (SBC);
  - iii. Information about PARTICIPANT HEALTH BENEFIT PROGRAM requirements, including prior authorizations and referrals;
  - iv. Ability for PARTICIPANTS to submit questions via the CONTRACTOR'S website; and,
  - v. Contact information including the CONTRACTOR'S dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and mailing address.
- o. To ensure accessibility among persons with a disability, the CONTRACTOR'S website must comply with Section 508 of the Rehabilitation Act of 1973 [29 U.S.C. § 794 (d)] and implementing regulations at 36 CFR 1194 Subparts A-D. The CONTRACTOR'S website must also conform to the most recent Web Content Accessibility Guidelines (WCAG) <https://www.w3.org/WAI/standards-guidelines/wcag/>.
- p. The CONTRACTOR'S website must be hosted in a SECURE data center with system monitoring, managed firewall services and managed backup services within the United States and be available twenty-four (24) hours a DAY, seven (7) DAYS a week, except for regularly scheduled maintenance.
- q. The CONTRACTOR'S data center network must include robust firewall, intrusion prevention and intrusion detection systems to prevent and detect unauthorized access. Any scheduled maintenance must occur between the hours of midnight and 5:00 a.m. CST/CDT or another time agreed to by the DEPARTMENT Program Manager and must be scheduled in advance with a notification on the CONTRACTOR'S website/web-portal dedicated to the HEALTH BENEFIT

PROGRAM. Unscheduled disruption to the availability of the website or web-portal must be communicated to the DEPARTMENT Program Manager within one (1) hour of realization that a problem occurred.

- r. The CONTRACTOR must have a regular patch management process defined for the CONTRACTOR'S infrastructure. The CONTRACTOR must have a defined maintenance time window for system patches, software upgrades. Outages in the system must be communicated through the website/web-portal or via alerts.
- s. The CONTRACTOR must be able to link PARTICIPANT profiles and site access permissions to the daily enrollment file provided by the DEPARTMENT and make updates based on current enrollment within three (3) BUSINESS DAYS of receipt of the enrollment file. The CONTRACTOR may utilize another process for validation if the process is pre-approved by the DEPARTMENT.
- t. The CONTRACTOR must have web-portal content and functionality updated, tested, and approved by the DEPARTMENT Program Manager or designee at least fourteen (14) calendar DAYS prior to the benefit period start date. The web-portal will SECURELY authenticate the user. After the user is authenticated, all web-portal features must be available without the need for an additional login. Available features must include:
  - i. Username and password creation and recovery;
  - ii. Enrollment confirmation;
  - iii. Secure upload functionality for submitting program required documentation;
  - iv. Communication functions that allow users to submit SECURE questions to the CONTRACTOR and allow the CONTRACTOR to push general and targeted communications to users via United States Postal Service mail, e-mail, text and other standard communication vehicles, as requested by the DEPARTMENT; and,
- u. The CONTRACTOR must ensure that critical PARTICIPANT, PROVIDER, and other web accessible and/or telephone-based functionality and information, including the CONTRACTOR'S website containing HEALTH BENEFIT PROGRAM information and the web-portal, are available to the applicable system users, except during periods of scheduled system unavailability agreed upon by the DEPARTMENT and the CONTRACTOR. Unavailability caused by events outside of the CONTRACTOR'S span of control is outside of the scope of this requirement. Any scheduled maintenance must be scheduled in advance with notification on the CONTRACTOR'S website and web-portal.

## F. Provider Access

This section addresses requirements regarding PROVIDER network availability and continuity of care when networks change.

### 1. Provider Access Standards

- a. The CONTRACTOR must submit an annual PROVIDER network list for the upcoming benefit period to the DEPARTMENT and the BOARD'S consulting actuary. This is in addition to the monthly PROVIDER data submission detailed in [Section III.D. Data and Information Security](#).
- b. The CONTRACTOR must sort providers by zip code based on where they are physically located within each county and major city in the region. Major cities are those that have over thirty-

three percent (33%) of the county population. These providers must agree to accept new patients.

- c. The CONTRACTOR must comply with the provider network access standards set forth in Wis. Admin. Code § INS 9.32 and Wis. Stat. § 609.22, if not preempted by federal law. The CONTRACTOR must also meet the provider access standards as described in the Provider Network Submission Tool that is collected by the DEPARTMENT annually via the DEPARTMENT'S actuary. The DEPARTMENT will use this data to determine the counties in which the CONTRACTOR is qualified. CONTRACTORS are determined to be qualified on a county-by-county basis by meeting the provider access standards in this section and the operating experience required for CONTRACTORS.
- d. The BOARD reserves the right to offer the State Maintenance Plan (SMP) in any counties in which a qualified Tier 1 plan is not available. See [Section 2 of Certificate of Coverage: Eligibility, Enrollment, and Termination](#) for information about tiers. A Preferred Provider Organization (PPO) is not qualified in areas served by the SMP.
- e. The DEPARTMENT may determine a CONTRACTOR is not qualified in a county if the CONTRACTOR meets the provider access standards and the DEPARTMENT determines the CONTRACTOR is not effectively administering the HEALTH BENEFIT PROGRAM in accordance with this AGREEMENT (e.g., failure to provide effective medical management, etc.).
- f. The DEPARTMENT will list the CONTRACTORS determined to be qualified in each county in the annual OPEN ENROLLMENT materials. At its discretion, the DEPARTMENT may also list the CONTRACTORS determined to be non-qualified in each county.
- g. The BOARD reserves the right to allow for exceptions in certain counties when the CONTRACTOR can demonstrate the criteria in [Section III.F. Provider Access](#) cannot be met.

## 2. OUT-OF-NETWORK Services

- a. Care from an OUT-OF-NETWORK PROVIDER may require prior-authorization from the CONTRACTOR unless it is an emergency or urgent care situation.
- b. The CONTRACTOR must have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent care situation that results in care from OUT-OF-NETWORK PROVIDERS.

## 3. Continuity of Care

- a. The CONTRACTOR must comply with the continuity of care provisions under Wis. Stat. § 609.24, if not preempted by federal law, for PROVIDERS listed in the annual OPEN ENROLLMENT materials and listed in the CONTRACTOR'S provider network submission. In the event a PROVIDER or PROVIDER group terminates its contract with the CONTRACTOR during a benefit period, the CONTRACTOR will follow the continuity of care provisions and pay claims for covered services at the negotiated rate. In this case, the PARTICIPANT shall be held harmless and indemnified by the CONTRACTOR. This does not apply in the case of loss of providers due to normal attrition (death, retirement, a move from the service area) or as a result of a formal disciplinary action relating to quality of care.

- b. At least thirty (30) calendar DAYS (or as soon as is practicable) prior to the termination of a PROVIDER agreement, or the closing of an IN-NETWORK clinic, PROVIDER location, or HOSPITAL during the benefit period, the CONTRACTOR must:
  - i. Send written notification to all PARTICIPANTS who have had services from that PROVIDER in the past twelve (12) months that includes the following information:
    - How to find a new IN-NETWORK PROVIDER or facility;
    - The continuity of care provision as it relates to this situation; and,
    - Contact information for questions.
  - ii. Update the PROVIDER directory on the CONTRACTOR'S website.
- c. The CONTRACTOR must keep a record of this notification mailing and provide the DEPARTMENT with documentation, including PARTICIPANT and mailing address used, upon the DEPARTMENT'S request.
- d. The CONTRACTOR will assist the PARTICIPANT in selecting a new IN-NETWORK PROVIDER or facility and obtaining any necessary referrals or authorizations.
- e. If the CONTRACTOR offers more than one (1) network to PARTICIPANTS and the networks change on January 1st, a SUBSCRIBER who failed to make an election during the OPEN ENROLLMENT period to change networks in order to maintain access to his or her current PROVIDERS may change to the appropriate network during the next OPEN ENROLLMENT period or other enrollment opportunity as specified in this AGREEMENT.

## G. Care Management

This section addresses the DEPARTMENT'S care management-related initiatives, requirements related to designating a PRIMARY CARE PROVIDER or PRIMARY CARE CLINIC, and pilot programs offered by the CONTRACTOR.

### 1. DEPARTMENT Initiatives

- a. The CONTRACTOR is required to implement and report on the DEPARTMENT Initiatives upon request by the DEPARTMENT. DEPARTMENT Initiatives are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM PARTICIPANTS. The DEPARTMENT may request input and collaboration from the CONTRACTOR in identifying opportunities for population health management initiatives across GHIP contractors for an overall population health management approach. The CONTRACTOR may coordinate with HOSPITALS, PROVIDER groups, or vendors to ensure the requirements of the DEPARTMENT Initiatives are met.
  - i. The current DEPARTMENT Initiative is limited to Care Coordination. The CONTRACTOR must ensure care coordination is offered for PARTICIPANTS with high-risk health condition(s) by conducting outreach within three (3) to five (5) BUSINESS DAYS of a PARTICIPANT'S initial discharge from an INPATIENT HOSPITAL stay of more than twenty-four (24) hours.

## 2. PRIMARY CARE PROVIDER/PRIMARY CARE CLINIC Designation

- a. If a SUBSCRIBER files an application during a prescribed enrollment period listing a PCP/PCC that is not IN-NETWORK with the selected CONTRACTOR, the CONTRACTOR must notify the SUBSCRIBER within five (5) BUSINESS DAYS of either the DEPARTMENT'S transmission of the enrollment data or the beginning of the new program year and aid the person in selecting an IN-NETWORK PCP/PCC.
- b. If the SUBSCRIBER is not responsive to the CONTRACTOR'S efforts, the CONTRACTOR will assign a PCP/PCC, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP/PCC.

