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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10
(session year)

Senate
(Assembly, Senate or Joint)

Committee on ... Health, Health Insurance, Privacy, Property Tax Relief, and Revenue (SC-HHIPPTRR)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

October 8, 2009

Members of the Legislature

Re: Emergency Rule affecting Section Ins ch. 57, Wis. Adm. Code, relating to care management organizations and affecting small business

Dear Senator or Representative to the Assembly:

I have promulgated the attached rule as an emergency rule. The rule will be published in the official State newspaper on October 10, 2009.

The attached copy of the rule includes the Finding of Emergency which required promulgation of the rule.

If you have any questions, please contact Julie E. Walsh at (608) 264-8101 or e-mail at julie.walsh@wisconsin.gov.

Sincerely,

Sean Dilweg
Commissioner of Insurance

SD:JW
Attachment: 1 copy rule

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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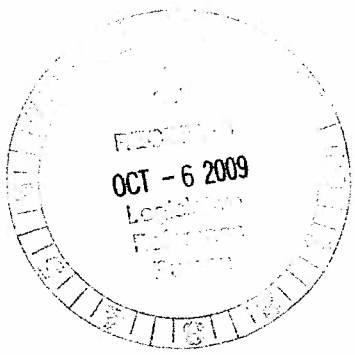


STATE OF WISCONSIN |
| SS
OFFICE OF THE COMMISSIONER OF INSURANCE |

I, Sean Dilweg, Commissioner of Insurance and custodian of the official records, certify that the annexed emergency rule affecting Section Ins ch. 57, Wis. Adm. Code, relating to care management organizations and affecting small business, is duly approved and adopted by this Office on October 5, 2009.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand at 125 South Webster Street, Madison, Wisconsin, on October 5, 2009.

Sean Dilweg
Commissioner of Insurance

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE CREATING A RULE

To create ch. Ins 57, Wis. Adm. Code,

Relating to care management organizations and affecting small business.

FINDING OF EMERGENCY

The Commissioner of Insurance finds that an emergency exists and that the attached rule is necessary for the immediate preservation of the public peace, health, safety, or welfare. Facts constituting the emergency are as follows:

Beginning January 1, 2010, care management organizations are required to obtain a permit from the commissioner to provide services under the Family Care program. In order to ensure no gap in services to enrollees, organizations and the office need to complete and accept applications for permits prior to January 1, 2010. Promulgation of this rule will permit the timely filing and review of permitees.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 600.01, 628.34 (12), ch. 648, Stats.

2. **Statutory authority:**

   ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), 648.10 (1), Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

   2009 Wisconsin Act 28 created chapter 648, Wis. Stat., establishing the regulation of care management organizations. The statute specifically authorizes the commissioner to promulgate rules that are necessary to carry out the intent of the statute with consultation with the department. These proposed rules are the result of numerous discussions with the department and incorporate effective regulatory tools modified appropriately for care management organizations.

4. **Related statutes or rules:**

   The proposed rule is consistent with and related to existing financial regulations including, chs. Ins 9, 40 and 50, Wis. Adm. Code.

5. **The plain language analysis and summary of the proposed rule:**

Ch. 648, Wis. Stats., was created to establishes financial regulation of care management organizations that provide and coordinate services for the Family Care program. Family Care is a Wisconsin Medicaid program that was designed to provide cost-effective, comprehensive and flexible long-term care that fosters consumers' independence and quality of life, while recognizing the need for interdependence and support. Family Care improves the cost-effective coordination of long-term care services by creating a single flexible benefit that includes a large number of health and long-term care services that are typically only available separately. Enrollees have access to specific health care services offered by Medicaid as well as long-term care services in the Home and Community-Based Waivers and the state-funded Community Options Program.

Family Care is a public program operated by the Wisconsin Department of Health Services ("Department"), that contracts with both private and public plans to provide consumers an option for coverage of long-term care services beyond fee-for-service and the self-directed supports waiver. The care management organizations receive a fixed capitated amount per enrollee from the Department through the waiver programs. However, due to the nature of the organizations and the structure of the plan, care management organizations, unlike insurers, may be less able to build and draw upon reserves both during the expansion periods and due to the potential for unforeseen expenditures.

The proposed rule implements ch. 648, Stats., financial regulatory oversight of the care management organizations in coordination with the Department to ensure the organizations use sound financial tools when commencing operations and ongoing oversight of the financial condition of the organizations. Specifically the proposed rule establishes minimum financial standards, financial reporting requirements, regulatory examinations and restricted reserves for care management organizations in the event of an insolvency.

6. **Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

There is no existing or proposed federal regulation related to oversight of care management organizations.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: None

Iowa: None

Michigan: None

Minnesota: None

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

The Office engaged along with the Department of Health Services engaged PricewaterhouseCoopers to analyze the necessary reserves and regulatory structure for the Family Care program. In addition the office reviewed care management organizations' financial information, coordinated the proposed regulatory scheme with current oversight provided by the Department and reviewed accounting principles best suited for care management organizations

9. **Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

The Office worked with the Department of Health Services to determine the rule's effect on small businesses that are care management organizations.

10. **See the attached Private Sector Fiscal Analysis.**

See below

11. **A description of the Effect on Small Business:**

This rule will have minimal to no effect on small businesses that are care management organizations. This rule may effect small businesses that are care management organizations seeking a permit from the commissioner. The office worked closely with the Department to minimize the impact on the care management organizations and will share information between departments so not to overly burden care management organizations

12. **Agency contact person:**

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. **Place where comments are to be submitted and deadline for submission:**

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 57
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 57
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Email address:

Julie E. Walsh
julie.walsh@wisconsin.gov

Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Chapter Ins 57 is created to read:

Ins 57.01 Definitions. In addition to the definitions in s. 648.01, Stats, in this chapter:

(1) "Affiliate" of, or person "affiliated" with, a specific person means a person that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

(2) "Commissioner" means the "commissioner of insurance" of this state or the commissioner's designee.

(3) "Independent certified public accountant" means an independent certified public accountant, or independent accounting firm, in good standing with the American Institute of Certified Public Accountants and in the states in which the accountant or firm is licensed, or required to be licensed, to practice.

(4) "Net assets" means assets minus liabilities.

(5) "Restricted reserve" means liquid assets maintained in a segregated account by a care management organization.

(6) "Subsidiary" of a person means a person which is controlled, directly or indirectly through one or more intermediaries, by the first person.

(7) "Ultimate controlling person" means a person who is not controlled by any other person.

(8) "Work papers" means records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the independent certified public accountant's examination of the financial statements of a care management organization. "Work papers" include, but are not limited to, audit planning documentation, audit guides, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of examination of the financial statements of a care management organization or which support the opinion of the independent certified public accountant regarding the financial statements.

(9) "Working capital" means a measure calculated as current assets minus current liabilities.

