2019-2021 HMO Accreditation Deeming Plan

Wisconsin's Department of Health Services (DHS) has developed this Accreditation Deeming Plan in accordance with 42 CFR § 438.360 to request approval from the Centers for Medicare and Medicaid Services (CMS) to use information from a private accreditation review of a Managed Care Organization (MCO) for some of the annual external quality review activities defined in 42 CFR § 438.350. DHS developed this Accreditation Deeming Plan with its External Quality Review Organization (EQRO), MetaStar, for HMOs that have attained and maintain health plan accreditation by the National Committee of Quality Assurance (NCQA).

This HMO Accreditation Deeming Plan will be piloted as part of the DHS certification of HMOs for the 2019-2021 BadgerCare Plus and Medicaid SSI HMO Contract period. The Deeming Plan describes how DHS and MetaStar will ensure compliance of NCQA accredited HMOs with the federal Medicaid Managed Care requirements. As part of this plan, DHS and MetaStar have identified gaps between NCQA accreditation requirements and the federal Managed Care requirements; to address those gaps, DHS will enhance the HMO certification review process (see description in "B" below), align it with the EQRO review protocol, amend the BadgerCare Plus and Medicaid SSI Contract to include the accreditation deeming policy, and introduce a streamlined EQRO review process for NCQA-accredited HMOs.

As background information, Wisconsin Medicaid updates the BadgerCare Plus and Medicaid SSI Managed Care contracts every two years and reviews each HMO's certification application as part of the contract signature process and mid-contract:

A. 2018-2019 BadgerCare Plus and Medicaid SSI Contract

A link to the 2018-2019 Wisconsin Medicaid contract with HMOs is below:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/pdf/2018-2019HMOContract.pdf.spage

B. DHS HMO Certification Process (for DHS' contracted BadgerCare Plus and/or Medicaid SSI HMOs)

As part of the Department's contract signature process, DHS reviews HMO readiness to serve the Medicaid population through the HMO certification review process. Through this process, DHS ensures HMO compliance with key contract requirements (according to Wisconsin administrative code DHS 105.47) and with federal requirements in 42 CFR 434.20.

The certification process begins with each HMO completing the certification application template provided by DHS which includes the following sections:

a) Subcontracts & MOUs
b) Access to Care
c) Quality Improvement and Accreditation
d) Member Complaint and Grievance System
e) Provider Appeals System
f) Reporting and Data Administration
g) Fraud & Abuse Policies and Procedures
h) Language Access Policies and Procedures
i) Care Management System and Continuity of Care

HMOs are required to complete the certification template and submit all documentation related to each of the certification focus areas. HMOs are also required to submit verification of its current accreditation status and a copy of their accreditation report, if applicable. The most recent HMO certification was conducted from October 2017 through March 2018 for the contract period that began January 1, 2018 through December 31, 2019. For the 2018-2019 contract, DHS has divided the review of the Certification Application over the course of two years. The most recent DHS certification application template is provided below as a reference: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/word/2018_HMO_Certification_Application.docx.spage

The Accreditation Deeming Plan developed by DHS and MetaStar would be updated every three years to align with the HMOs' NCQA accreditation period and will incorporate updated NCQA accreditation crosswalks and other information as needed. The 2019-2021 HMO Accreditation Deeming Plan includes the following:

1. **Development of the Accreditation Crosswalk -** DHS and MetaStar created a crosswalk between the National Committee of Quality Assurance (NCQA) standards for commercial and Medicaid accreditation with the federal Managed Care requirements.

2. **Gap Analysis** – Subsequently, DHS and MetaStar identified gaps between NCQA accreditation requirements, the federal Managed Care requirements and state contract requirements. Then DHS and MetaStar analyzed and determined that those gaps can be met through the updated DHS' HMO certification application review process and an abbreviated external quality review process.

3. **Review of DHS Policy and Update the EQRO Review Processes -** As a result of the gap analysis, DHS identified areas in which the current HMO contract and HMO certification requirements could be strengthened to address the gaps in the crosswalk. Subsequently, MetaStar and DHS determined that there were elements in the EQRO review process that could be collected and analyzed jointly as part of the HMO certification application process. Lastly, MetaStar identified areas in the EQRO review processes that needed to be updated to better coordinate the HMO certification and the EQRO review processes. This approach will reduce duplication related to the review processes for the HMOs.

2019-2021 HMO Accreditation Deeming Plan

1. Accreditation Crosswalk

DHS/MetaStar

Develop Accreditation Crosswalk

- Crosswalk between federal Medicaid Managed Care rules & NCQA Accreditation .

Notes

- This process applies to HMOs accredited by **NCQA only**.
- The **accreditation crosswalk** will be **updated** as part of the BadgerCare Plus and Medicaid SSI HMO contract renewal process.

2. Gap Analysis

DHS/MetaStar

Gaps btw federal reqs. & NCQA Accreditation

- Identified areas not covered by NCQA.

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DHS

Compare Gaps to HMO Contract & Certification Application

- From crosswalk, identify areas to strengthen in HMO contract & certification application

3. Review DHS Policy & Update EQRO Proc.

DHS/MetaStar

Review EQRO Process & DHS Policies

- Identify changes to HMO Contract & Certification Application

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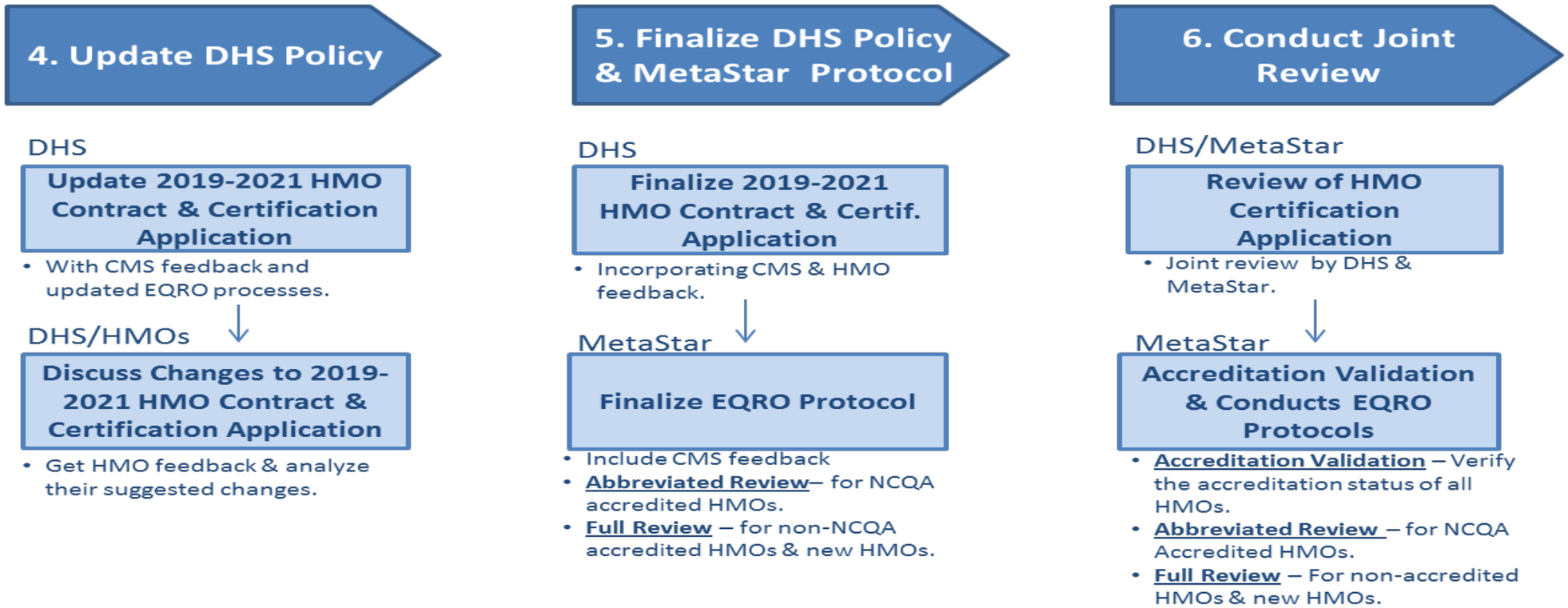
MetaStar

Develop Plan to Update EQRO Process & Tools

- **Abbreviated Review** – for NCQA Accredited HMOs.
- **Full Review** – For non-accredited HMOs & new HMOs.

2019-2021 HMO Accreditation Deeming Plan



Notes

- This process applies to HMOs accredited by **NCQA only**.
- The **accreditation crosswalk** will be **updated** as part of the BadgerCare Plus & Medicaid SSI HMO contract renewal process.

4. **Updating DHS' Accreditation Deeming Policy -** DHS plans to update the HMO certification requirements and the BadgerCare Plus and Medicaid SSI contract for the 2019-2021 contract period. The updates to the 2019-2021 HMO certification application will incorporate the elements identified in the Accreditation Crosswalk and the EQRO review processes.

   Subsequently, DHS will share the Accreditation Deeming Plan and review the updated HMO certification review process with HMOs.

5. **Finalize DHS Accreditation Policy and MetaStar's Review Processes -** DHS will gather feedback from HMOs about the certification process and may update it based on their recommendations. DHS will incorporate the final changes to the 2019-2021 HMO contract, the HMO certification application, and MetaStar will update the EQRO review processes.

6. **Conduct Joint Review –** Lastly the updated HMO certification application review process and the Accreditation Process will be conducted jointly by DHS and MetaStar:
   a) MetaStar will determine each HMO accreditation status.
   b) The HMOs will complete the revised HMO certification application.
   c) DHS and MetaStar will share the information submitted by the HMOs in their certification applications and conduct the review of the certification applications jointly.
   d) After completing the certification application review and the BadgerCare Plus and Medicaid SSI contract is awarded, MetaStar will conduct the abbreviated EQRO review for NCQA-accredited HMOs and the full EQRO review for non-accredited HMOs during the contract period. Any areas of non-compliance would be readily identified and corrective actions implemented as needed.

Questions

If there are any questions about this document, please send an email to:

dhsdmsqualitystrategy@dhs.wisconsin.gov

MCO Accreditation Crosswalk

This Accreditation Crosswalk was prepared by the Department of Health Services and its External Quality Review Organization, MetaStar, in order to request approval from the Centers for Medicaid and Medicare (CMS) to deem NCQA accredited MCOs in compliance with some of the federal managed care requirements related to external quality review. As instructed by CMS, this crosswalk was developed as the first step in the MCO Accreditation Deeming Plan to compare NCQA accreditation requirements with the federal Managed Care requirements for Medicaid MCOs (42 Code of Federal Regulations section 438) in order to determine if there are any gaps between both requirements. The Accreditation Deeming Plan on pages 1-5 outlines Wisconsin's plan to seek CMS' approval for its Accreditation Deeming Policy and the next steps to cover any gaps identified in the crosswalk. This crosswalk was prepared using the 2018 Standards and Guidelines for the Accreditation of Health Plans, effective July 1, 2018.

Beginning July 1 2018, NCQA is including a new standard, *Population Health Management*. NCQA uses acronyms to identify each standard. The names and acronyms used in the following tables are: Quality Management and Improvement (QI), Population Health Management (PHM), Network Management (NET) Utilization Management (UM), Credentialing and Recredentialing (CR), Members' Rights and Responsibilities (RR), Member Connections (MEM), and Medicaid Services and Benefits (MED). The MED standard is only applicable for MCOs seeking Medicaid accreditation.