## 3. Population Health Management

- a. The CONTRACTOR must apply effective methods to support PARTICIPANTS' health, reduce risks and prevent unnecessary costs. This includes, but is not limited to:
  - i. Managing costs for medical services, HOSPITAL confinement or other BENEFITS to be provided with evidence-based peer and utilization review mechanisms for monitoring healthcare costs.
  - ii. Offering complex case management programming to PARTICIPANTS.
  - iii. Coordinating programming with the DEPARTMENT'S wellness and chronic condition management vendor(s) by:
    - Integrating PARTICIPANT data provided by the DEPARTMENT'S wellness and chronic condition management vendor(s) into CONTRACTOR'S population health management system(s) and/or processes;
    - Using PARTICIPANT level data from the DEPARTMENT'S wellness and chronic condition management vendor(s) to identify PARTICIPANTS eligible for complex/chronic case management and enroll PARTICIPANTS in such programs; and
    - Refer PARTICIPANTS to the appropriate resources provided by the DEPARTMENT'S wellness and chronic condition management vendor(s) as applicable.
- b. The CONTRACTOR will not give PARTICIPANTS financial or other incentives of monetary value that do not qualify as a medical expense under IRS Code Section 213(d) for participation in population health management programming.
- c. The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the PARTICIPANT level data as stated in [Section III.D.3. Data Integration and Technical Requirements](#), in [Section 4 of the Certificate of Coverage: Benefits & Coverages](#), and from the DEPARTMENT'S wellness and chronic condition management vendor(s) to manage population health.
- d. The CONTRACTOR must provide the DEPARTMENT, upon the DEPARTMENT'S request, aggregate data on engagement and impact of the CONTRACTOR'S population health programming efforts on behalf of PARTICIPANT health, program quality and financial impact.

## 4. Pilot Programs

- a. Pilot programs are those that impact Uniform Benefits, including but not limited to cost-sharing or changes to covered medical services.

- b. The CONTRACTOR may provide a pilot program, with the DEPARTMENT'S prior approval, for limited-term trial to PARTICIPANTS to study the program's impact and evaluate options for future year Uniform Benefit change proposals.
- c. The CONTRACTOR may not assess a fee for the pilot program to the DEPARTMENT or PARTICIPANTS.
- d. Pilot programs cannot include financial or other incentives of monetary value that do not qualify as a medical expense under IRS Code Section 213(d) for participation unless approved by the DEPARTMENT.
- e. The CONTRACTOR may submit pilot proposals to the DEPARTMENT during the annual time frame specified by the DEPARTMENT (usually between November 15 – December 15) that include the following elements:
  - i. An estimate of the cost to implement the program, as well as the cost savings estimated from implementing the program.
  - ii. An estimate of the number of GHIP members who would be eligible for the program.
  - iii. An estimate of the number of GHIP members who are expected to participate in a program if offered.
  - iv. Copies of at least two (2) peer-reviewed studies that show the program's methodologies or intervention components are successful in impacting population health and are appropriate for GHIP members.
  - v. Evaluation methods and reporting that will be used to monitor the implementation of the proposed program design, as well as the outcomes of program participants.
- f. Pilot programs must result in minimal burden to other DEPARTMENT-contracted vendors who would be affected by the program. Existing processes or cooperative arrangements should be used, if possible, when cross-vendor programming is proposed (examples: health plan-pharmacy vendor, health plan-wellness vendor).
- g. CONTRACTOR may include pilot program promotional information via links on CONTRACTOR'S GHIP-dedicated website, on OPEN ENROLLMENT materials, new member welcome packets or other member materials, if such information does not exceed 25% of the materials provided. Pilot program materials should be submitted to the DEPARTMENT for review prior to the release of the materials and should include the following:
  - i. A clear reference in the description of the program that it is a pilot for PARTICIPANTS for the current benefit year and may be changed or discontinued in future years.
  - ii. A description of any limitation to enrollment numbers, eligibility requirements, or other factors that would be relevant to the member being able to receive the benefits (e.g., availability to high-deductible health plan members, retirees versus active, etc.).
- h. The CONTRACTOR must report annually to the DEPARTMENT on the progress and outcomes of the pilot.

#### H. Administrative Services and Supports

This section addresses administrative services provided by the CONTRACTOR not specified in other sections. The CONTRACTOR must not modify any of the services or program content provided as part of the CONTRACT without prior written approval by the DEPARTMENT Program Manager.

## 1. Account Management and Staffing

- a. Upon execution of the CONTRACT, the CONTRACTOR must designate an Account Manager and backup Account Manager to support the DEPARTMENT for the life of the CONTRACT.
- b. The DEPARTMENT reserves the right to reasonably deny the CONTRACTOR'S designated Account Manager and request a replacement. The CONTRACTOR'S Account Manager or backup must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT.
- c. The CONTRACTOR'S Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR must resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.
- d. The CONTRACTOR must designate an Information Technology contact and a backup Information Technology contact who will have overall responsibility for the information technology aspects of the CONTRACT. The Information Technology contact must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.
- e. The CONTRACTOR must provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. Key staff are staff in positions of executive or managerial responsibility and/or whose performance affects the services provided under this AGREEMENT. The CONTRACTOR must ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT have the experience and credentials necessary to perform the work required. The CONTRACTOR must provide the DEPARTMENT with contact information for the CONTRACTOR'S key staff, which the DEPARTMENT will share with EMPLOYERS.
- f. The CONTRACTOR must notify the DEPARTMENT'S Program Manager if the CONTRACTOR'S Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to reasonably deny the CONTRACTOR'S replacement personnel designees.
- g. The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must acknowledge receipt of the inquiry from the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff.
- h. The CONTRACTOR must provide staff attendance at the annual EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the OPEN ENROLLMENT period, and any ANNUITANT group meetings, as appropriate.



- i. The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR'S operations and policies.
- j. The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include bimonthly or QUARTERLY coordination meetings with other stakeholders of the HEALTH BENEFIT PROGRAM. Meetings may be in person or by teleconference/webinar, as determined by the DEPARTMENT.
- k. The CONTRACTOR'S Account Manager must notify the DEPARTMENT of any major system changes to the CONTRACTOR'S administrative and/or operative systems; the DEPARTMENT will then notify the BOARD.

## 2. Claims

- a. Targets for claims processing performance standards and associated penalties are specified in [Section IV. Performance Standards and Penalties](#).
- b. Upon request, the CONTRACTOR will assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).
- c. Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR must provide a listing of the total dollar amount of the applicable claims paid by the HEALTH BENEFIT PROGRAM on behalf of the PARTICIPANT.
- d. In the event that the CONTRACTOR approves or reimburses for a service in error that is considered non-covered under UNIFORM BENEFITS, the CONTRACTOR agrees it will not seek reimbursement from the DEPARTMENT or the PARTICIPANT for such service and shall hold the DEPARTMENT and the PARTICIPANT harmless from any liability for payment of such service.
- e. The CONTRACTOR is responsible for resolving discrepancies in claims payments for all Medicare data match inquiries.

## 3. Customer Service

- a. The CONTRACTOR must operate a customer service department for the HEALTH BENEFIT PROGRAM during normal CONTRACTOR business hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT, except official State of Wisconsin holidays as listed under Wis. Stat. §230.35(4)(a). The CONTRACTOR must report its standard customer service department hours of operation and anticipated closures to the DEPARTMENT on an annual basis in the format specified by the DEPARTMENT. The CONTRACTOR must report any unanticipated CONTRACTOR customer service closures promptly to the DEPARTMENT in the format specified by the DEPARTMENT.
- b. The CONTRACTOR must have a dedicated toll-free number for the HEALTH BENEFIT PROGRAM and have customer service staff who are sufficiently trained to respond appropriately to

PARTICIPANT inquiries, correspondence, complaints, and issues. The dedicated toll-free number must not have more than two (2) menu prompts to reach a live person.

- c. PARTICIPANTS must be able to submit questions using e-mail and via a website. For the hearing-impaired population, the CONTRACTOR'S call center will utilize the national relay service (711) or the caller can use their own relay system. The CONTRACTOR must track, document, and record all calls and correspondence to CONTRACTOR'S customer service representatives and retrieve such calls and correspondence, when necessary, by PARTICIPANT name or the PARTICIPANT'S DEPARTMENT eight (8)-digit member ID.
- d. The CONTRACTOR must notify the DEPARTMENT Program Manager of any disruption in customer service availability or toll-free access regardless of reason for disruption, within one (1) hour of realization that a problem exists.
- e. The CONTRACTOR must monitor and report to the DEPARTMENT on the performance standards for the HEALTH BENEFIT PROGRAM that include call answer timeliness and call abandonment rate. Targets for the customer service performance standards and associated penalties are specified in [Section IV. Performance Standards and Penalties](#).
- f. The CONTRACTOR must have a customer service inquiry system for inquiries received by phone and email and/or website. The system must maintain a history of inquiries for performance management, quality management and audit purposes. Related correspondence and calls must be indexed and properly recorded by CONTRACTOR to allow for reporting and analysis based on a distinct transaction.
- g. The CONTRACTOR must certify annually that their customer service inquiry system meets the requirements in [Section IV. Performance Standards and Penalties](#). The DEPARTMENT reserves the right to request from the CONTRACTOR a report by month for a rolling twelve (12) month period showing the volume and type of inquiry with a break-down by topic. The report must include a comparison to the same month of the previous calendar year and illustrate trends.
- h. Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request.
- i. At the DEPARTMENT'S request, the CONTRACTOR must provide the policies and procedures related to the operation of the CONTRACTOR'S customer service department. The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.
- j. The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five percent (5%) each year of all PARTICIPANT inquiries made by each submission type (e.g., phone, email, website) must be audited (e.g., by lead worker, supervisor, manager, auditor, etc.) to ensure accurate information was given to PARTICIPANTS and appropriate coaching and training is given to customer service representatives who failed to accurately respond to PARTICIPANTS. At the DEPARTMENT'S request, the CONTRACTOR must provide the audit results.