Ins 57.04 Financial requirements. The following are the minimum financial requirements for compliance with this section unless a different amount is ordered by the commissioner, after consultation with the department:

(1) WORKING CAPITAL. Unless otherwise ordered by the commissioner the care management organization shall maintain working capital of not less than 3% of the projected annual capitation made over the effective contract period.

(2) RESTRICTED RESERVE. Unless otherwise ordered by the commissioner the care management organization shall maintain a restricted reserve of not less than the sum of the following:

(a) 8% of the first $5 million of annual budgeted capitation revenue;

(b) 4% of the next $5 million annual budgeted capitation revenue;

(c) 3% of the next $10 million annual budgeted capitation revenue;

(d) 2% of the next $30 million annual budgeted capitation revenue;

(e) 1% of annual budgeted capitation revenue in excess of $50 million.

(3) ACCESSING RESTRICTED RESERVE FUNDS. A care management organization may not access the restricted reserve unless:

(a) A plan for accessing the funds is filed with the commissioner at least 30 days prior to the proposed effective date; and

(b) The commissioner, after consulting with the department, does not disapprove the plan in the 30 day timeframe.

(4) RISKS. Risks and factors the commissioner may consider in determining whether to require greater restricted reserves by order include all of the following:

(a) Types of contingencies. The commissioner shall consider the risks of:

1. Increases in the frequency or severity of losses beyond the levels contemplated by the capitation payments received;

2. Increases in expenses beyond those contemplated by the capitation payments received; and

3. Any other contingencies the commissioner can identify which may affect the care management organization's operations.

(b) Controlling factors. In making the determination under this subsection, the commissioner shall take into account the following factors:

1. The most reliable information available as to the magnitude of the various risks under par. (a);

2. The extent to which the risks in par. (a) are independent of each other or are related, and whether any dependency is direct or inverse;

3. The care management organization's recent history of profits or losses;

4. The extent to which the care management organization has provided protection against the contingencies in other ways than the establishment of restricted reserves, including the use of conservative actuarial assumptions to provide a margin of security; and

5. Any other relevant factors.

(5) CORRECTIVE ACTION PLAN. A care management organization that does not meet the requirements in subs. (1) or (2) shall file a corrective action plan with the commissioner. The corrective action plan will include all of the following:

(a) Identification of the conditions which contribute to the deficiency.

(b) Proposals of corrective actions which the care management organization intends to take and would be expected to result in compliance with subs. (1) and (2).

(c) Projections of the care management organization's financial results in the current year and at least the first succeeding year.

(d) Identification of the key assumptions impacting the care management organization's projections and the sensitivity of the projections to the assumptions.

(e) Such other information as is requested by the commissioner, after consultation with the department.

Ins 57.05 Business plan. All applications for permits of a care management organization shall include a proposed business plan. In addition to the items listed in s. 648.05 (2), Stats., the following information shall be contained in the business plan:

(1) ORGANIZATIONAL INFORMATION. All care management organization business plans will include:

(a) A narrative that discusses the business environment, the strategies and tactics that will be employed to manage the business including, but not limited to, the Bring Care Under Management Plan, targets associated with that plan, and other areas of focus, stress, change, efficiency or any other information that supports or affects the financial projections.

(b) A description of the general business model to be employed by the care management organization.

(c) A brief organizational history, providing and describing major milestones in the development of the care management organization including organizational strengths and deficits, as they relate to the ongoing delivery of the Family Care program.

(d) A description of the care management organization's governance structure, including organizing documents (e.g., articles, by-laws, mission statement, etc.), and an organizational

chart that clearly demonstrates reporting lines and domains of management authority, with names of current incumbents for management positions.

(e) Information for all persons or entities who are in direct control of the care management organization, including the names, addresses and occupations of all controlling persons, directors and principal officers of the care management organization currently and for the preceding 10 years. The care management organization shall also include the position held and target group representation, if applicable, for each member of the Board of Directors.

(2) GEOGRAPHICAL SERVICE AREA. The geographical service area by county including a chart showing the number of providers with locations and service areas by county. A description and the method of handling out–of–area services shall also be included.

(3) ENROLLMENT. A description of the target populations being served by the care management organization, in what proportions these target groups are currently being served, what the long range expectations of the care management organization are in serving each target group (i.e., anticipated program growth), and how historical trends or projections are similar to, or different, from program averages.

(4) PROVIDER AGREEMENTS. The extent to which any of the following will be included in provider agreements and the form of any provisions that do any of the following:

(a) Permit or require the provider to assume a financial risk in the care management organization, including any provisions for assessing the provider, adjusting capitation or fee–for–service rates, or sharing in the earnings or losses.

(b) Govern amending or terminating agreements with providers.

(5) PROVIDER AVAILABILITY. A description of the care management organization's general plan for delivering care management services to its members. Differences in the delivery of this service across target groups or counties shall be described. Changes in the delivery of care management over time, either completed or anticipated shall be described. .

(6) PLAN ADMINISTRATION. A summary of how administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to capitation income. If administrative services are to be provided by a

person outside the organization, the business plan shall include a copy of the contract. The contract shall include all of the following:

(a) The services to be provided.

(b) The standards of performance for the manager.

(c) The method of payment.

(d) The duration of the contract.

(e) Any provisions for modifying, terminating or renewing the contract.

(7) FINANCIAL PROJECTIONS. A summary of all of the following:

(a) Current and projected enrollment.

(b) Income from capitation payments.

(c) Other income.

(d) Expenses associated with providing services to enrollees. A budget narrative that accompanies any projections related to care management utilization shall be provided. The narrative will identify assumed staff-to-member ratios, by type of staff; historical trends and projections regarding care management utilization; explanations regarding any major changes; and unit cost trends for each time period and target group.

(e) Administrative and other costs.

(f) The estimated break even point if a loss is being projected.

(g) A summary of the assumptions made in developing projected operating results.

(8) SWOT ANALYSIS. A description of the major challenges the MCO faces, both internal and external to the organization, in providing services to each target group and the strategies it is employing, or plans to employ, to address those challenges.

(9) FINANCIAL GUARANTEES. A summary of all financial guarantees by providers, sponsors, affiliates or parents within a holding company system, or any other guarantees which are intended to ensure the financial success of the care management organization. These include hold harmless agreements by providers, stop loss insurance, or other guarantees.

(10) BUSINESS PLAN REQUIREMENTS OF THE DEPARTMENT. The business plan filed with the department pursuant to provisions in the family care contract will be acceptable for the purposes of this section.