Attachment 2: 42 CFR 438 Managed Care - Subpart C

Enrollee Rights and Protections

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.100 (a) (1) and (2) a) *General rule.* The State must ensure that: (1) Each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in this section; and	**2/2**	RR1 CR5 CR7	**Met** RR 1 evaluates if an organization has a written policy that states its commitment to treating members in a manner that respects their rights, and its expectations of members' responsibilities.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article VI-Marketing and Member Materials, D. Member Handbook, Provider Directory, Education and Outreach for Newly Enrolled Members, 2.MCOs make	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(2) Each MCO, PIHP, PAHP, PCCM and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect those rights.			RR1 also requires verification of the distribution of member rights policies and procedures to practitioners.	members aware of their rights in the Member Handbook which shall be provided in hardcopy to new members within 10 days of final enrollment notification to the MCO. The Member Handbook template is present as Addendum II of the BadgerCare Plus and Medicaid SSI Contract. If a member has an issue about their rights not being respected, they can contact the MCO Member Advocate, the Enrollment Specialist, the BadgerCare Plus and Medicaid SSI Ombudsman, grieve to the Department, or contact the SSI External Advocate (if in SSI Managed Care). DHS monitors member grievances trends quarterly. Article VII – Member Rights and Responsibilities MCO must have written		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				policies guaranteeing each member's rights, and share those policies with staff and affiliated providers to be considered when providing services to members.		
438.100 (b) (1) (2)(b) *Specific rights*—(1) *Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (3) of this section. (2) An enrollee of an MCO, PIHP, PAHP, PCCM, o**r** PCCM entity has the following rights: The right to— (i) Receive information in accordance with §438.10. (ii) Be treated with respect and with due consideration for his or her dignity and privacy. (iii) Receive information on available treatment options and	**1/2**	RR1 RR2 RR3 RR4 NET1 NET6	**Not Met** The NCQA standards do not fully address the following details found in 438.100: • Access to family planning services • The right to refuse treatment; and • The right to be free of restraint or seclusion.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Addendum II- Standard Member Handbook Language for BadgerCare Plus and Medicaid SSI- includes Family Planning information section. The information about Member Rights is included in the Member Handbook which all MCOs are required to send to their membership upon enrollment. MCOs are required to make the Member Handbook available to members in different languages and formats. The Member Handbook template is	**1/1** **2018 Certification Application:** 10.1 Member Handbook	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(g)(2)(ii)(A) and (B).) (iv) Participate in decisions regarding his or her health care, including the right to refuse treatment. (v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. (vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and				present as Addendum II of the BadgerCare Plus and Medicaid SSI Contract. MCOs also send the provider directory to members which is available online. The provider directory has information on every provider in network, their specialty, address, hours of operation, languages spoken, etc. Article VII – Member Rights and Responsibilities As cited in 42 CFR 438.100, enrollees of MCOs have specific rights including the right to refuse treatment and to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.						
438.100 (b) (3) (3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§438.206 through 438.210.	**1/1**	RR1 RR2 RR3 RR4 NET1 NET7	**Met** RR1-Member Rights RR3-Benefits and services included and excluded from coverage RR4-Covered and Non-covered benefits	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article VII-Member Rights and Responsibilities- As cited in 42 CFR 438.100, enrollees of MCOs have specific rights. Article VI-Marketing and Member Materials, D. Member Handbook, Provider Directory, Education and Outreach for Newly Enrolled Members, 2.MCOs make members aware of their rights in the Member Handbook which shall be provided in hardcopy to new members within 10 days of final enrollment notification to the MCO. The Member Handbook	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				template is present as Addendum II of the BadgerCare Plus and Medicaid SSI Contract. Article V-Provider Network and Access Requirements, I. Online Provider Directory-MCOs also send the provider directory to members which is available online. The provider directory has information on every provider in network, their specialty, address, languages spoken, etc. Article VI-Marketing and Member Materials, D. Member Handbook, Provider Directory, Education and Outreach for Newly Enrolled Members.		
438.100 (c) The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights	**0/1**	RR 1 RR2 RR3 UM 7 UM8	**Not Met** RR sections address the member's rights and responsibilities and their ability to file	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Addendum II- Standard Member Handbook	**1/1** **2018 Certification Application:** 10.1 Member Handbook	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
does not adversely affect the way the MCO, PIHP, PAHP, PCCM or PCCM entity and its network providers or the State agency treat the enrollee.		UM9	appeals/complaints, but there is no mention of adverse treatment by the MCO due to the exercise of their rights. UM 7-9 also deal with member appeal rights	Language for BadgerCare Plus and Medicaid SSI-Your Member Rights section-The information about Member Rights is included in the Member Handbook which all MCOs are required to send in hardcopy to new members within 10 days of final enrollment notification to the MCO. MCOs are required to make the Member Handbook available to members in different languages and formats. If a member has an issue about rights not being respected, they can contact the MCO Member Advocate, the Enrollment Specialist, the BadgerCare Plus and Medicaid SSI Ombudsman, grieve to the Department, or contact the SSI External Advocate (if in SSI Managed Care). All of these resources and an explanation of the Member Grievances process are		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				included in the Member Handbook. DHS monitors member grievances trends quarterly. Article VII – Member Rights and Responsibilities As cited in 42 CFR 438.100, enrollees of MCOs have specific rights including freedom for the enrollee to exercise his or her rights, and that exercise of those rights does not adversely affect the way the MCO and its network providers treat the enrollee.		
438.102 (a) (a) *General rules.* (1) An MCO, PIHP, or PAHP may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: (i) The enrollee's health	**2/5**	RR1	**Not Met** The NCQA guidance notes that the organization must not have any policies restricting dialogue between practitioner and patient and that it affirms that it does not direct practitioners to restrict information about treatment options.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article I, Definitions, Authorized Representative specifies that providers are allowed to be an authorized representative of the member advocating on his/her behalf. Article VII-Member	**3/3** **2018 Certification Application:** 10.1 Member Handbook	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
status, medical care, or treatment options, including any alternative treatment that may be self-administered. (ii) Any information the enrollee needs to decide among all relevant treatment options. (iii) The risks, benefits, and consequences of treatment or non-treatment. (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.			It does not, however, specifically address the following elements of this requirement: • The advocacy role of the practitioner; • The self-administered alternative treatment; and • The right of the enrollee to refuse treatment and express preferences.	Rights and Responsibilities - The Member Handbook includes language about an enrollee's right to participate in decisions, including the right to refuse treatment. Also includes that enrollees have the right to receive information on available treatment options and alternatives. MCOs are required to send a Member Handbook in hardcopy to new members within 10 days of final enrollment notification to the MCO.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.102 (b) (b) *Information requirements: MCO, PIHP, and PAHP responsibility.* (1)(i) An MCO, PIHP, or PAHP that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows: (A) To the State— (*1*) With its application for a Medicaid contract. (*2*) Whenever it adopts the policy during the term of the contract.	**0/2**	RR1	**Not Met** No element in the NCQA standards addresses this elected option and related communication requirements.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Per Article IV-Services, H. Provider Moral or Religious Objection, MCOs are required to furnish information about the services it does not cover as follows: • To the Department and Enrollment Specialist so the Department can notify members of the MCO's non-coverage of service; • With the MCO's certification application for a BadgerCare Plus and/or Medicaid SSI contract; • Whenever the MCO adopts the policy during the term of the contract; • It must be consistent with the provisions of 42	**1/2** **2018 Certification Application:** 6.6 Moral or Religious Objections to Care	**1** (b)(2) Both remaining elements are addressed in the 2018-2019 contract, but one is not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				CFR 438.10; • It must be provided to potential members before and during enrollment; • It must be provided to members within ninety (90) days after adopting the policy with respect to any particular service; and • In written and prominent manner, the MCO shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI but which are not available through the MCO because of an objection on moral or religious grounds.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				Article II Enrollment and Disenrollment, B. Disenrollment, 1. Voluntary Disenrollment, b. Medicaid SSI-Per the contract, a member can disenroll from an MCO if it refuses to provide medically necessary treatment due to moral or religious objections. All MCOs provide information to members about covered services through the Member Handbook		
438.102 (c) (c) *Information requirements: State responsibility.* For each service excluded by an MCO, PIHP, or PAHP under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in §438.10.	**0/0**	None	**Not Applicable, state responsibility**	**N/A**	**N/A**	**N/A**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.102 (d) (d) *Sanction.* An MCO that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.	**0/0**	None	**Not Applicable, state responsibility**	**N/A**	**N/A**	**N/A**
438.104 (a) *Definitions.* As used in this section, the following terms have the indicated meanings: *Cold-call marketing* means any unsolicited personal contact by the MCO, PIHP, PAHP, PCCM or PCCM entity with a potential enrollee for the purpose of marketing as defined in this paragraph (a). *Marketing* means any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the	**0/2**	None	**Not Met** RR4 notes that NCQA does not review marketing materials if the MCO plan is government sponsored (Medicare/Medicaid).	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article VI-Marketing and Member Materials, A. Marketing Plans and Informing Materials, 4. Prohibited Activities & 5. MCO Agreement to Abide by Member Communication/Informing Criteria- The MCO agrees to engage only in member communication and outreach activities and distribute only those materials that are pre-approved in writing. The MCO that fails to abide by these requirements may be subject to sanctions.	**0/2** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**2** 2 (b)(1) (2) 2 All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan. *Marketing materials* means materials that— (i) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, PCCM, or PCCM entity; and (ii) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM, or PCCM entity to potential enrollees. *MCO, PIHP, PAHP, PCCM or PCCM entity*						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
include any of the entity's employees, network providers, agents, or contractors. *Private insurance* does not include a qualified health plan, as defined in 45 CFR 155.20. (b) *Contract requirements.* Each contract with an MCO, PIHP, PAHP, PCCM, or PCCM entity must comply with the following requirements: (1) Provide that the entity— (i) Does not distribute any marketing materials without first obtaining State approval. (ii) Distributes the materials to its entire service area as indicated in the contract. (iii) Complies with the information requirements of §438.10 to ensure that, before enrolling, the beneficiary receives, from the entity or the						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll. (iv) Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance. (v) Does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (2) Specify the methods by which the entity ensures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the State agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that—						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(i) The beneficiary must enroll in the MCO, PIHP, PAHP, PCCM or PCCM entity to obtain benefits or to not lose benefits; or (ii) The MCO, PIHP, PAHP, PCCM or PCCM entity is endorsed by CMS, the Federal or State government, or similar entity. (c) *State agency review.* In reviewing the marketing materials submitted by the entity, the State must consult with the Medical Care Advisory Committee established under §431.12 of this chapter or an advisory committee with similar membership.						
438.106 Each MCO, PIHP, and PAHP must provide that its Medicaid enrollees are not held liable for any of the following: (a) The MCO's, PIHP's, or PAHP's debts, in the event of the entity's	**0/5**	None	**Not Met** While NCQA standard, MEM2, references information about financial responsibility for pharmaceutical benefits, the relevance to these requirements is limited.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article XVII-MCO Specific Contract Terms, C. Miscellaneous, 1. Indemnification - The MCO agrees to defend,	**0/5** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**5** (a) (b) (1) (2) (c)