- k. The CONTRACTOR must respond directly to PARTICIPANTS upon the DEPARTMENT'S request. For matters designated as urgent by the DEPARTMENT, the CONTRACTOR must contact the PARTICIPANT within one (1) BUSINESS DAY of receiving a request from the DEPARTMENT and actively communicate to the DEPARTMENT'S Program Manager or designee on issue resolution status until the issue is resolved.

#### 4. Incentives

The CONTRACTOR may not offer any financial incentives or discounts that do not qualify as a 213(d) medical expense under federal law (see the IRS publication 502) to PARTICIPANTS. All incentives offered must be approved in advance by the DEPARTMENT.

#### 5. Recovery of Overpayments

The CONTRACTOR must have procedures to recover or collect overpayments made under this AGREEMENT, including those payments made for an ineligible person.

#### 6. Subrogation and Other Payers

The CONTRACTOR must correspond with PARTICIPANTS to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other payers such as worker's compensation, insurance contracts, or government-sponsored benefit programs.

#### 7. Gifts and/or Kickbacks Prohibited

No gifts from the CONTRACTOR or any of the CONTRACTOR'S subcontractors are permissible to any EMPLOYEES whose work relates to the HEALTH BENEFIT PROGRAM, or members of the BOARD. Neither the CONTRACTOR nor any of its subcontractors shall request or receive kickbacks.

#### 8. Notice of Significant Events

- a. The CONTRACTOR must notify the DEPARTMENT Program Manager in writing of any "Significant Event" within ten (10) calendar DAYS after the CONTRACTOR becomes aware of it. A "Significant Event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect on the CONTRACTOR'S ability to meet its obligations under this AGREEMENT, including, but not limited to, any of the following:
  - i. disposal of major assets;
  - ii. loss of fifteen percent (15%) or more of the CONTRACTOR'S membership;
  - iii. termination or modification of any contract or subcontract if such termination or modification will have a material effect on the CONTRACTOR'S obligations under this AGREEMENT;
  - iv. the imposition of, or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;
  - v. the withdrawal of, or notice of intent to withdraw, dissolution of existing relationship, state licensing or certification, United States Department of Health and Human Services (HHS) qualification or any other status under STATE or federal law;
  - vi. default on a loan or other financial obligations;
  - vii. strikes, slow-downs, or substantial impairment of the CONTRACTOR'S facilities or of other facilities used by the CONTRACTOR in the performance of this AGREEMENT.

- b. In addition, any change in the ownership of or controlling interest in the CONTRACTOR, any merger with another entity or the CONTRACTOR'S acquisition of another organization that participates in the HEALTH BENEFIT PROGRAM is a "Significant Event." A change in ownership or controlling interest means any change in ownership that results in a change to or acquisition of majority (fifty-one percent (51%) interest in the CONTRACTOR or any transfer of ten percent (10%) or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the DEPARTMENT Program Manager at least sixty (60) calendar DAYS advance notice (or as soon as is practicable) of any such event in order to fulfill the BOARD'S responsibility to assess the effects of the pending action upon the interests of the HEALTH BENEFIT PROGRAM and its PARTICIPANTS. The DEPARTMENT may accept a shorter period of notice when circumstances justify.
- c. The DEPARTMENT and the BOARD agree to keep the information disclosed as required above confidential under [Wis. Stat. § 19.36 \(5\)](#) of the Wisconsin Public Records Law until the earliest of one of the dates noted in section III.H.8.d. below, unless:
  - i. The CONTRACTOR waives confidentiality, or
  - ii. A court orders the DEPARTMENT or BOARD to disclose the information, or
  - iii. The DEPARTMENT or BOARD determines that, under the particular circumstances, any harm to the public interest that would result from permitting inspection is outweighed by the public interest in immediate inspection of the records.
- d. The DEPARTMENT also agrees to notify the CONTRACTOR of a request to disclose the information as a public record prior to making such disclosure, to permit the CONTRACTOR to defend the confidentiality of the information.
- e. Information disclosed by a CONTRACTOR concerning any change in ownership or controlling interest, any merger, or any acquisition of another entity will be disclosed by the DEPARTMENT as a public record beginning on the earliest of the following dates:
  - i. The date the pending change in ownership or controlling interest, any merger or any acquisition of another entity becomes public knowledge, as evidenced by public discussion of the action including but not limited to newspaper accounts.
  - ii. The date such action becomes effective.
  - iii. Sixty (60) calendar DAYS after the DEPARTMENT receives the information.

#### 9. Bonding, Reinsurance and Insolvency

- a. The CONTRACTOR must maintain appropriate bonding and/or reinsurance and must submit documentation evidencing such upon request by the DEPARTMENT. The appropriate bonding and/or reinsurance ensures that, in the event the CONTRACTOR becomes insolvent or otherwise unable to meet the financial provisions of the CONTRACT, bonding or reinsurance exists to pay those obligations.
- b. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT confined as an INPATIENT, BENEFITS must continue until:
  - i. the confinement ceases;
  - ii. the attending physician determines confinement is no longer medically necessary;

- iii. the end of 12 months from the date of insolvency; or
  - iv. the contract maximum is reached, whichever occurs first.
- c. The DEPARTMENT will establish enrollment periods during which SUBSCRIBERS may transfer coverage to another CONTRACTOR in the event that a CONTRACTOR becomes insolvent or is otherwise unable to meet the financial provisions of the CONTRACT.
- d. In the event a CONTRACTOR becomes or is at risk for becoming insolvent, experiences a “Significant Event,” a significant loss of primary PROVIDERS and/or HOSPITALS, or no longer meets the minimum provider access standards defined under [Wis. Stat. § 609.22](#) and [Wis. Admin. Code INS 9.32](#), and included in [Section III.F.1. Provider Access Standards](#), or if the BOARD so directs due to a “Significant Event,” the BOARD may do any of the following, including any combination of the following:
- i. Terminate the CONTRACT upon any notice it deems appropriate, including no notice.
  - ii. Authorize a special enrollment period and require that each SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR enroll in another health plan.
  - iii. Authorize a special enrollment period so that a SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR may voluntarily enroll in another health plan.
  - iv. Close the benefit plan administered by the CONTRACTOR to any new enrollments for the remainder of the CONTRACT period.
  - v. Require that prior to selecting a health plan, prospective SUBSCRIBERS be given a written notice describing the BOARD'S concerns.
  - vi. Take no action.

#### 10. Contract Termination

- a. In the event the CONTRACT is terminated by the CONTRACTOR, the CONTRACTOR must continue to cover BENEFITS for any PARTICIPANT who is admitted to a HOSPITAL as an INPATIENT on the date of CONTRACT termination until the earliest of the following dates:
- i. The BENEFIT maximum is reached;
  - ii. The attending physician determines that INPATIENT confinement is no longer medically necessary;
  - iii. The end of twelve (12) months after the date of CONTRACT termination; or
  - iv. The PARTICIPANT’S confinement ends.
- b. If the BOARD terminates the CONTRACT, all rights to BENEFITS provided by the CONTRACTOR shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the CONTRACT termination date. Such arrangements may include, but are not limited to, transferring the patient to another facility, or permitting OUT-OF-NETWORK PROVIDERS to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.
- c. The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT’S approval.
- d. The CONTRACTOR must submit claims data as specified in [Section III.D. Data and Information Security](#) during a six (6) month run-out period following the CONTRACT termination date. The

DEPARTMENT will withhold twenty-five percent (25%) of premium payment for the last month of the CONTRACT period, to be paid no later than ninety (90) calendar DAYS following complete and accurate run-out file submission (applies to both medical and PROVIDER files), unless there are issues receiving timely run-out claims data.

- e. If the CONTRACTOR terminates the CONTRACT, the CONTRACTOR shall not again be considered for participation in the HEALTH BENEFIT PROGRAM under [Wis. Stat. § 40.03 \(6\) \(a\)](#) for a period of three (3) calendar years.
- f. See Section 16.0 of the Department Terms and Conditions for additional requirements related to CONTRACT termination.

#### 11. Transition Plan

- a. The CONTRACTOR must provide a first draft of a transition plan within ten (10) BUSINESS DAYS of the determination that the CONTRACT will be terminated and work with the DEPARTMENT'S Program Manager to establish a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks and activities, including those identified by the DEPARTMENT within thirty (30) calendar DAYS of the determination. The transition plan must be approved by the DEPARTMENT prior to the transition start date.
- b. Notwithstanding language in the Department Terms and Conditions, the CONTRACTOR shall provide transition services even if the DEPARTMENT withholds premiums owed the CONTRACTOR in the last month of the CONTRACT period, as stated above in [Section III.H.11. Transition Plan](#).

#### 12. Expert Services

- a. At the request of the DEPARTMENT, the CONTRACTOR must make available qualified medical consultants to assist the DEPARTMENT in its reviews of questionable claims, claims recommended for denial for medical reasons, reconsiderations, and appealed claim determinations.
- b. The CONTRACTOR must have legal and technical staff available to the DEPARTMENT for consultation as needed for program administration, and for assistance with any appeals processes.
- c. The CONTRACTOR must monitor the development of and provide notification and information to the DEPARTMENT in a timely manner concerning state or federal regulations or legislation that may affect the HEALTH BENEFITS PROGRAM.