Ins 57.06 Changes in the business plan. A care management organization shall file a written report of any proposed substantial change in its business plan. The care management organization shall file the report at least 30 days prior to the effective date of the change. The office, after consulting with the department, may disapprove the change. The care management organization may not enter into any transaction, contract, amendment to a transaction or contract or take action or make any omission that is a substantial change in the care management organization's business plan prior to the effective date of the change or if the change is disapproved. Substantial changes include changes in articles and bylaws, organization type, geographical service areas, provider agreements, provider availability, plan administration, financial projections and guarantees and any other change that might affect the financial solvency of the organization. Any transaction or series of transactions that exceed the lesser of 5% of the care management organization's assets or 10% of net assets as of December 31 of the immediately preceding calendar year shall be deemed material. Any changes in the items listed in s. Ins 9.05 (3) shall be filed under this section.

Ins 57.07 Copies of provider agreements. (1) Notwithstanding any claim of trade secret or proprietary information, all care management organizations shall, upon request, from the commissioner, make available to the commissioner all executed copies of any provider agreements between the care management organization and intermediate entities or individual providers. Any party to a provider agreement may assert that a portion of the contracts contain trade secrets, and the commissioner may withhold that portion to the extent it may be withheld under s. Ins 6.13.

(2) All care management organizations shall file with the commissioner, a list of providers executing a standard contract and a copy of the form of the contract may be filed instead of copies of the executed contracts.

Ins 57.10 Acquisition of control of or merger with a care management organization. **(1)** FILING REQUIREMENTS. (a) No person other than the care management organization may enter into an agreement to merge with or otherwise to acquire or attempt to acquire control of a care management organization or any person having control of a care management organization unless all of the following are complied with:

1. The person first files the information required under sub. (2) with the commissioner and sends a copy of the information to the care management organization; and

2. The offer, request, invitation, agreement or acquisition has been approved by the commissioner.

(b) For purposes of this section "care management organization" includes any person having control of a care management organization.

(2) CONTENT OF STATEMENT. A person required to file under sub. (1) shall file the following information not less than 30 days after the care management organization signs a letter of intent, using information substantially similar to that contained in form A in Appendix 1 to this chapter, in a sworn statement by an official of the care management organization:

(a) For each acquiring person:

1. The acquiring person's name and address;

2. If the acquiring person is an individual, his or her principal occupation and all offices and positions held during the past 5 years, any conviction of crimes other than traffic violations not involving death or injury during the past 10 years and all relevant information regarding any occupational license or registration; and

3. If the acquiring person is not an individual, a report of the nature of its business operations during the past 5 years or for the lesser period that the acquiring person and any predecessors of the acquiring person have been in existence, if shorter, an informative description of the business intended to be done by the acquiring person and the acquiring person's subsidiaries, and a list of all individuals who are or who have been selected to become directors or executive officers of the acquiring person, or who perform or will perform functions

similar to those positions. The list shall include for each individual the information required by subds. 1. and 2.

(b) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction from which funds were or are to be obtained for that purpose, including any pledge of the care management organization's assets or the assets of any of its subsidiaries or affiliates which control the care management organization, the criteria used in determining the nature and amount of consideration and the identity of persons furnishing the consideration.

(c) Fully audited financial information as to the earnings and financial condition of each acquiring person for the preceding 5 fiscal years of each acquiring person or for the period the acquiring person and any predecessors of the acquiring person have been in existence, if shorter, and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement.

(d) Any plans or proposals which any acquiring person is considering to liquidate, to sell assets of, or to merge or consolidate the care management organization or to make any other material change in the care management organization's business or corporate structure or management.

(e) A full description of any contracts, arrangements or understandings with respect to any security in which any acquiring person is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, guarantees of loans, guarantees against loss or guarantees of profits, or division of losses or profits. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into.

(3) MATERIAL CHANGES. A person required to file under sub. (1) shall file an amendment to the filing if any material change occurs in the facts set forth in a statement previously filed with the commissioner. The person shall include in the amendment a description of the change and copies of all documents and other material relevant to the change. The amendment shall be

filed with the commissioner and sent to the care management organization within 2 business days after the person learns of the change.

Ins 57.12 Standards for transactions within a holding company system.

(1) TRANSACTIONS WITHIN A HOLDING COMPANY SYSTEM. A care management organization or affiliate of a care management organization may not enter directly or indirectly into a transaction between the care management organization and the affiliate unless the care management organization and affiliate comply with all of the following:

(a) Comply with s. 648.45 (5) and (6), Stats.

(b) Expenses incurred and payment received for the transaction are allocated to the care management organization in conformity with customary accounting practices consistently applied.

(c) The books, accounts and records of each party to the transaction clearly and accurately disclose the nature and details of the transaction including the accounting information which is necessary to support the reasonableness of the charges or fees to the respective parties.

(2) TRANSACTIONS REQUIRED TO BE REPORTED AND SUBJECT TO DISAPPROVAL. A care management organization, and a person attempting to acquire control of a care management organization, or an affiliate of a care management organization, which directly or indirectly is involved in or benefits from, a transaction, shall report, under s. 648.45 (6), Stats., each of the following transactions to the commissioner in writing at least 30 days before the care management organization enters into the transaction, unless the commissioner in writing approves a shorter period:

(a) Sales, purchases, exchanges, loans, extensions of credit, guarantees, or investments involving the care management organization and an affiliate or a person attempting to acquire control of the care management organization if the transactions are equal to or exceed the lesser of 2% of the care management organization's assets or 10% of net assets as of December 31 of the immediately preceding calendar year.

(b) Loans or extensions of credit or guarantees to any person who is not an affiliate, where the care management organization makes loans, extensions of credit or guarantees with the agreement or understanding that the proceeds of the transactions or benefit of the guarantees, in whole or in significant part, directly or indirectly, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the care management organization making the loans, extensions of credit, or guarantee, or any person attempting to acquire control of the care management organization, if the transactions are equal to or exceed the lesser of 2% of the care management organization's assets or 10% of net assets as of December 31 of the immediately preceding calendar year.

(c) All management agreements, exclusive agency agreements, service contracts or cost-sharing arrangements which involve a care management organization and either an affiliate or a person attempting to acquire control of the care management organization.

(d) A transaction not in the ordinary course of business which involves a care management organization and either an affiliate of, or a person attempting to acquire control of, a care management organization and which involves or exposes to risk an amount equal to or exceeding the lesser of 2% of the care management organization's assets or 10% of net assets as of the 31st day of December of the immediately preceding calendar year.

(e) Any material transactions which the commissioner requires to be reported by order.

(3) ILLEGAL TRANSACTIONS NOT AUTHORIZED. This section does not authorize or permit any transaction which would be otherwise contrary to law.

(4) GROUP OR SERIES OF RELATED TRANSACTIONS. For the purpose of applying sub. (2), a group or series of related transactions shall be treated as if they are a single transaction.

(5) SUBTERFUGE PROHIBITED. A care management organization, person attempting to acquire control of a care management organization, person having control of a care management organization or affiliate of a care management organization may not enter into transactions which are part of a group or series of transactions if the purpose of those separate transactions is to attempt to avoid a threshold amount under this chapter.