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
insolvency. (b) Covered services provided to the enrollee, for which— (1) The State does not pay the MCO, PIHP, or PAHP; or (2) The State, or the MCO, PIHP, or PAHP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement. (c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or PAHP covered the services directly.			MEM3 also contains language related to the organization's responsibility for considering members' financial responsibility, but as above, the specific details do not align with requirements.	indemnify and hold the Department harmless with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees that are related to or arise out of: a. Any failure, inability, or refusal of the MCO or any of its subcontractors to provide contract services. b. The negligent provision of contract services by the MCO or any of its subcontractors. c. Any failure, inability or refusal of the MCO to pay any of its subcontractors for contract services.		All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application.
438.116	**0/1**	None	**Not Met**	**2018-2019 BadgerCare**	**0/1**	**1**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(a) *Requirement for assurances.* (1) Each MCO, PIHP, and PAHP that is not a Federally qualified MCO (as defined in section 1310 of the Public Health Service Act) must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the MCO's, PIHP's, or PAHP's debts if the entity becomes insolvent. (2) Federally qualified MCOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement. (b) *Other requirements*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, an MCO or PIHP, must meet the solvency standards established	**Not Met:** 438.116		While NCQA standard, MEM2, references information about financial responsibility for pharmaceutical benefits, the relevance to these requirements is limited. MEM3 also contains language related to the organization's responsibility for considering members' financial responsibility, but as above, the specific details do not align with requirements.	**Plus and Medicaid SSI Contract:** Article XVII-MCO Specific Contract Terms, C. Miscellaneous, 1. Indemnification-The MCO agrees to defend, indemnify and hold the Department harmless with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees that are related to or arise out of: a. Any failure, inability, or refusal of the MCO or any of its subcontractors to provide contract services. b. The negligent provision of contract services by the MCO or any of its subcontractors. c. Any failure, inability or refusal of the MCO to pay any of its subcontractors for contract services. Article XV- Fiscal	**2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	438.116 All elements are addressed in the 2018-2019 contract, but are not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity. (2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP that meets any of the following conditions: (i) Does not provide both inpatient hospital services and physician services. (ii) Is a public entity. (iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers. (iv) Has its solvency guaranteed by the State.				Components/Provisions, A. Billing Members – For BadgerCare Plus and Medicaid SSI, any provider who knowingly and willfully bills a BadgerCare Plus and Medicaid SSI member for a covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1) [42 U.S.C. 1320a-7b] of the Social Security Act and Wis. Stats. 49.49(3p). This provision shall continue to be in effect even if the MCO becomes insolvent. The MCO and its providers and subcontractors must not bill a BadgerCare Plus or Medicaid SSI member for medically necessary covered services provided to the member, for which the State does not pay the MCO; or the State or the		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				MCO does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member's period of MCO enrollment, except for allowable co-payments and premiums established by the Department for covered services provided during the member's period of enrollment in BadgerCare Plus. In addition, the MCO must ensure that its Medicaid members are not held liable for payments for medically necessary covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the MCO covered the services directly. Article XII-Reports and		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				Data, B. Access to and/or Disclosure of Financial Records		
438.108 **Cost Sharing** The contract must provide that any cost sharing imposed on Medicaid enrollees is in accordance with §§ 447.50 through 447.82 of this chapter.	**0/1** **Not Met:** 438.108	None	**Not Met** NCQA standards do not reflect the details included this requirement.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Addendum V-Benefits and Cost Sharing Chart defines the Medicaid covered benefits and the member cost-sharing per benefit which were defined following federal requirements. Addendum II- Standard Member Handbook Language for BadgerCare Plus and Medicaid SSI- The MCO notifies members of the copays in the Member Handbook. Article XV- Fiscal Components/Provisions, A. Billing Members – The MCO and its providers and subcontractors must not bill a BadgerCare Plus or Medicaid SSI member for medically necessary	**0/1** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**1** 438.108 All elements are addressed in the 2018-2019 contract, but are not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				covered services provided to the member for which the State does not pay the MCO; or the State or the MCO does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member's period of MCO enrollment, except for allowable co-payments and premiums established by the Department for covered services provided during the member's period of enrollment in BadgerCare Plus		
438.114 (a) *Definitions.* As used in this section— *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent	**0/7**	MED3	**Not Met** While these standards address information to members about emergency services, they do not specifically note the requirements for MCO payments to these providers found in this federal requirement or the limitation on holding the enrollee liable. Per NCQA,	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article IV-Services, A. BadgerCare Plus and/or Medicaid SSI Services, 9. Emergency and Post-Stabilization Services-Establishes that the MCO is responsible for coverage and payment of emergency and post-stabilization care.	**0/7** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**7** (b)(1)(2) (c) (i)(ii) (A) (B) (2) (d) (i)(ii) All elements are addressed in the 2018-2019 contract, but are not included in the

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (ii) Serious impairment to bodily functions. (iii) Serious dysfunction of any bodily organ or part. *Emergency services* means covered inpatient and outpatient services that are as follows: (i) Furnished by a provider that is qualified to furnish these services under this Title. (ii) Needed to evaluate or stabilize an emergency medical condition. *Poststabilization care*			the organization will meet this element if its policies and procedures state that it covers all Emergency Department (ER) claims or does not deny any ER claims. The standard addresses when a representative of the MCO entity instructs the enrollee to seek emergency services and screening enrollee for need for emergency services. Post-stabilization services are not specifically addressed.	It also defines emergency, post-stabilization, and it addresses all the elements outlined in 438.114.		current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition. (b) *Coverage and payment: General rule.* The following entities are responsible for coverage and payment of emergency services and poststabilization care services. (1) The MCO, PIHP, or PAHP. (2) The State, for managed care programs that contract with PCCMs or PCCM entities (c) *Coverage and payment: Emergency services.* (1) The entities identified in paragraph (b) of this section—						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, PCCM or PCCM entity; and (ii) May not deny payment for treatment obtained under either of the following circumstances: (A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section. (B) A representative of the MCO, PIHP, PAHP, PCCM, or PCCM entity instructs the enrollee to seek emergency services. (2) A PCCM or PCCM						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
entity must allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services. (d) *Additional rules for emergency services.* (1) The entities specified in paragraph (b) of this section may not— (i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and (ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. (2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. (3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment. (e) *Coverage and payment:*						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
Poststabilization care services. Poststabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those provisions, reference to "MA organization" and "financially responsible" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the States. (f) *Applicability to PIHPs and PAHPs.* To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.						

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Access Standards

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.206 and 438.68 438.206 (a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68. (b) *Delivery network.* The State must ensure, through its contracts, that each MCO, PIHP and PAHP, consistent with the scope of its contracted services, meets the following	**2/6** **Not Met:** 438.68(c) (1) (iii) and (iv) 438.68 (b) (2) and (c) (2) are N/A and were not counted in the total elements.	QI3 NET1 NET2 NET3 MED4 CR5 CR7	**Not Met** QI3 reviews the organization's contracts to ensure providers foster open communication and cooperation with QI activities. If the organization holds the providers accountable for elements in its provider manual as an extension of contract, some requirements may be met, but would require specific knowledge of what NCQA reviewed for a particular MCO. NET1, CR5, CR7 address maintenance and monitoring of the provider network, though are not specific about confirming that the network is supported by written agreements. Number and availability	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article V. Provider Network and Access Requirements mandate that MCOs must provide medical care to its BadgerCare Plus and/or Medicaid SSI members that are accessible to them, in terms of timeliness, amount, duration, and scope, as those services to non-enrolled BadgerCare Plus and/or Medicaid SSI members within the area served by the MCO.	**4/4** **2018 Certification Application:** Section 5. Service Area – The MCO is required to self-declare its service area by county and zip code for the BadgerCare Plus and SSI programs, as applicable. Additionally, each MCO must provide copies of the policies and procedures in place describing the process to ensure the provider network meets distance requirements for primary care, mental health and substance abuse, dental care, hospitals, and urgent care centers/walk-in clinics. Policies and procedures describing the process to ensure the provider network meets the standards for primary care, dental care, and access to psychiatry,	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
requirements: (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. 438.68 (a) *General rule.* A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section. (b) *Provider-specific network adequacy standard.* (1) At a minimum, a State must develop			standards documented in NET1 do not align with DHS expectations, which are greater than NCQA. NET2 also addresses accessibility and evaluates organizations based on the organizations' self-declared standards for accessibility (i.e. time to secure appointment) MED4 addresses physical access, but only if Medicaid accredited. NCQA standards do not take into consideration the characteristics and health care needs of specific Medicaid populations.		including the plan to monitor compliance with these standards and how the MCO corrects for deficiencies if these ratios are not met must also be submitted. DHS conducts network reviews whenever an MCO requests changes to their service area or there are access issues. At a minimum, DHS reviews networks of all MCOs as part of the certification application. As part of the network review, DHS reviews access to primary care, mental health, dental care, hospitals and urgent care. DHS reviews providers accepting patients and makes sure that MCOs are providing needed care for members within acceptable geographic distance standards.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
time and distance standards for the following provider types, if covered under the contract: (i) Primary care, adult and pediatric. (ii) OB/GYN. (iii) Behavioral health (mental health and substance use disorder), adult and pediatric. (iv) Specialist, adult and pediatric. (v) Hospital. (vi) Pharmacy. (vii) Pediatric dental. (viii) Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards. (2) *LTSS.* States with MCO, PIHP or PAHP contracts which cover						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
LTSS must develop: (i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and (ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services. (3) *Scope of network adequacy standards.* Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
the same provider type based on geographic areas. (c) *Development of network adequacy standards.* (1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services. (iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract. (iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
services. (v) The numbers of network providers who are not accepting new Medicaid patients. (vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees. (vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language. (viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
mental disabilities. (ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions. (2) States developing standards consistent with paragraph (b)(2) of this section must consider the following: (i) All elements in paragraphs (c)(1)(i) through (ix) of this section. (ii) Elements that would support an enrollee's choice of provider. (iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee. (iv) Other						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
considerations that are in the best interest of the enrollees that need LTSS. (d) *Exceptions process.* (1) To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be: (i) Specified in the MCO, PIHP or PAHP contract. (ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area. (2) States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under §438.66.						
438.206 (b) (2) (2)The MCO provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	**1/1**	MED1	**Met, if Medicaid accredited.** NCQA does not review this element in its Commercial and Medicare accreditation processes. It evaluates this requirement in the Medicaid review.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article V, Provider Network and Access Requirements, E. Access to Selected BadgerCare Plus and Medicaid SSI Providers and/or Covered Services, 7. Women's Health Specialists. Also Addendum II Standard Member Handbook Language for BadgerCare Plus and Medicaid SSI The contract requires each MCO to provide female members with direct access to a women's health specialist within the network for covered	**1/1** **(if MCO is not Medicaid accredited)** **DHS Certification process:** Section 6.4 Access to Women's Health Specialists requires MCOs to provide to the Department policies and procedures to make women's health specialists available to members and the waiting times.	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				women's routine and preventive health care services. This is in addition to a primary care provider. Addendum II provides standard Member Handbook language to inform members of their right to choose a women's health specialist in addition to the primary care provider.		
438.206 (b) (3) (4) (5) (3) Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network at no cost to the enrollee. (4) If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, OR PAHP must adequately and timely cover the	**3/3**	MED1	**Met, if Medicaid accredited.** NCQA does not review this element in its Commercial and Medicare accreditation processes. It does evaluate these requirements in the Medicaid review.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Art. V, Provider Network and Access Requirements, E. Access to Selected BadgerCare Plus and Medicaid SSI Providers and/or Covered Services, 4. MCO Referrals to Out-of-Network Providers for Services and 6. Second Medical Opinions. The MCOs must have written policies and procedures for providing	**3/3** **(if MCO is not Medicaid accredited)** **2018 Certification Application:** Section 6.5 Second Medical Opinions requires MCOs to provide to the Department policies and procedures regarding provision of second medical opinions from a qualified provider in-network or out-of-network if needed.	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP's provider network is unable to provide them. (5) Requires out-of-network providers to coordinate with the MCO, PIHP or PAHP for payment and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.				members the opportunity to have a second opinion. When a second opinion is outside of the network, it must be at no charge to the member, excluding allowable copayments. The MCO must also provide adequate and timely coverage of services provided out-of- network, when the required medical service is not available within the MCO network. Addendum II provides standard Member Handbook language to inform members of their right to a second opinion.		
438.206 (b) (6) (6) Demonstrates that its network providers are credentialed as required by §438.214.	**0/0**	None	**Not Applicable** See 438.214 in the Structure and Operations standards section of this appendix.	**N/A**	**N/A**	**N/A**
438.206 (b) (7) The MCO demonstrates its network includes	**0/1** **Not Met:** 438.206 (b) (7)	NET1 NET2 NET3	**Not Met** NCQA standards reference the accessibility of services and network	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** The contract addresses	**0/1** **2018 Certification Application:**	**1** 438.206(b) (7) This element is addressed in