#### 13. Mailing and Postage

The CONTRACTOR must pay for all mailing, postage, and handling costs for the distribution of materials as required by [Section III.E. Communications](#), or by other express provisions of the CONTRACT.

### I. Grievances and Appeals

This section addresses the process by which PARTICIPANTS can express and seek remedy for any dissatisfaction with the CONTRACTOR.

## 1. Grievance Process Overview

- a. The CONTRACTOR must have an internal grievance process in accordance with applicable federal or STATE law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance process, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process (for new CONTRACTORS) and upon request by the DEPARTMENT. (See [Section III.I.4. Investigation and Resolution Requirements](#) and [Section III.I.5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights](#).)
- b. Any dispute about BENEFITS or claims arising under this AGREEMENT must first be submitted for resolution through the CONTRACTOR'S internal grievance process and may then, if necessary and appropriate, be submitted to the DEPARTMENT for administrative review or to an Independent Review Organization, if applicable.
- c. Grievances regarding non-covered services or services excluded from coverage by the HEALTH BENEFIT PROGRAM must be handled like any other grievance. Written inquiries received by the CONTRACTOR not related to BENEFITS determinations must be resolved by the CONTRACTOR within ten (10) BUSINESS DAYS following the CONTRACTOR'S receipt of the inquiry.
- d. If any PARTICIPANT has a problem or complaint relating to a determination of BENEFITS, the PARTICIPANT should contact the CONTRACTOR. The CONTRACTOR must assist the PARTICIPANT in trying to resolve the matter on an informal basis and may initiate a claim review of the BENEFITS determination. If the PARTICIPANT wishes, they may omit this step and immediately file a formal grievance. A claim review is not a substitute for a grievance.
- e. The steps in the PARTICIPANT grievance process include (with Section references):
  - i. Claim review (optional for PARTICIPANT) ([Section III.I.2. Claim Review](#));
  - ii. PARTICIPANT notice ([Section III.I.3. PARTICIPANT Notice](#));
  - iii. Investigation and resolution ([Section III.I.4. Investigation and Resolution Requirements](#));
  - iv. Notification of DEPARTMENT Administrative Review Rights or External Review Rights ([Section III.I.5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights](#)); and,
  - v. External review ([Section III.I.6. External Review](#)).

## 2. Claim Review

- a. The CONTRACTOR must perform a claim review when a PARTICIPANT requests a review of denied BENEFITS. When a claim review has been completed, the CONTRACTOR must notify the PARTICIPANT of the decision.
- b. If the decision is to uphold the denial of BENEFITS, the CONTRACTOR must provide the PARTICIPANT written notification as to the specific reason(s) for the continued denial of BENEFITS and of their right to file a grievance.

## 3. PARTICIPANT Notice

The CONTRACTOR must provide the PARTICIPANT with notice of their grievance rights and a period of ninety (90) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the

cause of the grievance along with the UNIFORM BENEFITS contractual provision(s) upon which the denial is based.

#### 4. Investigation and Resolution Requirements

- a. Investigation of any grievance will be initiated by the CONTRACTOR within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem.
- b. Grievances related to an urgent health concern will be handled within three (3) BUSINESS DAYS of the CONTRACTOR'S receipt of the grievance.

#### 5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights

- a. In the final grievance decision letters, the CONTRACTOR must inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision or their right to request an external review in accordance with applicable federal or STATE law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR must cite the specific UNIFORM BENEFITS contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision.
- b. If the PARTICIPANT disagrees with the grievance committee's final decision, the PARTICIPANT may submit a written request for review to the DEPARTMENT within sixty (60) calendar DAYS of the date of the final grievance decision letter. The DEPARTMENT will review and communicate the outcome of the review to the PARTICIPANT. If the PARTICIPANT disagrees with the outcome, and the grievance committee's final decision is not eligible for external review, they may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within sixty (60) calendar DAYS of the date of the DEPARTMENT'S final review letter.
- c. The determination of the DEPARTMENT is final and not subject to further review unless the PARTICIPANT submits a timely appeal of the determination by the DEPARTMENT to the BOARD, as provided by [Wis. Stat. § 40.03 \(6\) \(i\)](#) and [Wis. Adm. Code ETF 11.01 \(3\)](#).
- d. The DEPARTMENT will not issue a determination regarding denials of coverage by a CONTRACTOR and/or PBM based on medical necessity, appropriateness, healthcare setting, level of care, effectiveness of a covered benefit, experimental treatment, or the rescission of a policy or certificate that can be resolved through the external review process under applicable federal or STATE law. See [Section III.I.6. External Review](#).
- e. If the PARTICIPANT disagrees with a determination by the DEPARTMENT, the PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and . This process may include an administrative hearing. The CONTRACTOR must, upon the DEPARTMENT'S request, participate in all administrative reviews, including administrative hearings, requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings must be conducted in accordance with the guidelines, rules, and regulations promulgated by the DEPARTMENT.



- f. BOARD decisions can only be further reviewed as provided by Wis. Stat. § 40.08 (12) and Wis. Adm. Code ETF 11.15.

## 6. External Review

- a. The PARTICIPANT must have the option to request an external review by an Independent Review Organization (IRO), subject to applicable federal and STATE law. Denials of coverage by a CONTRACTOR and/or PBM are eligible for external review if based on medical necessity, appropriateness, healthcare setting, level of care, effectiveness of a covered benefit, experimental treatment, or the rescission of a policy or certificate. In accordance with federal or STATE law, any decision by an IRO is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the external review decision is rendered.
- b. Within five (5) calendar DAYS of the CONTRACTOR'S receipt of a PARTICIPANT'S request for external review, the CONTRACTOR must notify the DEPARTMENT of the request in the format specified by the DEPARTMENT.
- c. Within fourteen (14) calendar DAYS of the CONTRACTOR'S receipt of the external review determination, the CONTRACTOR must notify the DEPARTMENT of the outcome.
- d. Within thirty (30) calendar DAYS of the CONTRACTOR'S receipt of the final external review determination, the CONTRACTOR must send a copy of the detailed report provided from the external reviewer to the DEPARTMENT. The CONTRACTOR must redact all member-identifying information from this copy before sending it to the DEPARTMENT.
- e. The CONTRACTOR shall not be in breach of this AGREEMENT solely because the external reviewer does not comply with the timeframes set forth in the statutes or regulations.

## 7. Provision of Complaint Information

- a. All information and documentation related to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a CONTRACTOR must be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the CONTRACTOR must cooperate in obtaining the authorization and accept the DEPARTMENT'S form that complies with all applicable laws regarding patient privacy.
- b. Information may include complete copies of grievance files, medical records, consultant reports, customer service contact worksheets or any other documentation the DEPARTMENT deems necessary to review a PARTICIPANT complaint, resolve disputes or to formulate determinations. Such information must be provided to the DEPARTMENT at no charge within fifteen (15) BUSINESS DAYS of the DEPARTMENT'S request, or by an earlier date as requested by the DEPARTMENT.

## 8. DEPARTMENT Request for Grievance

The DEPARTMENT may require the CONTRACTOR to treat and process a complaint received by the DEPARTMENT as a grievance and the DEPARTMENT will forward the complaint to the CONTRACTOR on behalf of the PARTICIPANT. The CONTRACTOR must process the complaint as a grievance in compliance with the HEALTH BENEFIT PROGRAM'S provisions regarding a formal grievance.

## 9. Notification of Legal Action

If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR must notify the DEPARTMENT'S general counsel and the DEPARTMENT Program Manager within ten (10) BUSINESS DAYS after CONTRACTOR is served a Summons and Complaint involving a PARTICIPANT. This requirement does not extend to cases of subrogation.

## 10. Compliance with Departmental Determinations

If a departmental determination overturns a CONTRACTOR'S decision on a PARTICIPANT'S grievance, the CONTRACTOR shall comply with the determination within ninety (90) calendar DAYS of the date of the determination. As used in this section, "comply" means to take action as directed in the departmental determination or to appeal the determination to the BOARD within ninety (90) calendar DAYS.

## J. Audits and Disclosure Requirements

This section addresses the process by which the DEPARTMENT and other government entities may conduct audits, the requirement to participate in audits, and requirements to retain records.

### 1. Audit and Other Services

- a. The CONTRACTOR must maintain sufficient documentation to provide for the financial and management audit of its performance under this AGREEMENT. Such documentation must include, but not be limited to, program expenditures, claim processing efficiency and accuracy, and customer service. The CONTRACTOR must make financial records, claims documentation, and all other relevant records available for review or audit as requested by the DEPARTMENT and assist as needed in review of these records.
- b. At its discretion, the BOARD may require an independent third-party audit or review of any function relating to the HEALTH BENEFIT PROGRAM, including a pre-implementation configuration audit.
- c. The CONTRACTOR must address any areas for improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. The CONTRACTOR must notify the DEPARTMENT of all identified areas for improvement and the status of all improvements as necessary.
- d. The BOARD will make a diligent attempt to select a third-party audit firm that is not a competitor of the CONTRACTOR or affiliated with or under the control of a competitor of the CONTRACTOR.
- e. The frequency and extent of such audits will be determined by the BOARD or DEPARTMENT. Records of paid claims must be maintained in a format and in a media acceptable to the DEPARTMENT.
- f. In addition to third-party audits, at the request of the DEPARTMENT, the CONTRACTOR must make available prior to the beginning of any benefit year a full description of the configuration of the CONTRACTOR'S claims processing system. The CONTRACTOR will also certify to the

DEPARTMENT that the claims processing system will properly process claims according to the CONTRACT prior to the start of the benefit year.