(6) DISAPPROVAL. Transactions subject to reporting under sub. (2) may be disapproved by the commissioner, after consulting with the department, under s. 648.45 (6) (b), Stats. No person may enter into or assent to a transaction that is disapproved by the commissioner or which is subject to reporting under sub. (2) but not reported.

(7) CARE MANAGEMENT ORGANIZATION MAY REPORT ON BEHALF OF AFFILIATE OR PERSON ATTEMPTING TO ACQUIRE CONTROL. A care management organization may file a report under sub. (2) on behalf of its affiliate or of the person attempting to acquire control of the care management organization. Lack of knowledge that a care management organization has not reported on behalf of the affiliate or person or that the report is incomplete or inaccurate is not a defense for the affiliate or person attempting to acquire control of the care management organization.

Ins 57.13 Privileged information. The information required to be filed with the commissioner under s. Ins 57.10 is required under s. 601.42, Stats., and the commissioner may keep it confidential under s. 601.465, Stats.

Ins 57.20 Forms and Instructions. (1) GENERAL. Forms A and B contained in Appendix 1 to this chapter are intended to be guides in the preparation of the statements required by subch. I of this chapter. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer is in the negative, an appropriate statement to that effect shall be made.

(2) FILING FORMAT AND PROCEDURE. (a) One complete copy of each statement, including exhibits and all other papers and documents filed as a part of the statement, shall be filed with the commissioner. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is

affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

(b) Statements shall be prepared on paper 8 1/2x 11 in size and preferably bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements or exhibits shall be clear, easily readable and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency shall be converted into United States currency.

Ins 57.22 Forms—incorporation by reference, summaries and omissions.

(1) INCORPORATION BY REFERENCE. Information required by any item of forms A, B or C contained at Appendix 1, may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of form A, B or C provided the document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the commissioner which were filed within 3 years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that the material is to be incorporated by reference in answer to the item. Information shall not be incorporated by reference in any case where the incorporation would render the statement incomplete, unclear or confusing.

(2) SUMMARY. Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline may incorporate by reference particular

parts of any exhibit or document currently on file with the commissioner which was filed within 3 years and may be incorporated in its entirety by the reference. In any case where 2 or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties to the documents, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents, a copy of which is filed.

Ins 57.23 Transactions subject to prior notice—notice filing. A person required to give notice of a proposed transaction under this chapter shall furnish the required information in substantially similar in format and in response to questions presented on form B in Appendix 1.

Ins 57.24 Dividends and other distributions. Requests for approval of dividends or any other distributions to shareholders or corporate members shall include the following:

(1) The amount of the proposed dividend or distribution;

(2) The date established for payment of the dividend or distribution;

(3) A statement as to whether the dividend or distribution is to be in cash or other property and, if in property, a description of the property, its cost, and its fair market value together with an explanation of the basis for valuation;

(4) A balance sheet and statement of income for the period intervening from the last annual statement filed with the commissioner and the end of the month preceding the month in which the request for dividend approval is submitted.

(5) A brief statement as to the effect of the proposed dividend upon the care management organization's net assets and the reasonableness of net assets in relation to the care management organization's outstanding liabilities and the adequacy of net assets relative to the care management organization's financial needs.

Ins 57.25 Consent to jurisdiction. Any person required to file consent to jurisdiction under s. 648.45 (3), Stats., shall do so in a format substantially similar to the format and questions contained in form C of Appendix 1 to this chapter.

Ins 57.26 General requirements related to filing and extensions for filing of annual audited financial reports. (1) A care management organization shall:

(a) Annually obtain or cause an audit of the care management organization by an independent certified public accountant; and

(b) File an audited financial report that complies with s. Ins 57.30 with the commissioner on or before June 1 for the immediately preceding calendar year. If the care management organization is part of a county financial audit, the deadline for the Family Care care management organization audit is the deadline for the county financial audit, which is nine months from the end of the fiscal period.

(2) The commissioner may require a care management organization to file the audited financial report earlier than the date specified under sub. (1) if the commissioner gives 90 days advance notice to the care management organization.

(3) The commissioner may grant extensions of the filing date under sub. (1) for 31-day periods if the care management organization and independent certified public accountant establish there is good cause for an extension. A request for an extension shall be submitted in writing not less than 10 days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

(4) A care management organization may not retain an accountant or accounting firm to comply with sub. (1) or s. Ins 57.31 unless the accountant or accounting firm is an independent certified public accountant, regardless of whether the commissioner has issued a ruling under s. Ins 57.32 (1). A care management organization may not retain an accountant or accounting firm to comply with sub. (1) or s. Ins 57.31 if the commissioner under s. Ins 57.32 (1) rules that the accountant or accounting firm is not qualified or if the accountant or accounting firm does not comply with s. Ins 57.32 (2).

Ins 57.30 Contents of annual audited financial report. The annual audited financial report required under s. Ins 57.26 shall comply with all of the following:

(1) Report the financial position of the care management organization as of the end of the most recent calendar year and the results of its operations, cash flows and changes in net

assets for the year then ended in conformity with generally accepted accounting principles. care management

(2) Include all of the following:

(a) The report of the independent certified public accountant.

(b) A balance sheet reporting assets, liabilities, and net assets.

(c) A statement of operations.

(d) A statement of cash flows.

(e) A statement of changes in net assets.

(f) A report on the internal control environment of the MCO.

(g) A report describing the system of cost allocation for shared overhead and direct services between programs or lines of business as required.

(h) A supplemental financial report that demonstrates the financial position and segregated reserves of the MCO business for each State program contract where the organization serves members under multiple Medicaid managed care contracts and/or other lines of business. The report shall be in columnar format for the various programs as required.

(i) Letter to Management as issued or written assurance that a Management Letter was not issued with the audit report.

(j) Management responses and corrective action plan for each audit issue identified in the audit report or in the Management letter.

(k) Notes to financial statements. These notes shall be those required by generally accepted accounting principles. The notes shall include a reconciliation of differences, if any, between the audited financial statements and the annual statement filed pursuant to subch. II with a written description of the nature of these differences.

(3) The financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31, except in the first year in which a care management organization is required to file an audited financial report, the comparative data may be omitted.

Ins 57.31 Designation of independent certified public accountant. (1) A care management organization shall, within 60 days after the care management organization becomes subject to this subchapter:

(a) Provide the commissioner in writing the name and address of the independent certified public accountant retained to conduct the annual audit required by this subchapter.

(b) File with the commissioner a copy of the letter required to be obtained under sub. (3).

(2) Care management organizations not retaining an independent certified public accountant on the effective date of this rule shall register the name and address of their retained independent certified public accountant not less than 6 months before the date when the first audited financial report is to be filed.