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
sufficient family planning providers to ensure timely access to covered services.			adequacy as a whole, but do not specifically address the sufficiency of family planning providers.	the member's right to choose a family planning provider, as well as overall network adequacy, but does not specifically include the requirements of this CFR.	The current 2018 Certification Application addresses adequacy of a network, but does not cover timely access either in general or specific to family planning providers.	the 2018-2019 contract, but is not included in the current certification process.
438.206 (c) (1) (2) (3) (1) The MCO, PIHP, AND PAHP must comply with the following requirements: (i) Meet and require its network providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services; (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees	**5/8** **Not Met:** (c)(1)(i), (iii), and (vi)	NET1 NET2 CR5 CR7 MED1 MED4	**Not Met** NCQA commercial and Medicare standards are not specific about the hours of operation and availability in the context of serving Medicaid enrollees. These standards also do not address the accessibility considerations required. NET 1 addresses assessment of network to ensure sufficient practitioners to meet language and cultural considerations. CR5 and CR7 address monitoring and assessment of providers. The Medicaid (MED) review covers hours of	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Art. V. Provider Network and Access Requirements, C. Written Standards for Accessibility of Care, D. Monitoring Compliance and E. Access to Selected BadgerCare Plus and/or Medicaid SSI Providers and Covered Services. Art VII. Member Rights and Responsibilities, G. Cultural Competency and Culturally and Linguistically Appropriate Services (CLAS) Standards, 2. National Culturally and Linguistically Appropriate Services (CLAS)	**3/3** **2018 Certification Application:** Sections 5 Service Area and 6 Access to Care require MCOs to submit policies and procedures to ensure the MCO's provider network meets the access standards in the contract. It also requires MCOs to submit their plans to monitor compliance with the standards and how the MCO corrects for deficiencies, if required ratios are not met. The process additionally requires submission of the MCO's plans for communicating standards to providers of primary, mental health and dental	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees; (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary; (iv) Establish mechanisms to ensure compliance by network providers; (v) Monitor network providers regularly to determine compliance; and (vi) Take corrective action for any failure to comply by a network provider. (2) Access and cultural considerations. Each MCO, PIHP, AND PAHP participates in the state's efforts to promote the delivery of services			operation no less than those offered to commercial enrollees as well as accessibility considerations.	Standards, c. Communication and Language Assistance addresses cultural considerations The contract establishes that MCOs must have written standards for accessibility of care including specific waiting times for appointments. The contract also defines distance requirements for dental providers, primary care, mental health, substance abuse, urgent care, and hospital access. MCOs are required to provide access to appropriate prenatal care services for high-risk pregnant women, women's health specialists, access to Indian health providers, and to monitor network adequacy regularly.	care.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (3) Accessibility considerations. Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodation, and accessible equipment for Medicaid enrollees with physical or mental disabilities.						
438.207 (a) *Basic rule*. The State must ensure, through its contracts, that each MCO, PIHP,	**0/3** **Not Met:** 438.207(b), (c), and (d)	None	**Not Met** NCQA standards address network adequacy, but do not include provisions specific to the CFR	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Network adequacy and reporting requirements are	**3/3** **2018 Certification Application:** Section 6. Access to Care –	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at §438.68 and §438.206(c)(1). (b) *Nature of supporting documentation.* Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: (1) Offers an appropriate range of preventive, primary			requirements. Additionally, standards associated with network capacity/ accessibility do not align with DHS standards.	located in several areas of the contract. They are not specifically listed to conserve space and preserve document readability.	Coordination and Continuity of Care monitors network adequacy and collects the required documentation. **Other:** This element is met as a result of DHS practices related to MCO contracting and certification.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area. (2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. (c) *Timing of documentation.* Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following: (1) At the time it enters into a contract with the State. (2) On an annual basis. (3) At any time there has been a significant						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including— (i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; or (ii) Enrollment of a new population in the MCO, PIHP, or PAHP. (d) *State review and certification to CMS.* After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the State's requirements for availability of						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
services, as set forth in §438.68 and §438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP or PAHP related to its provider network. (e) *CMS' right to inspect documentation.* The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.						
438.208 a) *Basic requirement—* (1) *General rule.* Except as specified in paragraphs (a)(2) and (3) of this section, the State must ensure through its contracts, that each MCO, PIHP,	**2/6** **Not Met:** 438.208 (b)(1), (b)(2)(iii), (b)(3), and (b)(4)	NET5 QI5 QI6	**Not Met** These standards address coordination and continuity of care; however, assurances for designating an entity with primary responsibility for coordination, except for those with complex conditions are not	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article III. Care Management, C. Care Coordination for All Members requires MCOs to coordinate care between settings of care, with services provided by	**4/4** **2018 Certification Application:** Section 6. Access to Care MCOs must provide their primary care assignment policies and procedures to the Department for review which includes a	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
and PAHP complies with the requirements of this section. (2) *PIHP and PAHP exception.* For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section. (3) *Exception for MCOs that serve dually eligible enrollees.* (i) For each MCO that serves enrollees who are also enrolled in and receive			included in the guideline. They also do not address the need to share assessment results to prevent duplication of activities. Privacy protections are addressed in 438.224 below. NET5 element B addresses continued access to a provider for active treatment/or for up to 90 days whichever is less if member has chronic or acute condition. QI5 and QI6 address collecting information and identifying opportunities for improvement in coordination of care.	another MCO, with services a member receives through Medicaid Fee-for-Service, and with services a member receives through community and social support providers. Article VII. Member Rights and Responsibilities require MCOs to have a system in place that ensures well-managed patient care, including: 1. Management and integration of health care through primary provider/ gatekeeper/other means. 2. Systems to ensure referrals for medically necessary, specialty, secondary and tertiary care. 3. Systems to ensure provision of care in emergency situations, including an education process to ensure that	description of the following: a. The processes and procedures to allow members a choice of providers before assignment. b. The communication plan to inform members about their primary care provider options, the assignment process, and their rights to change after assignment. c. The process to assist members in getting a primary care visit as part of the primary care assignment process. d. How the primary care assignment process takes into account members' health care needs and how members with chronic conditions are identified (including clinical guidelines and other tools used). e. How the MCO ensures	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
Medicare benefits from a Medicare Advantage Organization (as defined in §422.2 of this chapter), the State determines to what extent the MCO must meet the identification, assessment, and treatment planning provisions of paragraph (c) of this section for dually eligible individuals. (ii) The State bases its determination on the needs of the population it requires the MCO to serve. (b) *Care and coordination of services for all MCO, PIHP, and PAHP enrollees.* Each MCO, PIHP, and PAHP must implement procedures to deliver care to and coordinate services for all MCO, PIHP, and PAHP enrollees. These				members know where and how to obtain medically necessary care in emergency situations. 4. Systems that clearly specify referral requirements to providers and subcontractors. The MCO must keep copies of referrals (approved and denied) in a central file or the patient's medical records. 5. Systems to ensure the provision of a clinical determination of the medical necessity and appropriateness of the member to continue with mental health and substance abuse providers who are not subcontracted with the MCO. 6. Sharing with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that	that PCPs provide culturally sensitive care for members. f. Policies and procedures for members that want to change their assigned primary care provider. h. Processes and procedures to ensure coordination of care and information sharing between the primary care provider and the specialists, including pharmacy data. h. Processes and procedures for ensuring patient-centered care and that a comprehensive treatment plan is developed between members and their primary care provider. i. Processes and procedures MCOs use to evaluate the effectiveness of their primary care assignment strategies.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
procedures must meet State requirements and must do the following: (1) Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity; (2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee: (i) Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; (ii) With the services				those activities need not be duplicated.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
the enrollee receives from any other MCO, PIHP, or PAHP; (iii) With the services the enrollee receives in FFS Medicaid; and (iv) With the services the enrollee receives from community and social support providers. (3) Provide that the MCO, PIHP or PAHP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful; (4) Share with the State or other MCOs, PIHPs, and PAHPs serving the enrollee the results of any identification and						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
assessment of that enrollee's needs to prevent duplication of those activities; (5) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and (6) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.						
438.208 (c) (1) (c) *Additional services for enrollees with special health care needs or who need LTSS—*	**0/0**	None	**Not applicable; state responsibility**	**N/A**	**N/A**	**N/A**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(1) *Identification.* The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms— (i) Must be specified in the State's quality strategy under §438.340. (ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs.						
438.208 (c) (2) (3) (4) (2) *Assessment.* Each MCO, PIHP, and PAHP must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State (through the mechanism specified	**2/2** (c)(3) is N/A and was not included in the total elements.	PHM4 QI5 QI6	**Met** The NCQA guidance notes the look back period for this requirement is six months for first surveys and 24 months for renewals. The Medicaid product line is exempted if the state conducts its own assessment or	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X – Quality Assessment Performance Improvement, C. Health Promotion and Disease Prevention Services 1. The MCO must identify at-risk populations for	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO, PIHP, or PAHP as appropriate. (3) *Treatment/service plans.* MCOs, PIHPs, or PAHPs must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i)			mandates a tool for the MCO to conduct the assessment, but the MCO must provide proof of such a requirement. QI5 and QI6 focus on continuity and coordination of medical care and medical/behavioral health care.	preventive services and develop strategies for reaching BadgerCare Plus and/or Medicaid SSI members included in this population. 3. The Department encourages the MCO to develop and implement disease management programs and systems to enhance quality of care for individuals identified as having chronic or special health care needs known to be responsive to application of clinical practice guidelines and other techniques. 4. The MCO agrees to implement systems to independently identify members with special health care needs and to utilize data generated by the systems or data that may be provided by the Department to facilitate outreach, assessment and care for individuals with special health care needs.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
through (v) of this section for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: (i) Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee; (ii) Developed by a person trained in person-centered				Article III, Care Management, A. Care Management Model, 1. Care Management Elements, b. Comprehensive Assessments (Medicaid SSI only) requires all MCOs to conduct a comprehensive assessment for each SSI Managed Care member within 60 days of enrollment in the MCO. Article VII Member Rights and Responsibilities, C. Primary Care Provider Assignment, 1. MCO primary care provider or primary care clinic assignment strategy requires the development of a patient-centered and comprehensive treatment plan. Per the contract, DHS also receives policies and procedures related to the assessment, risk		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
planning using a person-centered process and plan as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans; (iii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP; (iv) In accordance with any applicable State quality assurance and utilization review standards; and (v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per §441.301(c)(3) of this chapter.				stratification, and treatment plan of childless adults.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(4) *Direct access to specialists.* For enrollees with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this section) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.						
438.210 (a) (a) *Coverage.* Each contract between a State and an MCO, PIHP, or PAHP must do the following: (1) Identify, define, and specify the	**1/4** **Not Met:** 438.210 (a) (1), (2), and (4)	UM1 UM2 UM3 UM4 UM5	**Not Met** NCQA UM standards address requirements in general, but NCQA does not specifically address this element**,** noting it as a state responsibility. The NCQA guidance	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** The contract defines the services that MCOs will cover in Article IV, medical necessity is	**3/3** **2018 Certification Application:** Section 5. Service Area requires submission of policies and procedures	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer. (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter. (3) Provide that the MCO, PIHP, or PAHP— (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for			includes several standards related to UM that are similar to DHS standards or protocols, but may not meet DHS' responsibilities to ensure that the MCO is not limiting services required in the benefit package described in DHS MCO contract. For example, the NCQA criteria describes that it "takes into account the local delivery system." If NCQA considers the Medicaid contract as part of the "local delivery system" in making its evaluation of the MCO, then the element may be comparable. UM 5 is focused on timeliness of decisions and those timelines may not align exactly with DHS contract standards Another example relates to timeframe differences between DHS and NCQA	defined in the contract as well as the standards of access to care that MCOs are accountable for.	along with data files that address the MCOs ability to provide an adequate, appropriate network of providers. Section 6. Access to Care – Continuation and Continuity of Care reviews policies, procedures, and guidelines to ensure member-specific care and coordination is provided.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
which the services are furnished. (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. (4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service— (i) On the basis of criteria applied under the State plan, such as medical necessity; or (ii) For the purpose of utilization control, provided that— (A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section; (B) The services supporting individuals with ongoing or chronic conditions or			standards: 14 days (DHS) vs 15 days (NCQA) for non-urgent decisions, and for urgent requests DHS contract notes three business days vs the NCQA requirement of 72 hours.			