- g. The CONTRACTOR must submit a Model Audit Rule (MAR) Certification to the DEPARTMENT on an annual basis.
- h. The CONTRACTOR must submit financial stability documentation to the DEPARTMENT on an annual basis, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles) as directed in [Section IV.G.5. Financial Stability Documentation](#).
- i. The CONTRACTOR is exempt from the Service Organization Control (SOC) audit report provision outlined in Section 6.1 of the Department Terms and Conditions for an annual Statement on Standards for Attestation Engagements (SSAE) No. 18 (SOC 1, Type 2) audit report.
- j. The CONTRACTOR must cooperate fully with audits and/or reviews conducted by the State of Wisconsin Legislative Audit Bureau (LAB). The LAB conducts periodic and other audits at the requests of legislators.

## 2. Examination of Records

- a. The DEPARTMENT, or its designee, shall have the right to examine any records of the CONTRACTOR relating to the HEALTH BENEFIT PROGRAM in compliance with Wis. Stat. § 40.07 and any applicable federal or other STATE laws and rules. CONTRACTOR shall furnish the requested records within ten (10) BUSINESS DAYS of CONTRACTOR'S receipt the DEPARTMENT'S request or as directed by the DEPARTMENT. All such records are the sole property of the DEPARTMENT.
- b. Upon a showing satisfactory to the BOARD that the CONTRACTOR is required by law to maintain a copy of such records, the DEPARTMENT and the CONTRACTOR shall agree to terms, conditions and provisions permitting the CONTRACTOR to maintain information to the minimum extent and for the minimum time required by law. Any such agreement will require the CONTRACTOR to:
  - i. Keep confidential and properly safeguard each "medical record" and all "personal information," as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;
  - ii. Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,
  - iii. Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record, provided by the DEPARTMENT to the CONTRACTOR, that would violate Wis. Stat. § 40.07 (1) or (2).

## 3. Record Retention

- a. The DEPARTMENT and the BOARD shall have the right to examine any of the CONTRACTOR'S pertinent records or other documentation and those of any parent, affiliate, or subsidiary organization performing under formal or informal arrangement any service or furnishing any supplies or equipment to the CONTRACTOR involving transactions related to this AGREEMENT,

until the expiration of seven (7) years after the termination of the CONTRACT and any extensions.

- b. Any records that relate to litigation or settlement of claims arising out of the performance of this AGREEMENT or costs or expenses of this AGREEMENT with which exception is taken by litigation, claims, or exceptions, must be retained for seven (7) years after the conclusion of the litigation, regardless of the termination date of the CONTRACT.
- c. The CONTRACTOR must accurately maintain records for seven (7) years after the termination of the CONTRACT. This requirement supersedes the period set forth in Section 37.0 of the Department Terms and Conditions.
- d. The CONTRACTOR shall insert the substance of this clause (Record Retention) into any contract that the CONTRACTOR enters into with a subcontractor to carry out any of the CONTRACTOR'S obligations under this AGREEMENT.

#### 4. Requirement to Review PROVIDERS

- a. The CONTRACTOR must, on a QUARTERLY basis, complete a fraud, waste, and abuse review according to a stated plan described under [Section IV.H. QUARTERLY Reporting Requirements](#). Upon execution of the CONTRACT, the CONTRACTOR will attest that such a plan exists, and will provide a written copy of the plan to the DEPARTMENT upon request. The CONTRACTOR must provide results of any material findings to the DEPARTMENT.
- b. Examples of potential PROVIDER fraud that could be included in QUARTERLY reviews:
  - i. Billing for items or services not rendered.
  - ii. Billing for work already reimbursed by another insurer.
  - iii. Overcharging for services or supplies.
  - iv. Completing an unjustified Certificate of Medical Necessity (CMN) form.
  - v. Double billing resulting in duplicate payment.
  - vi. Misrepresenting medical diagnoses or procedures to maximize payments.
  - vii. Inappropriate use of place of service codes.
  - viii. Knowingly misusing PROVIDER identification numbers resulting in improper billing.
  - ix. Providing medically unnecessary services.
  - x. Routinely waiving deductibles/coinsurances.
  - xi. Submitting bills exceeding the limiting charge.
  - xii. Unbundling (billing for each component of the service instead of billing or using an inclusive code).
  - xiii. Up-coding the level of service provided.
  - xiv. Billing for a known work-related injury.

#### K. Reporting Requirements

This section addresses requirements regarding data-driven means of benchmarking the performance of specific processes or functions, with the primary aim of increasing efficiency, reducing errors, and optimizing healthcare metrics.

## 1. Reporting Requirements

- a. The CONTRACTOR is required to submit reports to the DEPARTMENT to allow the DEPARTMENT to adequately monitor the HEALTH BENEFIT PROGRAM.
- b. Reports must be submitted SECURELY to the DEPARTMENT via email, the DEPARTMENT'S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT.
- c. The DEPARTMENT reserves the right to modify reporting requirements or frequency as deemed necessary to monitor the CONTRACT and programs. The CONTRACTOR must comply with such changes within forty-five (45) calendar DAYS, or another timeframe as approved by the DEPARTMENT. Instructions and specific due dates will be provided by the DEPARTMENT annually.
- d. Each report submitted by the CONTRACTOR to the DEPARTMENT must:
  - i. Be verified by the CONTRACTOR for accuracy and completeness prior to submission;
  - ii. Be delivered on or before scheduled due dates;
  - iii. Be submitted as directed by the DEPARTMENT;
  - iv. Fully disclose all required information in a manner that is responsive and with no material omission; and
  - v. Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report.
- e. The CONTRACTOR will provide process documentation for reporting to the DEPARTMENT upon request.
- f. Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book of business.
- g. The CONTRACTOR must notify the DEPARTMENT regarding any significant changes in its ability to collect information relative to required data or reports.
- h. The CONTRACTOR must fully support the BOARD and the DEPARTMENT in responding timely to informational requests made by the Legislature.

## L. STATE and Federal Mandates

1. The CONTRACTOR must report to the DEPARTMENT on any STATE and federally required compliance audits or other activities that involve the HEALTH BENEFIT PROGRAM, as requested by the DEPARTMENT.
2. Reporting on compliance will, at minimum, provide evidence that the CONTRACTOR has met the requirements of the compliance activities. Additional information may be required by the DEPARTMENT based upon the type of compliance activity being reported.
  - a. Specifically pertaining to the transparency requirements set forth in the Consolidated Appropriations Act of 2021, the CONTRACTOR must attest annually that transparency-related requirements have been met beginning with each compliance year specified by the Act and rules as they are finalized by Federal authorities. The CONTRACTOR must also make compliance reports required by the Act specific to Mental Health Parity available to the DEPARTMENT upon

request, and in the event that reporting is required by the federal government. The CONTRACTOR must also notify the DEPARTMENT if any aspect of the DEPARTMENT'S HEALTH BENEFIT PROGRAM design or administrative requirements create risks to compliance.

- b. In cases where the DEPARTMENT must provide STATE or federal reporting related to the CONTRACT and such reporting requires data to be submitted by the CONTRACTOR, the CONTRACTOR must provide that data in the format and by the timeline requested by the DEPARTMENT so that the DEPARTMENT can meet the STATE or federal requirement. The CONTRACTOR shall reasonably cooperate with the DEPARTMENT to meet this reporting requirement and will promptly meet with the DEPARTMENT to determine a mutually agreeable process to produce the necessary data in the required format.
- c. If any action, inaction, or error on the part of the CONTRACTOR with regards to a term, condition, or requirement under the CONTRACT results in federal or STATE tax penalties, interest, or fees, the CONTRACTOR shall be responsible for paying such costs either directly to the federal or STATE authority or to the DEPARTMENT or PARTICIPANTS as reimbursements if such costs were paid by the DEPARTMENT or PARTICIPANTS.

## IV. Performance Standards and Penalties

This section contains the performance standards and associated penalties for the services contained in this AGREEMENT. See [Section III.K. Reporting Requirements](#) for conditions on reporting.

### A. Performance Standards and Penalties

1. Performance standards are specific to the HEALTH BENEFIT PROGRAM, not general performance for the CONTRACTOR'S book of business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR must notify the DEPARTMENT upon realization that a standard will not be met prior to the deadline or in keeping with other performance reporting directives from the DEPARTMENT.
2. The CONTRACTOR must guarantee performance sufficient to fulfill the needs of the CONTRACT. The CONTRACTOR must meet all performance standards listed in [Section IV. Performance Standards and Penalties](#). After the CONTRACT start date, if additional resources are needed to meet the performance standards, the CONTRACTOR will bear all costs necessary to satisfy the requirements of the CONTRACT.
3. CONTRACTOR'S performance will be measured by the DEPARTMENT on a QUARTERLY basis. The DEPARTMENT will provide written notification to the CONTRACTOR when a penalty is assessed for a failure to meet a performance standard listed in [Section IV. Performance Standards and Penalties](#).

### B. Deliverable Reporting Requirements

1. The CONTRACTOR must provide deliverables and submit reports to the DEPARTMENT as specified in the sections below. Repeated or habitual failure to meet the deadlines as established may impact the CONTRACTOR'S ability to participate in the HEALTH BENEFIT PROGRAM in future years.
2. Deliverables must be submitted to the DEPARTMENT in the method specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify deliverable requirements as deemed necessary to monitor the CONTRACT and programs.
3. Instructions on submitting individual deliverables and specific due dates will be provided by the DEPARTMENT annually. Due dates may be revised with advance notice to CONTRACTOR via email.