(3) A care management organization shall obtain a letter from the independent certified public accountant it retains to conduct the annual audit required by this subchapter. The letter shall state that the independent certified public accountant:

(a) Is aware of the provisions of the administrative code and the rules and regulations of the insurance department or equivalent agency of the state of domicile of the care management organization that relate to accounting and financial matters of care management organizations; and

(b) Will express an opinion on whether the financial statements conform to the statutory accounting practices prescribed or otherwise permitted by that department or equivalent agency and will specify exceptions as appropriate.

(4) If an independent certified public accountant for the immediately preceding filed audited financial report of a care management organization is dismissed or resigns, the care management organization shall comply with all of the following:

(a) The care management organization shall within 5 business days notify the commissioner of the dismissal or resignation.

(b) The care management organization shall within 15 business days furnish the commissioner with a letter which clearly states that there was no disagreement required to be

disclosed under this paragraph or which describes any disagreement between the care management organization and the independent certified public accountant in the 24 months preceding the dismissal or resignation, which:

1. Was on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; and

2. Would require the independent certified public accountant to make reference to the subject matter of the disagreement in connection with the opinion required under s. Ins 57.30. The requirement to provide a description applies regardless of whether the disagreement was resolved or whether the former independent certified public accountant was satisfied with the resolution.

(c) The care management organization shall within 15 business days furnish the commissioner with a letter from the independent certified public accountant addressed to the care management organization stating whether the independent certified public accountant agrees with the statements contained in the care management organization's letter required under par. (b) and, if not, stating the reasons why not.

Ins 57.32 Qualifications of independent certified public accountants. (1) The commissioner may rule that an accountant or accounting firm is not qualified for purposes of expressing an opinion on the financial statements in the annual audited financial report required under this subchapter and prohibit care management organizations from retaining the accountant or an accounting firm, and require care management organizations to replace the accountant or accounting firm, if the commissioner finds there is cause, including, but not limited to, a finding that the accountant or accounting firm:

(a) Is not in good standing with the American institute of certified public accountants and in all states in which the accountant or accounting firm is, or is required to be, licensed to practice;

(b) Has either directly or indirectly entered into an agreement of indemnification with respect to the audit of the care management organization;

(c) Has not conformed to the standards of the accounting profession as contained in the code of professional ethics of the American institute of certified public accountants and rules and regulations and code of ethics and rules of professional conduct of the accounting examining board, or a similar code;

(d) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 USC 1961 to 1968, as revised, or any dishonest conduct or practices under federal or state law;

(e) Has been found to have violated the insurance laws or rules of this state; or

(f) Has demonstrated a pattern or practice of failing to detect or disclose material information in financial reports.

(2) The commissioner shall not recognize an independent certified public accountant as qualified for a particular care management organization if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for the care management organization, was employed by the independent certified public accountant and participated in the audit of the care management organization during the one-year period preceding the date that the most current statutory opinion is due. This paragraph shall only apply to partners and senior managers involved in the audit. A care management organization may make application to the commissioner for relief from the requirement of this paragraph on the basis of unusual circumstances.

Ins 57.33 Scope of audit and report of independent certified public accountant. Financial statements furnished under s. Ins 57.30 shall be audited by the independent certified public accountant. The independent certified public accountant shall conduct the audit of the care management organization's financial statements in accordance with generally accepted auditing standards.

Ins 57.35 Notification of adverse financial condition. (1) A care management organization shall require the independent certified public accountant to report, in writing and within 5 business days, to the board of directors of the care management organization or its audit committee any determination by the independent certified public accountant that the care

management organization has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under audit or that the care management organization does not meet the working capital or risk reserve requirements.

(2) A care management organization who receives a report required under sub. (1) shall forward a copy of the report to the commissioner within 5 business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence that the report has been furnished to the commissioner.

(3) An independent certified public accountant shall furnish to the commissioner a copy of its report required under sub. (1) within 10 business days after it is furnished to the care management organization under sub. (1) unless the independent certified public accountant receives evidence the care management organization has provided it within the 10 business day period to the commissioner as required under sub. (2).

(4) An executive officer or director of a care management organization which receives notice under sub. (1) shall report the notification in writing to the commissioner within 5 business days of the date the executive officer or director first acquires knowledge of the notification unless prior to that date the care management organization complies with sub. (2).

(5) If the independent certified public accountant, subsequent to the date of the audited financial report filed pursuant to this chapter, becomes aware of facts that might have affected the report, the independent certified public accountant shall take the action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

Ins 57.37 Accountant's letter of qualifications. An accountant or accounting firm retained by a care management organization to comply with this subchapter shall furnish the care management organization, and the care management organization shall obtain and include with the filing of the annual audited financial report required under s. Ins 57.26, a letter from the accountant or accounting firm stating:

(1) That the accountant or accounting firm is independent with respect to the care management organization and conforms to the standards of his or her profession as contained in the code of professional ethics and pronouncements of the American institute of certified

public accountants and the rules of professional conduct of the board of public accountancy of this state, or similar code.

(2) The background and experience in general, and the experience in audits of care management organizations of the staff assigned to the engagement and whether each is an independent certified public accountant. This subchapter does not prohibit the accountant or accounting firm from utilizing such staff as he or she deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards.

(3) That the accountant or accounting firm understands that the annual audited financial report and his or her opinion on the annual audited financial report will be filed in compliance with this chapter and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of care management organizations.

(4) That the accountant or accounting firm consents to the requirements of s. Ins 57.38 and that the accountant or accounting firm consents and agrees to make available work papers for review by the commissioner.

(5) A representation that the accountant or accounting firm is properly licensed by an appropriate state licensing authority and is a member in good standing in the American institute of certified public accountants.

(6) A representation that the accountant or accounting firm is an independent certified public accounting firm and that there are no grounds for disqualification of the accountant or accounting firm under s. Ins 57.32.

Ins 57.38 Availability and maintenance of CPA work papers. (1) A care management organization shall require the accountant or accounting firm which conducts an audit or other procedure under this subchapter to make available for review all work papers and any communications related to the audit or procedure between the care management organization and the accountant or accounting firm at the offices of the care management organization or at a reasonable place designated by the commissioner. The care management organization shall require that the accountant retain the audit work papers and communications

until the commissioner has filed a report on examination covering the period of the audit but no longer than 7 years from the date of the audit report.

(2) The commissioner may access work papers, reports, and other materials generated during the audit. Such access shall include the right to obtain photocopies of the work papers and copies of computer disks, or other electronic media, upon which records/working papers are stored. All working papers and communications obtained by the commissioner under this section may be treated by the commissioner as confidential under s. 601.465, Stats.

Ins 57.39 Conduct of care management organization in connection with the preparation of required reports and documents. (1) No director or officer of a care management organization shall, directly or indirectly:

(a) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this chapter.

(b) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this chapter.