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and (C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter. (5) Specify what constitutes “medically necessary services” in a manner that— (i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
Plan, and other State policy and procedures; and (ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that address: (A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability. (B) The ability for an enrollee to achieve age-appropriate growth and development. (C) The ability for an enrollee to attain, maintain, or regain functional capacity. (D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
living, to achieve person-centered goals, and live and work in the setting of their choice.						
438.210 (b) (b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require— (1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures. (2) That the MCO, PIHP, or PAHP— (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. (ii) Consult with the requesting provider for medical services when	**3/3**	UM1 UM2 UM4 UM6	**Met** NCQA utilization management (UM) standards require each organization to have a UM program with a clearly defined structure and processes, with responsibility assigned to appropriate individuals. This includes participation of a senior-level physician and behavioral healthcare practitioner. UM decision making criteria are objective and based on medical evidence.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X-Quality Assessment Performance Improvement. G. Utilization Management, 1. requires that the MCO and its subcontractors must have documented policies and procedures for all UM activities that involve determining medical necessity and processing requests for initial and continuing authorization of services (42 CFR 438.210(b)(1)). The MCO must communicate to providers the criteria used to determine medical necessity and appropriateness. The criteria for determining	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
appropriate. (iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan. (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.				medical necessity may not be more stringent than what is used in the State Medicaid program, as set forth in Wis. Adm. Code DHS 101.03(96m), including any quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other published State policy and procedures. Documentation of denial of services must be available to the Department upon request. Pursuant to 42 CFR § 438.210(b)(2), the MCO must: a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. b. Consult with the requesting provider for medical services when appropriate.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				When reviewing requests for authorization of services, qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s). The MCO may not deny coverage, penalize providers, or give incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or results in the under-utilization of services.		
438.210 (c) (d) (c) *Notice of adverse benefit determination.* Each contract must	**1/2** **Not Met:** 438.210 (d)	UM2 UM5 UM7 RR2	**Not Met** While timeframes for decision-making are addressed in these NCQA	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X-Quality Assessment	**0/1** **2018 Certification Application:**	**1** 438.210 (d)

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404. (d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices: (1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously			references, the details do not align with all timeframes associated with this requirement.	Performance Improvement. G. Utilization Management, 4. The MCO's policies must specify time frames for responding to requests for initial and continued service authorizations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. a. Within the time frames specified, the MCO must give the member and the requesting provider written notice of: 1) The decision to deny, limit, reduce, delay, or terminate a service along with the reasons for the decision.	The 2018 Certification Application does not review MCO policies, procedures, or document templates related to notice of adverse benefit determinations or authorization decisions.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— (i) The enrollee, or the provider, requests extension; or (ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. (2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard				2) The member's right to file a grievance or request a state fair hearing. b. Authorization decisions must be made within the following time frames and in all cases as expeditiously as the member's condition requires: 1) Within 14 days of the receipt of the request, or 2) Within three business days if the physician indicates or the MCO determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function. One extension of up to 14 days may be allowed if the member requests it or if the MCO justifies the need for more information.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. (ii) The MCO, PIHP, or PAHP may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.				On the date that the time frames expire, the MCO gives notice that service authorization decisions are not reached. Untimely service authorizations constitute a denial and are thus adverse actions.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act.						
438.210 (e) (e) *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with § § 438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	**1/1**	UM2 UM4	**Met** Standard UM2 requires MCOs to have written utilization management decision-making criteria that is objective and based on medical evidence. UM4 focuses on service denials being based upon medical necessity and no other criteria (other than the existence of coverage). It also includes an element that determines utilization management decisions are based on appropriateness of care and financial incentives do not encourage decisions that result in under-utilization or reward practitioners for denials of service.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement, G. Utilization Management. The MCO may not deny coverage, penalize providers, or give incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or result in the under-utilization of services. Article XV. Fiscal Components/Provisions, B. Physician Incentive Plans state MCOs may operate a physician incentive plan	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				only if no specific payment can be made directly or indirectly under such a plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.		

Structure and Operations Standards

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.214 (a) and (b) (a) The state must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers and that those policies and procedures, at a minimum, meet the requirements of this	**0/2** **Not Met:** 438.214 (a) and (b)	CR1	**Not Met** CR1 requires MCOs to have well-defined credentialing and recredentialing processes, though they do not specify adhering to a state's uniform credentialing and recredentialing policy.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X. Quality Assessment Performance Improvement, D. Provider Selection (Credentialing) and Periodic Evaluation (Re-credentialing) outlines the process MCOs must follow to credential and recredential providers.	**0/2** **DHS Certification process:** The 2018 Certification Application does not address credentialing or recredentialing.	**2** 438.214 (a) and (b) Both elements are addressed in the 2018-2019 contract, but are not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
section. (b) *Credentialing and recredentialing requirements.* (1) Each State must establish a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate, and requires each MCO, PIHP and PAHP to follow those policies. (2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of network providers.						
438.214 (c) Nondiscrimination (c) *Nondiscrimination.* MCO, PIHP, and PAHP network provider selection policies and procedures, consistent	**0/1** **Not Met:** 438.214 (c)	CR1	**Not Met** CR1 includes language related to nondiscrimination but is not specific about providers serving high risk/high cost consumers.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement, D. Provider Selection (Credentialing) and Periodic Evaluation	**0/1** **DHS Certification process:** The 2018 Certification Application does not address nondiscrimination in credentialing or	**1** 438.214 (c) This element is addressed in the 2018-2019 contract, but not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
with § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.				(Re-credentialing), 4. The selection process must not discriminate against providers such as those serving high-risk populations, or specialize in conditions that require costly treatment. The MCO must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners in the MCO's network.	recredentialing providers.	
438.214 (d) (d) Excluded providers. (1) MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	**1/1**	CR3 CR7	**Met** Although the NCQA standards do not specifically reference excluded providers, MCOs are required to confirm credentialed providers are in good standing with state and federal regulatory bodies.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment/Performance Improvement, D. Provider Selection (Credentialing) and Periodic Evaluation (Re-credentialing), 1. The MCO may not employ or contract with providers excluded from federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.214 (e) (e) Each MCO, PIHP, and PAHP must comply with any additional requirements established by the state.	**0/1**	None	**Not Met** NCQA standards do not address this requirement.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article XI., MCO Administration, addresses compliance with all federal and state statutes. This section also requires memoranda of understanding (MOU) to coordinate services with community based health organizations, Prenatal Care Coordination (PNCC) agencies, agencies that provide Mental Health and Substance Abuse services, Targeted Case Management Services, etc.	**0/1** **2018 Certification Application:** The 2018 Certification Application does not monitor or review the additional requirements included in the contract.	**1** 438.214(e) This element is addressed in the 2018-2019 contract, but not included in the current certification process.
438.224 Confidentiality The State must ensure, through its contracts, that (consistent with subpart F of part 431 of this chapter), for medical records and any other health and enrollment information that identifies a	**1/1** **Not Met:** 438.224 is not met if the MCO has not obtained Medicaid Accreditation.	MED5	**Met if Medicaid Accredited**	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article XI MCO Administration, D. Confidentiality of Records and HIPAA Requirements. This section defines appropriate disclosure of individually identifiable health information. It also	**None**	**1 (if not Medicaid Accredited)** 438.224 This element is addressed in the 2018-2019 contract, but not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
particular enrollee, each MCO, PIHP, and PAHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.				describes inappropriate disclosures of individually identifiable health information and sets liquidated damages in case of breaches.		
438.228 Grievance and appeal systems (a) The State must ensure, through its contracts that each MCO, PIHP, and PAHP has in effect a grievance and appeal system that meets the requirements of subpart F of this part. (b) If the State delegates to the MCO, PIHP, or PAHP responsibility for notice of action under	**0/0**	None	**See Subpart F, Grievance Systems for details related to this requirement.**	**N/A**	**N/A**	**N/A**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCO, PIHP, or PAHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.						
438.230 Subcontractual relationships and delegation agreement (a) *Applicability.* The requirements of this section apply to any contract or written arrangement that an MCO, PIHP, PAHP, or PCCM entity has with any subcontractor. (b) *General rule.* The State must ensure, through its contracts with MCOs, PIHPs, PAHPs, and PCCM entities that— (1) Notwithstanding any relationship(s) that	**0/3** **Not Met:** 438.230	QI7 PHM7 NET7 UM13 CR8 RR5 MEM5 MED6	**Not Met** Each section of the NCQA standards includes delegation of all or part of the section. Up to four delegation agreements in effect during the look-back period are reviewed. However, the NCQA requirements for delegation agreements do not align with the requirements of the CFR.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article XI. MCO Administration, B. Compliance with Applicable Law and C. Organizational Responsibilities and Duties address the requirement for all subcontractors to be in compliance with federal and state statutes, including the specific requirements of this section.	**0/3** **2018 Certification Application:** The Certification Application does not review MCO subcontract templates to ensure all CFR and state contract requirements are met.	**3** These elements are addressed in the 2018-2019 contract, but are not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
the MCO, PIHP, PAHP, or PCCM entity may have with any subcontractor, the MCO, PIHP, PAHP, or PCCM entity maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and (2) All contracts or written arrangements between the MCO, PIHP, PAHP, or PCCM entity and any subcontractor must meet the requirements of paragraph (c) of this section. (c) Each contract or written arrangement described in paragraph (b)(2) of this section must specify that: (1) If any of the MCO's, PIHP's, PAHP's, or PCCM						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
entity's activities or obligations under its contract with the State are delegated to a subcontractor— (i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. (ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, PAHP's, or PCCM entity's contract obligations. (iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
in instances where the State or the MCO, PIHP, PAHP, or PCCM entity determine that the subcontractor has not performed satisfactorily. (2) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions; (3) The subcontractor agrees that— (i) The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's, PIHP's, or PAHP's contract with the State. (ii) The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. (iii) The right to audit under paragraph (c)(3)(i) of this section will exist through 10 years from the final date of the contract period or from the date of completion of any						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
audit, whichever is later. (iv) If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.						