### C. Penalty Assessments

1. The total penalties assessed in [Section IV. Performance Standards and Penalties](#) shall not exceed three percent (3%) of the CONTRACTOR'S total medical premium in any given quarter.
2. The data warehouse penalties assessed in [Section III.D. Data and Information Security](#) and [Section IV., J. – L.](#) are not subject to an assessment maximum in any given quarter or year.
3. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. If the DEPARTMENT elects to not exercise a penalty clause in a particular instance, such decision shall not be construed as acceptance by the DEPARTMENT of the CONTRACTOR'S performance. The DEPARTMENT retains the right to pursue future assessment of that performance requirement and associated penalties. The DEPARTMENT shall be the sole

determinant as to whether the CONTRACTOR meets a performance standard. See [Section IV.L. Payment of Penalty Amounts Owed by CONTRACTOR.](#)

#### D. Administrative Deliverables

Instructions on submitting general administrative deliverables and specific due dates will be provided by the DEPARTMENT annually.

| <b>1. Approval of Communications</b>   |   |
|--|---|
| <b>Description</b>   | The CONTRACTOR must receive pre-approval from the DEPARTMENT of all communication materials specified by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS participating in the HEALTH BENEFIT PROGRAM. This includes written and electronic communication, such as marketing collateral, informational notices, standard letters, summary plan descriptions, claim denials and appeals, and Summary of Benefits and Coverage. <i>(See Sections III.E.2. Other Informational / Marketing Materials and III.E.3. CONTRACTOR web Content and Web-Portal.)</i> |
| <b>Frequency</b>   | As needed, certified QUARTERLY  |
| <b>2. Assignment of PRIMARY CARE PROVIDER (PCP) or PRIMARY CARE CLINIC (PCC)</b> |   |
| <b>Description</b>   | If a PARTICIPANT does not choose a PCP/PCC, or the PCP/PCC is no longer available, the CONTRACTOR must assign a PCP/PCC, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP/PCC. <i>(See Section III.G.2 PRIMARY CARE PROVIDER/PRIMARY CARE CLINIC Designation and Certificate of Coverage.)</i>   |
| <b>Frequency</b>   | As needed   |
| <b>3. Coordination of Benefits (COB) Report</b>                                  |   |
| <b>Description</b>   | The CONTRACTOR must collect from SUBSCRIBERS COB information necessary to coordinate BENEFITS under Wis. Admin. Code §3.40 and report this information to the DEPARTMENT as needed. <i>(See Section III.A.2. Enrollment.)</i>   |
| <b>Frequency</b>   | As needed   |
| <b>4. Enrollment Discrepancy Tracker</b>   |   |
| <b>Description</b>   | The CONTRACTOR must maintain an exception report spreadsheet that includes the error details and final resolution and submit it to the DEPARTMENT. <i>(See Section III.A.1. Eligibility.)</i>   |
| <b>Frequency</b>   | As directed by the DEPARTMENT   |
| <b>5. External Review Request Notification</b>                                   |   |
| <b>Description</b>   | Within five (5) calendar DAYS of the CONTRACTOR'S receipt of a PARTICIPANT'S request for external review, the CONTRACTOR must notify the DEPARTMENT of the request in the format specified by the DEPARTMENT. <i>(See Section III.I.6. External Review.)</i>  |
| <b>Frequency</b>   | See description   |
| <b>6. External Review Determination</b>  |   |
| <b>Description</b>   | Within fourteen (14) calendar DAYS of the CONTRACTOR'S receipt of the notification of the external review's determination, the CONTRACTOR must notify the DEPARTMENT of the outcome. Within thirty (30) calendar DAYS, the CONTRACTOR must provide a redacted copy of the determination to the DEPARTMENT. <i>(See Section III.I.6. External Review.)</i>   |
| <b>Frequency</b>   | See description   |



| <b>7. Identification (ID) Cards</b>                             |   |
|---|---|
| <i>Description</i>  | The CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the effective date of coverage, and the emergency room and office visit copayment amounts, if applicable. <i>(See Section III.A.4. Identification (ID) Cards.)</i>   |
| <i>Frequency</i>  | Upon enrollment and BENEFIT changes that impact the information printed on the ID cards.  |
| <b>8. ID Card Issuance Delay Notification</b>                   |   |
| <i>Description</i>  | The CONTRACTOR must notify the DEPARTMENT Program Manager of any delays with issuing the ID cards. <i>(See Section III.A.4. Identification (ID) Cards.)</i>   |
| <i>Frequency</i>  | Upon identification of issue  |
| <b>9. Key Contacts Listing (ET-1728)</b>                        |   |
| <i>Description</i>  | The CONTRACTOR must provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. <i>(See Section III.H.1. Account Management and Staffing.)</i>   |
| <i>Frequency</i>  | January, April, July, October   |
| <b>10. Major Administrative and Operative System Changes</b>    |   |
| <i>Description</i>  | The CONTRACTOR must submit written notice to the DEPARTMENT at least one hundred eighty (180) calendar DAYS prior to undertaking a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM. <i>(See Section III.D.1. Information Systems.)</i>   |
| <i>Frequency</i>  | As needed   |
| <b>11. Medicare Enrollment Denial</b>                           |   |
| <i>Description</i>  | The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare. <i>(See Certificate of Coverage.)</i>  |
| <i>Frequency</i>  | See description   |
| <b>12. Notification of Account Manager or Key Staff Changes</b> |   |
| <i>Description</i>  | The CONTRACTOR must notify the DEPARTMENT via <a href="mailto:ETFSMBInsuranceSubmit@etf.wi.gov">ETFSMBInsuranceSubmit@etf.wi.gov</a> and the Health Program Manager if the Account Manager, backup, or key staff changes. <i>(See Section III.H.1. Account Management and Staffing.)</i>  |
| <i>Frequency</i>  | As needed   |
| <b>13. Notification of Legal Action</b>                         |   |
| <i>Description</i>  | If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR must notify the DEPARTMENT'S chief legal counsel via <a href="mailto:ETFSMBOfficeofLegalServices@etf.wi.gov">ETFSMBOfficeofLegalServices@etf.wi.gov</a> within ten (10) BUSINESS DAYS of notification of the legal action. <i>(See Section III.I.9. Notification of Legal Action.)</i>  |
| <i>Frequency</i>  | As needed   |
| <b>14. Notification of Privacy Breach</b>                       |   |
| <i>Description</i>  | The CONTRACTOR must notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the protected health information (PHI) and/or personally identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by STATE and federal law, including <a href="#">Wis. Stat. § 134.98</a> , HIPAA, and GINA. <i>(See Department Terms and Conditions.)</i> |
| <i>Frequency</i>  | As needed   |

| <b>15. Notification of Significant Events</b>                                  |  |
|--|--|
| <i>Description</i>   | The CONTRACTOR must notify the DEPARTMENT of all Significant Events as described in Section II.B. Board Authority and Certificate of Coverage Section 7.   |
| <i>Frequency</i>   | As needed  |
| <b>16. Over-Age Disabled Child Review Notification</b>                         |  |
| <i>Description</i>   | The CONTRACTOR must notify the DEPARTMENT of individual over-age disabled DEPENDENT review results per DEPARTMENT submission instructions. CONTRACTOR may perform individual reviews at any time of the year. If it is found that the child no longer meets the criteria, termination of the child’s coverage must be prospective. The DEPARTMENT must be copied on the notification of the CONTRACTOR’S review prospectively and as described in the submission instructions. <i>(See Certificate of Coverage Section 7.)</i>   |
| <i>Frequency</i>   | Prior to termination of DEPENDENT'S coverage   |
| <b>17. PARTICIPANT Enrollment Information</b>                                  |  |
| <i>Description</i>   | The CONTRACTOR must provide the minimum following information described in section III.A.5, at a minimum, to all PARTICIPANTS upon enrollment: <ul style="list-style-type: none"> <li>• Information about PARTICIPANT requirements, including prior authorizations and referrals.</li> <li>• Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR’S website and directions on how to request a printed copy of the provider directory.</li> <li>• Directions on how to change their PCP/PCC.</li> <li>• The CONTRACTOR’S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address.</li> </ul> <i>(See Section III.A.5. Enrollment and Eligibility Information for PARTICIPANTS.)</i> |
| <i>Frequency</i>   | Upon enrollment  |
| <b>18. PARTICIPANT Notification of DEPARTMENT Administrative Review Rights</b> |  |
| <i>Description</i>   | In the final grievance decision letter, the CONTRACTOR must inform the PARTICIPANT of their right to request a DEPARTMENT review of the grievance committee’s final decision and their right to request an external review in accordance with applicable federal or STATE law, using the language approved by the DEPARTMENT. <i>(See Section III.I.5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights.)</i>   |
| <i>Frequency</i>   | See description  |
| <b>19. PARTICIPANT Notification of Grievance Rights</b>                        |  |
| <i>Description</i>   | The CONTRACTOR must provide the PARTICIPANT with notice of their grievance rights and a period of ninety (90) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the UNIFORM BENEFITS contractual provision(s) upon which the denial is based. <i>(See Section III.I.1. Grievance Process Overview or Section IV. Performance Standards and Penalties.)</i>  |
| <i>Frequency</i>   | See description  |
| <b>20. PARTICIPANT Notification of Terminated Provider Agreement</b>           |  |
| <i>Description</i>   | The CONTRACTOR must send written notification to all PARTICIPANTS receiving services from a terminated PROVIDER as described in Section III.F.3. Continuity of Care.   |
| <i>Frequency</i>   | See description  |

| <b>21. SUBSCRIBER Notification Upon Termination of Employment</b> |  |
|---|--|
| <i>Description</i>  | The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in <a href="#">Wis. Stat. § 632.897</a> , and/or a Marketplace plan, in the event of termination of employment. (See Section III.A.6.b.)   |
| <i>Frequency</i>  | See description  |
| <b>22. Transition Plan</b>  |  |
| <i>Description</i>  | The CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks and activities, including those identified by the DEPARTMENT. (See Section III.H.12. Expert Services.)  |
| <i>Due</i>  | First draft due within ten (10) BUSINESS DAYS of determining the CONTRACT will be terminated. Final plan due within thirty (30) BUSINESS DAYS of the determination.  |
| <b>23. Web Content and Web-Portal Design and Changes</b>          |  |
| <i>Description</i>  | The CONTRACTOR must submit the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. (See Section III.E.3. CONTRACTOR Web Content and Web-Portal.) |
| <i>Due</i>  | As directed by the DEPARTMENT  |