(2) No officer or director of a care management organization, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any independent certified public accountant engaged in the performance of an audit pursuant to this chapter if that person knew or should have known that the action, if successful, could result in rendering the care management organization's financial statements materially misleading. In this subsection, actions that "if successful, could result in rendering the care management organization's financial statements materially misleading" include actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an independent certified public accountant:

(a) To issue or reissue a report on a care management organization's financial statements that is not warranted in the circumstances, due to material violations of statutory

accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards.

(b) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards.

(c) Not to withdraw an issued report.

(d) Not to communicate matters to a care management organization's audit committee.

Ins 57.40 Care management organizations to file financial statements. (1) A care management organization shall file annual and quarterly financial statements with the commissioner. A care management organization shall file the financial statements in a format determined by the commissioner, after consultation with the department.

Ins 57.41 Exemptions and effective dates. (1) The commissioner may grant an exemption from compliance with s. Ins 57.26 if the commissioner finds that compliance would constitute a financial or organizational hardship upon the care management organization, except as provided in s. Ins 57.08 (2) (a).

(2) An exemption may be granted at any time and from time to time for a specified period.

APPENDIX

FORM A
STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A CARE MANAGEMENT ORGANIZATION

Filed with the office of the commissioner of insurance, state of Wisconsin
By

_____
Name of Registrant

On behalf of following care management organizations
Name: Address:
Date: _____, _____

Name, title, address and telephone number of individual to whom notices and correspondence concerning this statement should be addressed:

ITEM 1. CARE MANAGEMENT ORGANIZATION AND METHOD OF ACQUISITION

State the name and address of the care management organization to which this application relates and briefly describe how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the care management organization.

(b) If the applicant is not an individual, state the nature of its business operations for the past 5 years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. No affiliate need be identified if its total assets are equal to less than .5% of the total assets of the ultimate controlling person of the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing, indicate the type of organization (e.g., corporation, trust, partnership) and the state of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

State the following with respect to (1) the applicant if the applicant is an individual or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address;

(b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) Material occupations, positions, offices or employment during the last 5 years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection with the license or registration whether pending or concluded.

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding traffic violations not involving death or injury) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source and amount of funds or other considerations used, or to be used, in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

ITEM 5 FINANCIAL STATEMENTS AND EXHIBITS

(a) Attach financial statements and exhibits to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding 5 fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if the information is available. The statements may be prepared either on an individual basis or, unless the commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the person's last fiscal year, in conformity with generally accepted accounting principles or other accounting principles prescribed or permitted under law.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last 2 fiscal years, and any additional documents or papers required by form A or s. Ins 57.20, Wis. Adm. Code.

ITEM 6 SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of ch. Ins 57, Wis. Adm. Code, _____ has caused this notice to be duly signed on its behalf in the city of _____ and state of _____ on the _____ day of _____, _____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

The undersigned deposes and says that (s)he has duly executed the attached notice dated _____, _____, for and on behalf of _____; and that s(he) is the _____

(Name of Registrant) (Title of Officer)

and that s(he) is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Subscribed and sworn to this _____ day of _____, _____.,

Notary Public

My commission expires _____

FORM B
PRIOR NOTICE OF A TRANSACTION

Filed with the office of the commissioner of insurance, state of Wisconsin

By

_____
Name of Registrant

On behalf of following care management organizations

Name: Address:

Date: _____, _____

Name, title, address and telephone number of individual to whom notices and correspondence concerning this statement should be addressed:

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction covered under s. 648.45 (2), Stats., and s. Ins 57.12 (2), Wis. Adm. Code:

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure, i.e., corporation, partnership, individual, trust, etc.;

(e) A description of the nature of the parties' business operations;

(f) Relationship, if any, of other parties to the transaction to the care management organization filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the care management organization seeking approval, or by the care management organization filing the notice for the affiliates;

(g) Where the transaction is with a non–affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under s. Ins 57.12 (2) (a), (b), (c), (d), or (e);

(b) A statement of the nature of the transaction; and

(c) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment. Describe any provision for purchase of the care management organization filing notice, by any party to the transaction, or by any affiliate of the care management organization filing notice. Give a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the care management organization will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements.

Furnish a brief statement as to the effect of the transaction upon the care management organization's net assets.

No notice need be given if the maximum amount which can at any time be outstanding or for which the care management organization can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of nonlife care management organizations, the lesser of 2% of the care management organization's assets or 10% of net assets as of December 31 of the immediately preceding calendar year.

ITEM 4. LOANS, EXTENSIONS OF CREDIT, OR GUARANTEES TO OR FOR A NONAFFILIATE

If the transaction involves a loan, extension of credit, or guarantee to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the care management organization making such loans, extensions of credit, or guarantee. Specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, describe its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the care management organization's net assets.

No notice need be given if the loan or extension of credit is one which equals less than the lesser of 2% of the care management organization's assets or 10% of net assets as of December 31 of the immediately preceding calendar year.

ITEM 5. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST–SHARING ARRANGEMENTS

For management and service agreements, furnish:

(a) A brief description of the managerial responsibilities, or services to be performed;

(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost–sharing arrangements, furnish:

(a) A brief description of the purpose of the agreement;

(b) A description of the period of time during which the agreement is to be in effect;

(c) A brief description of each party's expenses or costs covered by the agreement;

(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement.

ITEM 6. TRANSACTIONS NOT IN THE ORDINARY COURSE OF BUSINESS

Provide a brief but complete description of any transaction not in the ordinary course of business.

ITEM 7. OTHER TRANSACTIONS REPORTABLE UNDER AN ORDER

Provide a brief but complete description of any transaction reportable under an order.

ITEM 8. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of ch. Ins 57, Wis. Adm. Code, _____ has caused this notice to be duly signed on its behalf in the city of _____ and state of _____ on the _____ day of _____, _____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

The undersigned deposes and says that (s)he has duly executed the attached notice dated _____, _____, for and on behalf of _____; and that s(he) is the _____

(Name of Registrant) (Title of Officer)

and that s(he) is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Subscribed and sworn to this _____ day of _____, _____.,

Notary Public

My commission expires _____

FORM C
CONSENT TO JURISDICTION STATEMENT
Filed with the office of the commissioner of insurance,
of the state of Wisconsin
BY

_____ _____
Name of Affiliate

On Behalf of the Following Care Management Organizations
Name Address

_____
_____
_____
_____
_____
_____

Date: _____, _____
Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

_____
_____
_____
_____
_____
_____

CONSENT TO JURISDICTION

The, (I),_____, an affiliate of
_,
(Affiliate) (Care Management Organization)
a care management organization permitted to do business in the state of Wisconsin, pursuant to the requirements of ch. 648, Stats., do hereby consent to the jurisdiction of the Commissioner of Insurance and the courts of the state of Wisconsin.