Measurement and Improvement Standards

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.236 (a) (b) (a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP meets the requirements of this section.	**0/4** **Not Met:** 438.236	None	**Not Met** Practice guidelines will be eliminated as a NCQA standard beginning July 1, 2018. Population health management was added as a new category, focusing on the whole	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X-Quality Assessment Performance Improvement, B. Monitoring and Evaluation 6. requires MCOs to	**0/4** **2018 Certification Application:** Section 6. Access to Care – Coordination and Continuity of Care requires submission of clinical	**4** 438.236 (b)(1-4)

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(b) *Adoption of practice guidelines.* Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements: (1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field. (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees. (3) Are adopted in consultation with contracting health care professionals. (4) Are reviewed and updated periodically as appropriate.			person and each member's needs. This change is too broad to cover the specific CFR requirements.	develop or adopt best practice guidelines in accordance with 42 CFR 438.236 (b) and meet the following requirements: a) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field. b) Consider the needs of the MCO members. c) Are adopted in consultation with contracting health care professionals. d) Are reviewed and updated periodically as appropriate.	guidelines used to assist in identifying members with chronic conditions. However, it does not review the MCOs process for establishing practice guidelines.	
438.236 (c) (c) *Dissemination of guidelines.* Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and,	**0/2** **Not Met:** dissemination of guidelines to enrollees and potential enrollees	MED7	**Not Met** NCQA will be eliminating practice guidelines as a standard beginning July 1, 2018. The dissemination of established practice standards to appropriate	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement, B. Monitoring and Evaluation 6. requires MCOs to	**0/2** **2018 Certification Application:** The 2018 Certification Application does not include the dissemination of guidelines to providers, enrollees or	**2**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
upon request, to enrollees and potential enrollees.			practitioners is an expectation for Medicaid accreditation. However, the standard referenced for evidence-based guidelines was eliminated for the same timeframe so the standard is not clear. Additionally, there are no requirements to disseminate practice guidelines to enrollees or potential enrollees.	disseminate established practice guidelines to providers and to members as appropriate or upon request.	potential enrollees.	
438.236 (d) (d) *Application of guidelines.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	**0/1** **Not Met:** 438.236(d)	UM2 QI8 QI9	**Not Met** While the UM standards reflect the need to adhere to evidence-based criteria and local delivery system practice, NCQA will be eliminating practice guidelines as a standard beginning July 1, 2018.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Art. X- Quality Assessment Performance Improvement, B. Monitoring and Evaluation 6. states that decisions with respect to utilization management, member education, coverage of services, and other areas to which the practice guidelines apply are consistent with the guidelines. Variations from the guidelines must be based on the clinical	**0/1** **2018 Certification Application:** The 2018 Certification Application covers network adequacy, but does not address nor monitor application of the practice guidelines.	**1** 438.236 (d)

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				situation.		
438.242 (a) (a) *General rule.* The State must ensure, through its contracts that each MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	**0/1** **Not Met:** 438.242 (a)	PHM2 UM2	**Not Met** NCQA standards for both PHM and UM focus on data collection from claims, encounters, electronic health records, or other data sources. However, there is no NCQA standard regarding an MCO maintaining a health information system that can collect, analyze, integrate, and report data.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article XII- Reports and Data Describes the requirements for MCOs to maintain their health information systems.	**1/1** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements. **Other:** DHS conducts encounter data testing with MCOs. In addition, all MCOs are required to report HEDIS audited results for Medicaid and therefore have to undergo an Information Systems Capabilities Assessment (ISCA). NCQA Accredited MCOs also have to be subject to the ISCA assessment in order to obtain or maintain their accreditation status.	**None**
438.242 (b) Basic elements of a health information system (b) *Basic elements of a health information*	**0/1** **Not Met:** 438.242 (b)	None	**Not Met** NCQA standards do not specify the basic elements needed for health information systems.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article XII Reports and Data Describes the requirements	**1/1** **2018 Certification Application:** Section 12 Reporting and Data Administration	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
system. The State must require, at a minimum, that each MCO, PIHP, and PAHP comply with the following: (1) Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act. (2) Collect data on enrollee and provider characteristics as specified by the State, and on all services furnished to enrollees through an encounter data				for MCOs to maintain their health information systems.	requires the MCOs to meet security, data, claims and encounter processing, computer system, and reporting standards outlined in the 2018-2019 BadgerCare Plus and Medicaid SSI Contract, Articles XI.D.5.g-h, XII.A, XII.C-F, XII.I, XIV.A-B, XV.D.1-2, XV.D.11, XVI.F, XVI.I-N, Addendum IV.F-H, and Addendum VI. This section of the Certification application requires submission of policies and procedures in place to meet the outlined requirements.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
system or other methods as may be specified by the State. (3) Ensure that data received from providers is accurate and complete by— (i) Verifying the accuracy and timeliness of reported data, including data from network providers the MCO, PIHP, or PAHP is compensating on the basis of capitation payments. (ii) Screening the data for completeness, logic, and consistency. (iii) Collecting data from providers in standardized formats to the extent feasible and appropriate,						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. (4) Make all collected data available to the State and upon request to CMS.						
438.242 (c) (d) (c) *Enrollee encounter data.* Contracts between a State and a MCO, PIHP, or PAHP must provide for: (1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees. (2) Submission of	**0/2** **Not Met:** 438.242 (c)(d)	None	**Not Met** NCQA standards focus on data collection and analytics in general, but do not address external reporting, submission, review, or validation of the data collected.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article XII Reports and Data Describes the requirements for MCOs to maintain their health information systems.	**2/2** **2018 Certification Application:** Section 12. Reporting and Data Administration requires the MCOs to meet security, data, claims and encounter processing, computer system, and reporting standards outlined in the 2018-2019 BadgerCare Plus and Medicaid SSI Contract, Articles XI.D.5.g-h, XII.A, XII.C-F, XII.I, XIV.A-B,	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs. (3) Submission of all enrollee encounter data that the State is required to report to CMS under §438.818. (4) Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. (d) *State review and validation of encounter data.* The State must review and validate that the encounter data collected, maintained, and submitted to the					XV.D.1-2, XV.D.11, XVI.F, XVI.I-N, Addendum IV.F-H, and Addendum VI. This section of the Certification application requires submission of policies and procedures in place to meet the outlined requirements.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
State by the MCO, PIHP, or PAHP, meets the requirements of this section. The State must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted under paragraph (c) of this section is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP.						

42 CFR 438 Managed Care - Subpart E

Quality Measurement and Improvement Standards

The majority of Subpart E is applicable to states and EQROs. Those sections of CFR not applicable to MCOs, PHIPs or PAHPs were excluded.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.330 (a) (b) (a) *General rules.* (1) The State must require, through its contracts, that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that includes the elements identified in paragraph (b) of this section. (2) After consulting with States and other stakeholders and providing public notice and opportunity to comment, CMS may specify performance measures and PIPs, which must be included in the standard measures identified and PIPs required by the State in	**2/4** **Not Met:** (b)(1) PIPs (b)(3) Mechanisms for overutilization and underutilization (b)(5)(ii) is N/A	QI1 QI2 QI5 QI6 PHM1 PHM6	**Not Met** The NCQA standards require a quality improvement infrastructure which includes an annual work plan and annual evaluation. The standards do not specifically require improvement projects and do not address monitoring for under- and over-utilization. QI5 and QI6 include coordination and continuity of care for both medical and behavioral health, but do not specifically address the CFR requirements. PHM1 and PHM6 require a strategy (with annual evaluation) to address member needs across the continuum, but do not specifically reference those with special health care needs.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Art. X. Quality Assessment and Performance Improvement, G. Utilization Management, J. Performance Improvement Priority Areas and Projects, and M. MCO Pay-for-Performance (P4P) program and Core Reporting. All specifically address the requirements of the CFR elements. The QAPI is not monitored annually, but must be made available to the Department upon request.	**0/2** **2018 Certification Application:** 9. Accreditation – All MCOs are required to submit its accreditation status including lines of business or specific population for which accreditation was obtained, specific accreditation status (including survey type and level as applicable), the results from the accrediting entity (including recommended actions or improvements, correction plans and summaries of findings) and the specific accreditation period (including the expiration date). The 2018-2019 Certification Application does not reference or request the MCO's most recent Quality Assessment/Performance Improvement (QAPI) work plan or QAPI annual report.	**2** (b)(1) and (b)(3) Both remaining elements are addressed in the 2018-2019 contract, but not included in the current certification process. DHS analysis of encounter data could cover element (b)(3).