## E. Administrative Performance Standards and Guarantees

Instructions for submissions and specific due dates will be provided by the DEPARTMENT annually.

| <b>1. Data Management</b>   |   |
|---|---|
| <i>Performance Standards</i>  | <i>Penalties</i>  |
| <b>a. Notification of Data Breach:</b> The CONTRACTOR must notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the PHI and/or PII of one (1) or more PARTICIPANTS may have been breached or has been breached. The CONTRACTOR is required to report using the form provided by the DEPARTMENT. (See Department Terms and Conditions.)   | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met |
| <b>2. Enrollment</b>  |   |
| <i>Performance Standards</i>  | <i>Penalties</i>  |
| <b>a. Enrollment File:</b> The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. The CONTRACTOR must certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. (See Section III.A.1. Eligibility.)  | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met |
| <b>b. Enrollment Discrepancies and Exceptions:</b> The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the DEPARTMENT. The CONTRACTOR shall certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. (See Sections III.A.1. Eligibility.) | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met |

| <i>Performance Standards</i>   | <i>Penalties</i>   |
|--|--|
| <p><b>c. ID Card Issuance for Elections During the Plan Year:</b> The CONTRACTOR must issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in Section IV.) regarding ID cards issued during the OPEN ENROLLMENT PERIOD. The CONTRACTOR must certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. <i>(See Section III.A.4. Identification (ID) Cards.)</i></p>  | <p>One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met</p> |
| <b>3. Enrollment</b>   |  |
| <i>Performance Standards</i>   | <i>Penalties</i>   |
| <p><b>a. ID Card Issuance for Elections During the OPEN ENROLLMENT Period:</b> The CONTRACTOR must issue ID cards by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1 calendar year, as submitted on enrollment files generated on the first DAY of the OPEN ENROLLMENT period through December 5. For enrollment files specific to the OPEN ENROLLMENT period generated after December 5 (i.e., between December 6 or December 31), ID cards must be mailed within 10 BUSINESS DAYS of receipt of the enrollment file. CONTRACTOR will confirm each ID card mailing date(s) and if any delays or changes to the mailing dates occur or are expected. Specific deliverable dates may be defined by the DEPARTMENT. <i>(See Section III.A.4. Identification (ID) Cards.)</i></p> | <p>One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met</p> |
| <p><b>b. Direct Pay Terminations:</b> The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. <i>(See Section III.B.2. PREMIUM Payments from the DEPARTMENT.)</i></p>   | <p>One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met</p> |
| <b>4. Other</b>  |  |
| <i>Performance Standards</i>   | <i>Penalties</i>   |
| <p><b>a. Audit:</b> The CONTRACTOR must address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. <i>(See Section III.J.1 Audit and Other Services.)</i></p>   | <p>One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met</p> |
| <p><b>b. Major System Changes and Conversions:</b> The CONTRACTOR must verify and commit that during the length of the CONTRACT, it must not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred eighty (180) calendar DAYS to the DEPARTMENT. The CONTRACTOR must certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. <i>(See Section III.D.1. Information Systems)</i></p>   | <p>One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met</p> |
| <p><b>c. Non-Disclosure:</b> The CONTRACTOR must not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. <i>(See Section II.B. Board Authority and Certificate of Coverage Section 7.)</i></p>   | <p>Five thousand (\$5,000) dollars per incident</p>                                      |

## F. Annual Deliverables

Instructions on submitting annual deliverables and specific due dates will be provided by the DEPARTMENT annually.

| <b>1. 1095-B Issuance Notification</b>   |  |
|--|--|
| <b>Description</b>   | The CONTRACTOR must submit a written notification to the DEPARTMENT Program Manager indicating the date(s) 1095-Bs were issued, or when the web notice was posted, as required by federal law. <i>(See Section III.A.5.c.)</i><br><b>Note:</b> 1095-Bs are not required for Medicare plans.  |
| <b>Due</b>   | Annually   |
| <b>2. Annual ID Card Issuance Confirmation</b>                                 |  |
| <b>Description</b>   | The CONTRACTOR must send a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. <i>(See Section III.A.4. Identification (ID) Cards.)</i>  |
| <b>Frequency</b>   | Annually (January)   |
| <b>3. Customer Service Department Operating Hours and Anticipated Closures</b> |  |
| <b>Description</b>   | The CONTRACTOR must report standard customer service department operating hours and anticipated closures to the DEPARTMENT on an annual basis in the format specified by the DEPARTMENT. The CONTRACTOR must promptly report any unanticipated closures to the DEPARTMENT in the format specified by the DEPARTMENT. <i>(See Section III.H.3. Customer Service.)</i>   |
| <b>Frequency</b>   | Annually   |
| <b>4. Model Audit Review Certification</b>                                     |  |
| <b>Description</b>   | The CONTRACTOR must submit a Model Audit Rule (MAR) on an annual basis. <i>(See Section III.J.1. Audit and Other Services.)</i>  |
| <b>Frequency</b>   | Annually (August)  |
| <b>5. OPEN ENROLLMENT Informational Materials Review</b>                       |  |
| <b>Description</b>   | The CONTRACTOR must submit all informational materials intended for distribution to PARTICIPANTS during the annual OPEN ENROLLMENT period to the DEPARTMENT for review and approval. <i>(See Section III.E.1. OPEN ENROLLMENT Informational / Marketing Materials.)</i>  |
| <b>6. SUBSCRIBER Notification of Changes Review</b>                            |  |
| <b>Description</b>   | The CONTRACTOR must submit the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the annual OPEN ENROLLMENT period identifying those PROVIDERS that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. The CONTRACTOR must issue the written notice after DEPARTMENT approval. <i>(See Section III.E.1. OPEN ENROLLMENT Informational / Marketing Materials.)</i> |
| <b>Frequency</b>   | Annually (September)   |

| <b>7. SUBSCRIBER Notification of Changes Issuance Confirmation</b> |  |
|--|--|
| <i>Description</i>   | The CONTRACTOR must submit a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in Item 10) above was issued to PARTICIPANTS. (See Section III.E.1. OPEN ENROLLMENT Informational / Marketing Materials.)  |
| <i>Frequency</i>   | Annually (October)   |
| <b>8. Summary of Benefits and Coverage</b>                         |  |
| <i>Description</i>   | The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual OPEN ENROLLMENT materials mailing process. (See Section III.A.1. Eligibility.)   |
| <i>Frequency</i>   | As needed  |
| <b>9. Utilization Review Meeting</b>                               |  |
| <i>Description</i>   | <p>The CONTRACTOR must meet with DEPARTMENT staff on an annual basis to report and discuss annual experience and utilization regarding:</p> <ul style="list-style-type: none"> <li>• Disease management capabilities and effectiveness in improving the health of PARTICIPANTS and encouraging healthy behaviors;</li> <li>• Demonstrating support for technology and automation;</li> <li>• DEPARTMENT experience by disease and risk categories;</li> <li>• Comparisons to aggregate benchmarks and any other measures the CONTRACTOR believes will be useful to DEPARTMENT staff and the BOARD in understanding the source of cost and utilization trends; and</li> <li>• DEPARTMENT Initiatives, which currently include: Care Coordination.</li> </ul> <p>This information must be presented in a format as determined by the DEPARTMENT. The DEPARTMENT will provide additional reporting criteria in advance of the meeting. (See Section III.G.1. Department Initiatives and Certificate of Coverage Section 4.)</p> |
| <i>Frequency</i>   | Annually   |

## G. Annual Reporting Requirements

Instructions on submitting reports and specific due dates will be provided by the DEPARTMENT annually.

| <b>1. Business Recovery Plan and Simulation Report</b>   |   |
|--|---|
| <i>Performance Standard</i>  | <i>Penalty</i>  |
| <b>Annually</b> , the CONTRACTOR must test its business recovery plan and submit the test results to the DEPARTMENT. (See Section III.D.1. Information Systems.) | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met |
| <b>2. CAHPS Survey Results Report</b>  |   |
| <i>Performance Standard</i>  | <i>Penalty</i>  |
| <b>Annually</b> , the CONTRACTOR must submit the results of its annual CAHPS survey to the DEPARTMENT. (See Section III.C.3. Quality.)                           | Disqualification from Quality Credit  |