SIGNATURE

_____ has caused this statement to be duly signed
(Name of Affiliate)
on its behalf in the city of _____and state of
_
on the_____ day of _____, _____

(Name of Affiliate)
(SEAL)

BY _____
(Name)

_____
(Title)

Attest:_____
(Signature of Officer)

_____
(Title)

SECTION 2. These changes first apply to care management organizations on January 1, 2010.

SECTION 3. This chapter may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or chs. 645, 648, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 4. These emergency rule changes will take effect on the day following publication, as provided in s. 227.24(1)(c), Stats.

Dated at Madison, Wisconsin, this 2 day of October, 2009.

Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 57 relating to care management organizations and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.

CERTIFICATION

The undersigned deposes and says that he or she has duly executed the attached statement dated _____, ____, for and on behalf of _____
(Name of Affiliate)
that he or she is the _____ of such company,
(Title of Officer)
and that he or she is authorized to execute and file such instrument. Deponent further says that he or she is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his or her knowledge and belief.

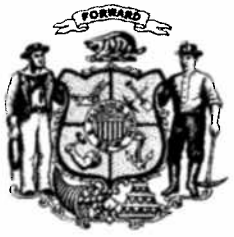
(Signature) _____

_____
(Type or print name beneath)

Subscribed and sworn to this ____ day of _____, ____

Notary Public
My commission expires _____

WISCONSIN STATE LEGISLATURE



State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

November 4, 2009

Honorable Jon Erpenbach, Chair
Senate Committee on Health, Health Insurance,
Privacy, Property Tax Relief, and Revenue
Room 8 South, State Capitol
Madison, WI 53707-7882

Dear Senator Erpenbach:

I am writing to notify you of an amendment to the contract between the Department of Health Services (DHS) and EDS for the Medicaid Management Information System (MMIS) and Fiscal Agent Services. The Department is required to notify the Joint Committee on Finance and appropriate standing committees in each house of the Legislature of amendments to the contract, pursuant to s. 49.45(2)(a)(16), Wis. Stats.

The contract amendment specifies changes to operational performance standards, documents additional services to be provided under the contract at no additional cost, and confirms the operational start date and term of the operations contract. These contract changes will help assure timely and accurate service to ForwardHealth program providers and members in the areas of the call center, managed care, and claims processing and payment.

Sincerely,

Karen E. Timberlake
Secretary

Attachment

cc: Senator Mark Miller, Co-Chair Joint Committee on Finance
Representative Mark Pocan, Co-Chair Joint Committee on Finance
Representative Jon Richards, Chair, Assembly Committee on Health and Health Care Reform

AMENDMENT TO CONTRACT FOR MMIS AND FISCAL AGENT SERVICES FOR THE WISCONSIN MEDICAID PROGRAM
AMENDMENT #2

Whereas, the State Department of Health Services, formerly contracting as the Department of Health and Family Services (herein referred to as the "Department") and EDS Information Services, L.L.C., formerly contracting as E.D.S. Federal Corporation (herein referred to as "Contractor") entered into and are now operating under a Contract for MMIS and Fiscal Agent Services for the Wisconsin Medicaid Program (herein referred to as "Contract") which took effect January 17, 2005; and,

Whereas, the Contract provided at Section 50.1310 that it may be modified or amended at any time by the mutual consent of Contractor and State, and that all such amendments shall become effective only when approved by the federal Centers for Medicare and Medicaid Services (herein referred to as "CMS") and State authorities, and subsequently executed by the parties hereto; and,

Now, therefore, in consideration of the foregoing recitals and of the mutual promises contained herein, State and Contractor hereby agree as follows:

1. Section 50.1210 Initial Term of Contract is amended as follows:

   The operations period of the Contract shall begin on November 10, 2008 and continue for sixty [60] months unless extended or terminated in accordance with applicable contract provisions. The Contractor shall not commence work, or commit funds, or incur costs, or in any way act to obligate the State of Wisconsin prior to contract execution.

2. Section 50.1720 Payments During the Operations Phase is amended to add the following:

   The Contractor will provide the following staff and services in addition to the levels it maintained prior to this amendment, at no additional cost to the State during the contract:
   - The Contractor will provide four additional provider representatives. One of the additional representatives will be hired by the end of July, 2009 and the remaining representatives will be hired by the end of October, 2009.
   - By July 1, 2009 the Contractor will staff a Dental Access Unit with six full-time workers to focus on helping Medicaid patients find dental providers and to work with dental offices, advocates, and the Wisconsin Dental Association to help encourage dentists to become Medicaid providers. The Contractor will dedicate telephone lines for these purposes on the existing member and provider toll free call center.

3. Section 50.1730 Payments for Scope of Work Changes is amended to add the following:
   - For calendar year 2009, the Contractor will provide an additional 35,000 hours of system modification hours so that the total number of hours for calendar year 2009 will be 70,000 hours. For calendar year 2010 and each contract year thereafter, the Contractor will provide an additional 10,000 hours of system modification hours so that the total number of hours for each of those calendar years will be 45,000 hours (plus any carryover hours from prior contract years.)

4. Replace Section 50.1911 in the Contract with the following:

Section 50.1911 Timeliness of Claims and Adjustments Processing – Performance Requirement

The Contractor must provide prompt and accurate processing of claims from receipt to approval or denial and not accumulate an excessive claims inventory or aged claims.

The Contractor shall process all paper claims and adjustments, from receipt to adjudication, except those specifically exempted by written notice by DHS or those days where a claim is physically in the custody of the Department staff, as determined by DHS, within the following time limits: seventy-five percent (75%) of all claims and adjustments shall be processed within ten (10) calendar days of receipt, ninety percent (90%) of all claims and adjustments shall be processed within twenty-one (21) calendar days of receipt, ninety-five percent (95%) of all claims and adjustments shall be processed within thirty (30) calendar days of receipt, one hundred percent (100%) of all claims and adjustments shall be processed within ninety (90) calendar days of receipt.

The Contractor shall process all electronic claims and adjustments, from receipt to adjudication, except those specifically exempted by written notice by DHFS or those days where a claim is physically in the custody of the Department staff, as determined by DHFS, within the following time limits: ninety percent (90%) of all claims and adjustments shall be processed within seven (7) calendar days of receipt, ninety-five percent (95%) of all claims and adjustments shall be processed within fourteen (14) calendar days of receipt, ninety-nine percent (99%) of all claims and adjustments shall be processed within thirty (30) calendar days of receipt and 100% of all claims and adjustments shall be processed within forty-five (45) days of receipt.

If the Contractor is unable to adjudicate any claim or adjustment because it lacks a policy determination or other information obtainable only from the Department, the Contractor shall immediately notify the Department, in writing. The Contractor shall have the days from notification receipt by the Department until the date the Contractor receives a response from the Department exempted from claims processing timeliness for purposes of imposing financial liability (the days will not count toward the timeliness thresholds).