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
accordance with paragraphs (c) and (d) of this section. A State may request an exemption from including the performance measures or PIPs established under paragraph (a)(2) of this section, by submitting a written request to CMS explaining the basis for such request. (3) The State must require, through its contracts, that each PCCM entity described in §438.310(c)(2) establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees which incorporates, at a minimum, paragraphs					**Other:** PIPs are reviewed and validated by the EQRO annually. DHS also monitors under- and over-utilization of services regularly through analysis of encounter data. As part of the pay for performance (P4P) requirements, DHS evaluates quality of care at least on an annual basis through specific performance indicators. See P4P requirements in the 2017 MCO P4P Guide.  MY2017HMOP4PGuide.pdf	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(b)(2) and (3) of this section and the performance measures identified by the State per paragraph (c) of this section. (b) *Basic elements of quality assessment and performance improvement programs.* The comprehensive quality assessment and performance improvement program described in paragraph (a) of this section must include at least the following elements: (1) Performance improvement projects in accordance with paragraph (d) of this section. (2) Collection and submission of performance measurement data in accordance with paragraph (c) of this section.						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(3) Mechanisms to detect both underutilization and overutilization of services. (4) Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under §438.340. (5) For MCOs, PIHPs, or PAHPs providing long-term services and supports: (i) Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
treatment/service plan, if applicable; and (ii) Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§441.302 and 441.730(a) of this chapter) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per §441.302(h) of this chapter.						
438.330 (c) (c) *Performance measurement.* The State must— (1)(i) Identify standard performance measures, including those performance measures that may be specified by CMS under paragraph (a)(2) of this section, relating to the	**0/1** **Not Met:** (c) Performance measurement (c)(1)(ii) is N/A	**None**	**Not Met** No reference for reporting obligations to outside entities is found in the standards.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Art. X. Quality Assessment and Performance Improvement.	**1/1** (c) **2018 Certification Application:** 12. B. 5. requires the MCO to describe its system's ability to provide data necessary to monitor program performance relative to pay for performance (P4P).	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
performance of MCOs, PIHPs, and PAHPs; and (ii) In addition to the measures specified in paragraph (c)(1)(i) of this section, in the case of an MCO, PIHP, or PAHP providing long-term services and supports, identify standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports. (2) Require that each MCO, PIHP, and PAHP annually— (i) Measure and report to the State on its performance, using the standard measures required by the State in paragraph (c)(1) of this section;					**Other:** The MCO P4P Guide (attached above in 438.330 (a) (b)) lists the performance measures used in the pay for performance program. As part of the P4P requirements, DHS evaluates quality of care at least on an annual basis through specific performance indicators. See P4P requirements in the 2017 MCO P4P Guide. The P4P measures are validated by the EQRO annually.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(ii) Submit to the State data, specified by the State, which enables the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State under paragraph (c)(1) of this section; or (iii) Perform a combination of the activities described in paragraphs (c)(2)(i) and (ii) of this section.						
438.330 (d) (d) *Performance improvement projects.* (1) The State must require that MCOs, PIHPs, and PAHPs conduct performance improvement projects, including any performance improvement projects required by CMS in accordance with paragraph (a)(2) of this section, that focus on	**1/5** **Not Met:** (d)(2) (d)(2)(i) (d)(2) (iii) (d)(2) (iv)	QI1 QI2 QI5 QI6	**Not Met** While NCQA standards address the need to complete QI activities that address quality and safety of care and quality of service, it is not specific in verifying that the plan has implemented specific performance improvement projects, meeting specific requirements, to impact care every year.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Art. X. Quality Assessment and Performance Improvement (QAPI), J. Performance Improvement Projects (PIPs) defines the process for MCOs to submit PIPs to DHS, the timeframe, and all the requirements they need to include in the PIP.	**4/4** **2018 Certification Application:** The Certification process does not address PIP requirements. **Other:** DHS, along with the EQRO, reviews PIP topics for all MCOs annually. DHS approves the topics, based on input from the EQRO.	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
both clinical and nonclinical areas. (2) Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: (i) Measurement of performance using objective quality indicators. (ii) Implementation of interventions to achieve improvement in the access to and quality of care. (iii) Evaluation of the effectiveness of the interventions based on the performance measures in paragraph (d)(2)(i) of this section. (iv) Planning and initiation of activities for increasing or					Final PIP reports are submitted annually by each MCO. The EQRO validates the final reports and provides written feedback to each MCO.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
sustaining improvement. (3) The State must require each MCO, PIHP, and PAHP to report the status and results of each project conducted per paragraph (d)(1) of this section to the State as requested, but not less than once per year. (4) The State may permit an MCO, PIHP, or PAHP exclusively serving dual eligibles to substitute an MA Organization quality improvement project conducted under §422.152(d) of this chapter for one or more of the performance improvement projects otherwise required under this section.						
438.330 (e) (e) *Program review by the State.* (1) The State must	**0/1** (e)(1)(ii) is N/A	None	**Not Met** No reference is found in the NCQA standards for external reporting	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Art. X. Quality Assessment	**0/1** **2018 Certification Application:**	**1** (e)(1) The element is addressed in

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP, and PCCM entity described in §438.310(c)(2). The review must include— (i) The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report. (ii) The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (iii) The results of any efforts by the MCO, PIHP, or PAHP to support community integration for enrollees using long-term services and supports. (2) The State may			obligations beyond making the QAPI program information available to members annually. NCQA does not address any regulatory oversight for the QAPI program.	and Performance Improvement (QAPI) The QAPI is not monitored or reviewed annually, but must be made available to the Department upon request.	The 2018-2019 Certification Application does not reference or request the MCO's most recent Quality Assessment/Performance Improvement (QAPI) work plan or QAPI annual report. **Other:** The MCO P4P Guide (attached above in 438.330 (a) (b)) lists the performance measures used in the pay-for-performance program. DHS, along with the EQRO, reviews PIP topics for all MCOs annually and DHS approves the topics, based on input from the EQRO. Once the final PIP reports are submitted, the EQRO validates the final report and provides feedback to each MCO. The EQRO validates the required performance measures annually.	the 2018-2019 contract, but is not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
require that an MCO, PIHP, PAHP, or PCCM entity described in §438.310(c)(2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program.						

Attachment 2: 42 CFR 438 Managed Care - Subpart F

Grievance Systems

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.400 (a) Statutory basis. This subpart is based on the following statutory sections: (1) Section 1902(a)(3) of the Act requires that a State plan provide an opportunity for a fair	**2/4**	UM8 UM9 RR2	**Not Met** The standards that address appeals and grievances do not include specific references to providers acting on behalf of an enrollee, except for expedited appeals and	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article IX- Member Grievances and Appeals- These sections define the grievance and appeal process MCOs must have in place for Medicaid	**0/2** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**2** (a)(3) (b)(1-7) All elements are addressed in the 2018-2019 contract, but none are included in the 2018 Certification Application.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
hearing to any person whose claim for assistance is denied or not acted upon promptly. (2) Section 1902(a)(4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan. (3) Section 1932(b)(4) of the Act requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. (b) Definitions. As used in this subpart, the following terms have the indicated meanings: Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following: (1) The denial or limited			relative to an appeal involving an independent review entity. While a reference to access to an independent review entity is noted, the standards do not reference the fair hearing process.	members.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (2) The reduction, suspension, or termination of a previously authorized service. (3) The denial, in whole or in part, of payment for a service. (4) The failure to provide services in a timely manner, as defined by the State. (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii),						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
to obtain services outside the network. (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
proposed by the MCO, PIHP or PAHP to make an authorization decision. Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them. State fair hearing means the process set forth in subpart E of part 431 of this chapter. (c) Applicability. This subpart applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states, MCOs, PIHPs, and PAHPs are required to continue to comply with subpart F contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.						
438.402	**4/9**	UM8	**Not Met**	**2018-2019 BadgerCare**	**0/5**	**5**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(a) The grievance and appeal system. Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in §438.9, are not subject to this subpart F. (b) Level of appeals. Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees. (c) Filing requirements—(1) Authority to file. (i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld. (A) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have		UM9 RR2	See notes above about the absence of references to providers acting on behalf of an enrollee. For grievances, no timeframes are specifically identified, but rather are noted in a general manner.	**Plus and Medicaid SSI Contract:** Article IX-Member Grievances and Appeals - These sections define the grievance and appeal process MCOs must have in place for Medicaid members.	**2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	(b) (A) (B)(1-4) (B)(ii) (2) (i) All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing. (B) External medical review. The State may offer and arrange for an external medical review if the following conditions are met. (1) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing. (2) The review must be independent of both the State and MCO, PIHP, or PAHP. (3) The review must be offered without any cost to the enrollee. (4) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420. (ii) If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
a grievance, or request a State fair hearing, on behalf of an enrollee. When the term "enrollee" is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in §438.420(b)(5). (2) Timing—(i) Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (ii) Appeal. Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan. (3) Procedures—(i) Grievance. The enrollee may file a grievance						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
either orally or in writing and, as determined by the State, either with the State or with the MCO, PIHP, or PAHP. (ii) Appeal. The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.404 (a) *Notice.* The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10. (b) *Content of notice.* The notice must explain the following: (1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make. (2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage	**1/3**	UM7 UM8 UM9 RR2	**Not Met** Notices are not required if the denial is either concurrent or post-service and the member is not at financial risk. While the standards include references to details such as the timeframe for appeal, how to submit information, and the timeframe within which the plan must make a decision, the standards do not include sufficient detail to fully meet federal requirements.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article IX-Member Grievances and Appeals, A. Procedures and C. Notifications to Members These sections define the content and timeframe for the notifications to members about the grievance and appeal process.	**0/2** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**2** (b)(1-5) (c) (1,2-6) All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
limits. (3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at §438.402(b) and the right to request a State fair hearing consistent with §438.402(c). (4) The procedures for exercising the rights specified in this paragraph (b). (5) The circumstances under which an appeal process can be expedited and how to request it. (6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services. (c) *Timing of notice.* The MCO, PIHP, or PAHP must mail the notice						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
within the following timeframes: (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter. (2) For denial of payment, at the time of any action affecting the claim. (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1). (4) If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must— (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
that decision; and (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. (6) For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.406 (a) *General requirements.* In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (b) *Special requirements.* An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must: (1) Acknowledge receipt of each grievance and appeal. (2) Ensure that the individuals who make decisions on grievances and appeals are individuals—	**2/6**	UM8 UM9 RR2	**Not Met** The standards do not address the following elements: • Require provision of assistance to the enrollees to access grievance and appeal systems, except to provide interpretation assistance; • The option to allow deceased enrollee's legal representative to appeal; • In-person presentation of information. NCQA standards related to expertise of those hearing an appeal are limited to medical necessity appeals only. The option to examine case files and medical records is noted, but more in the past tense as part of the interaction following a utilization	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals, B. Grievance and Appeal Process	**0/4** **2018 Certification Application:** 10.1 Member Handbook-Member Grievance and Appeal Procedures	**4** (a) (4) (6)(i)(ii) (B) (C) (5) All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. (ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity. (B) A grievance regarding denial of expedited resolution of an appeal. (C) A grievance or appeal that involves clinical issues. (iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.			management decision.			