| <b>3. Customer Service Inquiry System Certification</b>   |   |
|---|---|
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>Annually</b> , the CONTRACTOR must certify to the DEPARTMENT that CONTRACTOR’S customer service inquiry system meets the requirements in Section III.H.3. Customer Service.  | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met                 |
| <b>4. Financial and Utilization Data Submission</b>   |   |
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>Annually, in May</b> , the CONTRACTOR must submit to the DEPARTMENT or the DEPARTMENT’S designee, as specified by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information. <i>(See Sections II.B. Board Authority and III.C.1. Annual Rate Bidding Process.)</i>  | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met                 |
| <b>5. Financial Stability Documentation</b>   |   |
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>Annually, in June</b> , the CONTRACTOR must submit financial stability documentation, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public account in accordance with generally accepted accounting principles) to the DEPARTMENT. <i>(See Section III.J.1. Audit and Other Services.)</i>  | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met                 |
| <b>6. Grievance Summary Report</b>  |   |
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| The CONTRACTOR must retain records of grievances and submit an <b>annual</b> summary to the DEPARTMENT of the number, type, and the resolution or outcome of grievances received. <i>(See Section II.B. Board Authority and Certificate of Coverage Section 7.)</i>   | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met                 |
| <b>7. HEDIS Results Report</b>  |   |
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>Annually</b> , the CONTRACTOR must submit to the DEPARTMENT audited HEDIS data results for the previous calendar year for CONTRACTOR’S commercial membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. <i>(See Section III.C.3. Quality.)</i>   | Disqualification from Quality Credit  |
| <b>8. Model Audit Rule (MAR) Certification</b>  |   |
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>Annually</b> , the CONTRACTOR must submit a MAR Certification to the DEPARTMENT. <i>(See Section III.J.1. Audit and Other Services.)</i>   | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met                 |
| <b>9. Over-Age Disabled Child Eligibility Verification Report and Certification</b>   |   |
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>Annually</b> , the CONTRACTOR must report and certify to the DEPARTMENT total results from its process to verify the eligibility of adult disabled children age twenty-six (26) or older, which includes checking that the: <ul style="list-style-type: none"> <li>• Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year; and,</li> <li>• Support and maintenance requirement is met; and,</li> <li>• Child is not married.</li> </ul> <i>(See Certificate of Coverage Section 7.)</i> | Twenty-five hundred (\$2,500) dollars per report or deliverable for which the standard is not met |

| <i>Performance Standard</i>   |
|---|
| <b>10. Population Health and Pilot Program Report</b>   |
| <b>Annually</b> , in April, the CONTRACTOR must provide the DEPARTMENT with information and outcomes on the CONTRACTOR’S population health/chronic condition management and DEPARTMENT-approved pilot programs, as applicable. This information must be presented in a format as determined by the DEPARTMENT. The DEPARTMENT will provide additional reporting criteria in advance of the due date. <i>(See Sections III.G.3.d and III.G.4.h.)</i> |

#### H. QUARTERLY Reporting Requirements and Penalties

Instructions on submitting reports and specific due dates will be provided by the DEPARTMENT annually.

| <b>1. Fraud and Abuse Review Results</b>  |   |
|---|---|
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| The CONTRACTOR must perform <b>QUARTERLY</b> (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provide results of material findings to the DEPARTMENT. <i>(See Certificate of Coverage Section 7.)</i>                            | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met |
| <b>2. CONTRACTOR QUARTERLY Performance Report</b>   |   |
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>On a QUARTERLY basis, unless otherwise noted</b> , the CONTRACTOR must submit and certify all required data to measure CONTRACTOR’S adherence to the performance standards specified in this AGREEMENT to the DEPARTMENT, in the format specified by the DEPARTMENT. | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met |

#### I. QUARTERLY Performance Standards and Penalties

Instructions for submissions and specific due dates will be provided by the DEPARTMENT annually.

| <b>1. Claims Processing</b>   |   |
|---|---|
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>a. Processing Accuracy:</b> At least ninety-seven percent (97%) level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. <i>(See Section III.H.2. Claims.)</i> | Five thousand (\$5,000) dollars for each percentage point for which the standard is not met in each quarter |
| <b>b. Claims Processing Time:</b> At least ninety-five percent (95%) of all claims received must be processed within thirty (30) calendar DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. <i>(See Section III.H.2. Claims.)</i>              | Five thousand (\$5,000) dollars for each percentage point for which the standard is not met in each quarter |
| <b>2. Customer Service</b>  |   |
| <i>Performance Standard</i>   | <i>Penalty</i>  |
| <b>a. Call Answer Timeliness:</b> At least eighty percent (80%) of calls received by the CONTRACTOR’S customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. <i>(See Section III.H.3. Customer Service.)</i>   | Five thousand (\$5,000) dollars for each percentage point for which the standard is not met in each quarter |



| <i>Performance Standard</i>   | <i>Penalty</i>  |
|---|---|
| <b>b. Call Abandonment Rate:</b> No more than three percent (3%) of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. <i>(See Section III.H.3. Customer Service.)</i>   | Five thousand (\$5,000) dollars for each percentage point for which the standard is not met in each quarter |
| <b>c. Open Call Resolution Turn-Around-Time:</b> At least ninety percent (90%) of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. <i>(See Section III.H.3. Customer Service.)</i> | Five thousand (\$5,000) dollars for each percentage point for which the standard is not met in each quarter |
| <b>d. Electronic Written Inquiry Response:</b> At least ninety-eight percent (98%) of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. <i>(See Section III.H.3. Customer Service.)</i>   | Five thousand (\$5,000) dollars for each percentage point for which the standard is not met in each quarter |

#### J. Data Warehouse Deliverable Requirements

The CONTRACTOR must report to the DEPARTMENT'S data warehouse vendor in the file format specified by the DEPARTMENT.

|  |
|--|
| <b>1. Claims Data Transfer to Data Warehouse</b>   |
| <b>Monthly</b> , the CONTRACTOR must submit to the DEPARTMENT'S data warehouse, in the most recent file format specified by the DEPARTMENT, all claims processed for PARTICIPANTS. <i>(See Section III.D.4. Data Integration and Use.)</i>   |
| <b>2. Provider Data Transfer to Data Warehouse</b>   |
| <b>Monthly</b> , the CONTRACTOR must submit to the DEPARTMENT'S data warehouse, in the most recent file format specified by the DEPARTMENT, the specified data for all IN-NETWORK providers including subcontracted providers. <i>(See Section III.D.4. Data Integration and Use.)</i> |

#### K. Data Warehouse Performance Standards

The CONTRACTOR must submit data and corrected data, when necessary, by the dates indicated by the DEPARTMENT'S data warehouse vendor. Performance standards for the data warehouse will be measured by the DEPARTMENT as needed.

| <i>Performance Standard</i>  | <i>Penalty</i>  |
|--|---|
| <b>a. Claims Data Transfer:</b> The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse vendor, in the most recent file format specified by the DEPARTMENT, all claims processed for PARTICIPANTS according to the schedule established in Section III.D. Data and Information Security. <i>(See Section III.D.4.)</i>  | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met |
| <b>b. PROVIDER Enrollment Data Transfer:</b> The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse vendor in the most recent file format specified by the DEPARTMENT, the specified data for all IN-NETWORK PROVIDERS including subcontracted PROVIDERS according to the schedule established in the CERTIFICATE OF COVERAGE Section 7. <i>(See Section III.D.4.)</i> | One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met |

| <i>Performance Standard</i>   | <i>Penalty</i>  |
|---|---|
| <p><b>c. Data Warehouse Submission Delays:</b> The CONTRACTOR must communicate any delays in submitting program data to the DEPARTMENT’S data warehouse vendor via email to the DEPARTMENT Program Manager or designee and the designated data warehouse vendor as soon as the delay is known, but at least one (1) calendar DAY before the scheduled transfer. <i>(See Section III.D.4.)</i></p>   | <p>One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met</p>  |
| <p><b>d. Data File Corrections:</b> Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR must resolve any data errors on the file as identified by the DEPARTMENT’S data warehouse vendor or the DEPARTMENT. <i>(See Section III.D.4.)</i></p>  | <p>One thousand (\$1,000) dollars per BUSINESS DAY for which the standard is not met</p>  |
| <p><b>e. Two-Chance Rule:</b> During the implementation of the DEPARTMENT’S data warehouse or a new CONTRACTOR, the CONTRACTOR will have two (2) chances to submit acceptable data. The DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the second submission not accepted by the DEPARTMENT’S data warehouse vendor. <i>(See Section III.D.4.)</i></p>  | <p>One thousand seven hundred fifty dollars (\$1,750) for each submission after the allowed submissions.</p>  |
| <p><b>f. One-Chance Rule:</b> During the ongoing operation of the DEPARTMENT’S data warehouse, if the DEPARTMENT’S data warehouse vendor identifies an error with the CONTRACTOR’S initial data submission, the CONTRACTOR will have one opportunity to submit a corrected data file. If the CONTRACTOR requires additional submissions to correct identified errors, the DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the first corrected submission not accepted by the DEPARTMENT’S data warehouse vendor. <i>(See Section III.D.4.)</i></p> | <p>One thousand seven hundred fifty dollars (\$1,750) for each submission after the allowed submissions.</p>  |
| <p><b>g. Pass-Through Data Warehouse Penalties:</b> The DEPARTMENT will pass through any penalties assessed by the DEPARTMENT’S data warehouse vendor for failure to submit data in accordance with the CONTRACT. <i>(See Section III.D.4.)</i></p>   | <p>The amount charged by the DEPARTMENT’S data warehouse vendor for the CONTRACTOR’S failure to meet data submission requirements not otherwise subject to a penalty as described above</p> |

#### L. Payment of Penalty Amounts Owed by CONTRACTOR

The DEPARTMENT will provide the CONTRACTOR with an invoice for penalties or monies owed. The CONTRACTOR must document any dispute of amounts listed in the invoice and provide such documentation to the DEPARTMENT Program Manager within ten (10) BUSINESS DAYS of receiving the DEPARTMENT’S invoice. The DEPARTMENT will review the CONTRACTOR’S submitted documentation and make a determination as to whether the penalty or monies owed are waived or reduced. Funds owed to the DEPARTMENT must be paid within thirty (30) calendar DAYS from the date of the CONTRACTOR’S receipt of the DEPARTMENT’S invoice. After thirty (30) calendar DAYS, the DEPARTMENT may collect owed funds by deducting the amounts from the payments made to the CONTRACTOR, and the CONTRACTOR may be subject to further penalties.