5. Replace Section 50.1912 of the Contract with the following: Section 50.1912 Timeliness of Claims and Adjustments Processing – Damages

Damages will be assessed in the following amounts: one thousand dollars ($1,000.00) per zero point two percent (0.2%) of paper claims and adjustments processed under the seventy five percent (75%) threshold within ten (10) calendar days of receipt; one thousand five hundred dollars ($1,500.00) per zero point two percent (0.2%) of paper claims and adjustments processed under the ninety percent (90%) threshold within twenty-one (21) calendar days of receipt; two thousand dollars ($2,000.00) per zero point two percent (0.2%) of paper claims and adjustments processed under the ninety-five percent (95%) within thirty (30) calendar days of receipt; five thousand dollars ($5,000.00) per zero point two percent (0.2%) of paper claims and adjustments processed under the one hundred percent (100%) threshold within ninety (90) calendar days of receipt; five dollars ($5.00) per paper claim and/or adjustment, per day, for any paper claim or adjustment processed after ninety (90) calendar days of receipt. The Contractor

will automatically deduct the damage assessments from the next monthly invoice, itemizing the assessment deductions on the invoice.

Damages will be assessed in the following amounts: one thousand dollars ($1,000.00) per zero point two percent (0.2%) of electronic claims and adjustments processed under the ninety percent (90%) threshold within seven (7) calendar days of receipt; one thousand five hundred dollars ($1,500.00) per zero point two percent (0.2%) of electronic claims and adjustments processed under the ninety-five percent (95%) threshold within fourteen (14) calendar days of receipt; two thousand dollars ($2,000.00) per zero point two percent (0.2%) of electronic claims and adjustments processed under the ninety percent (99%) within thirty (30) calendar days of receipt; five thousand dollars ($5,000.00) per zero point two percent (0.2%) of electronic claims and adjustments processed under the one hundred percent (100%) threshold within forty-five (45) calendar days of receipt; five dollars ($5.00) per electronic claim and/or adjustment, per day, for any electronic claim or adjustment processed after forty-five (45) calendar days of receipt. The Contractor will automatically deduct the damage assessments from the next monthly invoice, itemizing the assessment deductions on the invoice.

5. Replace Section 50.19141 of the Contract with the following:

Section 50.19141 Call Center Availability – Performance Requirement

The Contractor will insure that the call center system is available ninety-nine percent (99%) of the time per day. The Member Call Center will be available and on line from 8:00 a.m until 6:00 p.m. (CT) Monday through Friday. The Provider Call Center will be available and on line from 7:00 a.m. until 6:00 p.m.(CT) Monday through Friday. The Contractor shall provide weekly administrative reports detailing the actual performance of the system and the availability of the system by hour.

6. Replace Section 50.19151 of the Contract with the following:

Section 50.19151 Call Center Response Time –Performance Requirement

The contractor must provide and maintain sufficient provider and member customer service phone lines and customer service correspondent staff so that for each toll free number:

- at least 90% of calls offered will be answered within three (3) minutes
- at least 95% of all calls offered will not encounter a busy condition

Calls offered is defined as calls received for call center staff to answer and do not include calls answered by automated voice response systems. Performance will be measured separately for each call center and will be measured weekly based on the average of actual performance of each call center for each business day during the week.

7. Replace Section 50.19152 of the Contract with the following

Section 50.19152 Call Center Response Time - Damages

Damages may be assessed at the rate of five hundred dollars ($500) per week for each percentage point below the requirement.

8. Create new Sections 50.19181 and 50.19182 as follows:

Section 50.19181 Managed Care –Performance Requirements:
The Contractor must:

- Generate accurate, and complete electronic and/or hard copy reports of enrollees for distribution to MCOs. The reports must be produced and distributed based on the requirements and schedule defined by DHS. Electronic reports must comply with applicable HIPAA mandated standards (834).
- Generate accurate and complete electronic and/or hard copy reports of payments to MCOs. The reports must be produced and distributed based on the requirements and schedule defined by DHS. Electronic reports must comply with applicable HIPAA mandated standards (820).
- Generate all electronic and/or hard copy reports required by DHS for distribution to MCOs and other parties defined by DHS to support managed care operations, encounter processing, and MCO contract compliance requirements. The reports must be produced and distributed based on the requirements and schedule defined by DHS. All reports must be accurate and complete and comply with RFP requirements including but not limited to requirements for format, content, technical and user documentation.
- Generate and send accurate State-approved enrollment materials to members in the enrollment process, at a minimum, on a weekly basis or on a schedule defined by DHS.
- Review and respond to MCO inquiries within three (3) business days.

Section 50.19182 Managed Care Performance Requirements – Damages

Damages for non compliance with the performance standards for all reports and enrollment materials in 50.19181 may be assessed at an amount of five hundred dollars ($500.00) per State of Wisconsin business day beyond the scheduled distribution date until the non-compliance is corrected.

Damages for non compliance with the performance standards for response to MCO inquiries in 50.19181 may be assessed at an amount of two hundred fifty dollars ($250.00) per State of Wisconsin business day for each day after the three-day standard until the non-compliance is corrected.

9. Replace Sections 50.1971 and 50.1972 of the contract as follows:

Section 50.1971 Data Warehouse Refresh Requirements – Performance Requirement

The Contractor must refresh Data Warehouse claims and financial tables weekly, no later than 6 am CST on Monday or the first business day after completion of the weekly ForwardHealth financial cycle. The Contractor must refresh other data warehouse tables, including but not limited to recipient eligibility and reference data files in accordance with the data refresh schedule designated by the State.

Section 50.1972 Data Warehouse Refresh Requirements- Damages

Damages of two thousand five hundred dollars ($2500.00) per day may be assessed when the data warehouse refresh was not performed by the data refresh timeframe and schedule of Section 50.1971 of the contract.

10. The above amendments to subsections within Section 50.1900 Performance Standards – Liquidated Damage are effective April 1, 2009.

11. All terms and conditions of the Contract and any prior amendments that are not affected by this Amendment shall remain in full force and effect through the duration of the Contract, and the terms of the Amendment shall be fully incorporated into the Contract by this reference and fully enforceable as any other term.

12. This amendment may itself be amended by mutual consent of the Contractor and State pursuant to Section 50.1310 of the Contract.

Except as otherwise noted above, this Amendment takes effect when executed by both parties as indicated below.

IN WITNESS THEREOF, the parties hereto have caused this Contract to be executed by their duly authorized representatives, on the dates indicated below each signature.

Electronic Data Systems. LLC
(Formerly Electronic Data Systems Corporation)

BY: _____
Kevin McFarling
Vice President

DATE: September 3, 2009

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES

BY: _____
Karen E. Timberlake
Secretary

DATE: 11/3/09