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. (4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. (5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c). (6) Include, as parties to the appeal— (i) The enrollee and his or her representative; or (ii) The legal representative of a deceased enrollee's estate.						
438.408 (a) *Basic rule.* Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes	**5/9** **Not Met:** (3)(c)(i)(ii) (3)	UM8 UM9 RR2	**Not Met** In general, policies for complaints and appeals are evaluated against the MCO's standards for timeliness, not specific timeframes associated with federal requirements. The timeframe for	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article IX-Member Grievances and Appeals, C. Notification to Members. This section defines the content and timeframe for the notifications to members about the grievance and appeal	**2/4** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**2** (3)(c)(i)(ii) (3) All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
specified in this section. (b) *Specific timeframes*—(1) *Standard resolution of grievances.* For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section. (3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO,			internal appeal resolution in the guidelines is 30 days from receipt of appeal. NCQA guidelines state the organization records the time and date of the notification and identifies the staff member that spoke with the member or practitioner. The notification process evaluation does not address communication of the potential for financial responsibility for services received under a continuation of benefits.	process.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section. (c) *Extension of timeframes.* (1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if— (i) The enrollee requests the extension; or (ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. (2) *Requirements following extension.* If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following: (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. (iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (3) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing. (d) *Format of notice—* (1) *Grievances.* The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
such methods meet, at a minimum, the standards described at §438.10. (2) *Appeals.* (i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10. (ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice. (e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following: (1) The results of the resolution process and the date it was completed. (2) For appeals not resolved wholly in favor of the enrollees— (i) The right to request a State fair hearing, and how to do so. (ii) The right to request and receive benefits while the hearing is						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
pending, and how to make the request. (iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (f) *Requirements for State fair hearings*—(1) *Availability.* An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination. (i) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing. (ii) *External medical review.* The State may offer and arrange for an						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
external medical review if the following conditions are met. (A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing. (B) The review must be independent of both the State and MCO, PIHP, or PAHP. (C) The review must be offered without any cost to the enrollee. (D) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420. (2) *State fair hearing.* The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution. (3) *Parties.* The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
representative of a deceased enrollee's estate.						
438.410 (a) *General rule.* Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (b) *Punitive action.* The MCO, PIHP, or PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal. (c) *Action following*	**0/3** **Not Met:** (a) (b) (c)(1)(2)	UM8 UM9 RR2	**Not Met** NCQA standards do not include references to assurances that providers do not suffer punitive action through their involvement in appeals and does address transfer to the standard process for appeals.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals - These sections define the grievance and appeal process MCOs must have in place for Medicaid members.	**0/3** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**3** (a) (b) (c)(1)(2) All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
denial of a request for expedited resolution. If the MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it must— (1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2). (2) Follow the requirements in §438.408(c)(2).						
438.414 The MCO, PIHP or PAHP must provide information specified in § 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.	**0/1**	None	**Not Met** NCQA standards do not address this requirement.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article IX- Member Grievances and Appeals, A., Procedures 15. Distribute to its gatekeepers, providers, subcontractors and Independent Practice Associations (IPAs) the informational flyer on member grievance and appeal rights (the Ombuds Brochure), at the time the contract is entered. When a new brochure is available, the MCO must distribute copies to its gatekeepers,	**0/1** **2018 Certification Application:** The 2018 Certification Application does not monitor or review these requirements.	**1** 438.414 This element is addressed in the 2018-2019 contract, but is not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				providers, subcontractors, and IPAs within three weeks of receipt of the new brochure. 16. Ensure that its gatekeepers, providers, subcontractors and IPAs have written procedures for describing how members are informed of denied services. The MCO will make copies of the gatekeepers', providers', subcontractors', and IPAs' grievance procedures available for review upon request by the Department.		
438.416 (a) The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. (b) The record of each grievance or appeal must contain, at a minimum, all of the following	**0/3**	RR2	**Not Met** This standard includes requirements for documentation of complaints and appeals but without regard for the need for state oversight. DHS may require specific elements to be included in MCO records.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract:** Article IX, Member Grievances and Appeals, A., Procedures 11. Maintain records of complaints and grievances that includes a short, dated summary of each problem, the response, and the resolution. 12. Maintain a record keeping system for	**0/3**	**3** (a) (b) (c) All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
information: (1) A general description of the reason for the appeal or grievance. (2) The date received. (3) The date of each review or, if applicable, review meeting. (4) Resolution at each level of the appeal or grievance, if applicable. (5) Date of resolution at each level, if applicable. (6) Name of the covered person for whom the appeal or grievance was filed. (c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.				grievances and appeals that includes a copy of the original grievance or appeal, the response, and the resolution., and E. Reporting of Grievances to the Department		
438.420 (a) *Definition.* As used in this section— *Timely files* means files for continuation of benefits on or before the later of the following: (i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination. (ii) The intended	**0/4** **Not Met:** (a)(i)(ii) (b)(1-5) (c)(1-3)	UM7 UM8 UM9 RR2	**Not Met** While the general concepts of these federal requirements are addressed in NCQA standards, specific details, especially those related to criteria for continuation of benefits, are not included.	**2018-2019 BadgerCare Plus and Medicaid SSI Contract**: Article IX-Member Grievances and Appeals C. Notifications to Members 15. Notification to members of terminations, suspension, or reduction of an ongoing benefit (including services authorized by the MCO the	**1/4** **2018 Certification Application:** 10.1 Member Handbook	**3** (a)(i)(ii) (b)(1-5) (c)(1-3) All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination. (b) *Continuation of benefits.* The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur: (1) The enrollee files the request for an appeal timely in accordance with §438.402(c)(1)(ii) and (c)(2)(ii); (2) The appeal involves the termination, suspension, or reduction of previously authorized services; (3) The services were ordered by an authorized provider; (4) The period covered by the original authorization has not expired; and (5) The enrollee timely files for continuation of benefits. (c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO, PIHP, or PAHP				member was previously enrolled in or services received by the member on a FFS basis) must in addition to items a. through n. above, also include the following: • The fact that a benefit will continue during the appeal or DHA fair hearing process if the member requests that it continue within 10 days of notification or before the effective date of the action, whichever is later. • The circumstances under which a benefit will continue during the grievance and appeal process. • The fact that if the member continues to receive the disputed service, the member may be liable for the cost of		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs: (1) The enrollee withdraws the appeal or request for state fair hearing. (2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2). (3) A State fair hearing office issues a hearing decision adverse to the enrollee. (d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit				care if the decision is adverse to the member. Article IX-Member Grievances and Appeals, D. Continuation of Benefits Requirements If the member files a request for a hearing with the Division of Hearings and Appeals (DHA) on or before the later of the effective date or within 10 days of the MCO mailing the notice of action to reduce, limit, terminate or suspend benefits, upon notification by the DHA the MCO will notify the member they are eligible to continue receiving care but may be liable for care if DHA upholds the MCO's decision. If the member requests that the services in question be continued pending the outcome of the fair hearing, the following conditions apply: a. If the DHA reverses the MCO's decision the MCO		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under §431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.				is responsible to cover services provided to the member during the administrative hearing process. b. If the DHA upholds the MCO's decision, the MCO may pursue reimbursement from the member for all services provided to the member, to the extent that the services were covered solely because of this requirement. Benefits must be continued until one of the following occurs: • The member withdraws the appeal. • A state fair hearing decision adverse to the member is made. • The authorization expires or the authorization service is met.		
438.424 *(a) Services not furnished while the*	**0/2** **Not Met:** (a) and (b)	**None**	**Not Met** NCQA standards do not reflect the details	**2018-2019 BadgerCare Plus and Medicaid SSI Contract**:	**0/2** **2018 Certification**	**2** (a) (b)

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
appeal is pending. If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (b) *Services furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations.			included this requirement.	Article IX Member Grievances and Appeals , B. Grievance and Appeal Process The MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal is pending and the decision to deny, limit, or delay services is reversed.	**Application:** The 2018 Certification Application does not monitor or review these requirements.	All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application

Accreditation Crosswalk Summary

In this section, DHS analyzed areas where NCQA accreditation requirements do not fully meet the federal Medicaid Managed Care requirements and proposed a plan to address those gaps.

Managed Care (MC) Rule Citation	# of MC Rule Elements	MC Rule Elements that are met by HMOs through NCQA Accreditation	Remaining MC Rule Elements Met with Current Certification Application	Remaining Gaps to Address in 2019 HMO Certification Application	Notes
Subpart C					
438.100(a)	2	2	0	0	
438.100(b)	2	1	1	0	
438.100(b)	1/1	1	0	0	
438.100(c)	0/1	0	1	0	
438.102(a)	5	2	3	0	
438.102(b)	2	0	1	1	HMO's not furnishing information about services it does not cover. Not included in the Certification Application, but is addressed in the contract. DHS will address it in the 2019 Certification Application.
438.104	0/2	0	0	2	Marketing materials. DHS reviews every member communication sent from HMOs per contract specifications. HMOs are required to submit to DHS for review and approval their Annual Outreach Member Communication Plan every January. Attached is a copy of the HMO Member Outreach and Communication Guide. HMO Communication Outreach and Marketir This guide describes DHS processes and guidelines for reviewing and approving all HMO communications to members or the public. The requirements of plans to submit member communication and marketing materials to the Department for approval will be added to the contract.

438.106	0/5	0	0	5	Liability for payments. All elements addressed in the contract, but not the Certification Application. DHS will address in the 2019 Certification Application.
438.116	0/1	0	0	1	Solvency standards. Federally qualified HMOs are exempt from this requirement. All elements are addressed in the contract, but not in the Certification Application. DHS will address in the 2019 Certification Application.
438.108	0/1	0	0	1	Cost Sharing. Addressed in the contract, but not in the Certification Application. DHS will address in the 2019 Certification Application.
438.114	0/7	0	0	7	Emergency and post stabilization services. Per NCQA, the organization will meet this element if its policies and procedures state that it covers all Emergency Department (ER) claims or does not deny any ER claims. All elements are addressed in the HMO contract, but not included in the 2018 Certification Application. DHS will address these elements in the 2019 Certification Application.

Managed Care (MC) Rule Citation	# of MC Rule Elements	MC Rule Elements that are met by HMOs through NCQA Accreditation	Remaining MC Rule Elements Met with Current Certification Application	Remaining Gaps to Address in 2019 HMO Certification Application	Notes
Subpart D					
438.206 and 438.68	2/6	2	4	0	Availability of services and network adequacy.
438.206	* 1/1	1	1	0	Provides female enrollees with direct access to a women's health specialist within the provider network. Certification Application does address this element.
438.206	* 3/3	3	3	0	Provides for a second opinion. The 2018 Certification Application addresses these elements.

438.206	0/1	0	0	1	438.206(b)(7). Sufficient family planning providers. This element is addressed in the contract, but not included in the 2018 Certification Application. DHS will address this element in the 2019 Certification Application.
438.206	5/8	5	3	0	Service area and access to care requirements.
438.207	0/3	0	3	0	Assurances of adequate capacity and services. Per the contract requirements, HMOs are required to submit a monthly file with provider network data. DHS conducts a network adequacy review using the file to assess HMO readiness to meet the terms of the contract. The network review consists of counting providers, analyzing the ratios of providers to members, and mapping providers. If there are gaps, DHS will work with the HMO to increase the number of provider in a given area. If the HMO fails to increase the provider count, DHS will not certify the HMO. When CMS releases the EQRO protocol for network adequacy and access to care, DHS will work with the EQRO to adopt the new process.
438.208	2/6	2	4	0	Coordination and continuity of care.
438.208	2/2	2	0	0	Coordination and continuity of care.
438.210	1/4	1	3	0	Coverage and authorization of services.
438.210	3/3	3	0	0	Coverage and authorization of services.
438.210(c)(d)	1/2	1	0	1	Notice of adverse benefit determination. The 2018 Certification Application does not review MCO policies, procedures, or document templates related to notice of adverse benefit determinations or authorization decisions. DHS will address this element in the 2019 Certification Application.
438.210 (e)	1/1	1	0	0	Compensation for utilization management activities.
438.214 (a) and (b)	0/2	0	0	2	Provider selection. Elements are addressed in the contract, but not in the 2018 Certification Application. DHS requires that HMOs must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides services to the HMO's members, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under BadgerCare Plus and/or Medicaid SSI. The HMO's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process. DHS will address these elements in the 2019 Certification Application.
438.214(c)	0/1	0	0	1	Non- discrimination. This element is addressed in the contract, but not in the Certification Application. DHS will address this element in the 2019 Certification Application.

438.214(d)	1/1	1	0	0	Excluded providers.
438.214(e)	0/1	0	0	1	Provider selection. This element is addressed in the contract, but not in the Certification Application. DHS will address this element in the 2019 Certification Application
438.224	* 1/1	1	1	*0	Confidentiality. Addressed in the contract, but not in the Certification Application. Applies to HMOs that have not obtained NCQA Medicaid Accreditation. This element will be addressed in the 2019 Certification Application.
438.230	0/3	0	0	3	Subcontractual relationship and delegation agreement (subcontracts). Addressed in the contract, but not in the Certification Application. DHS will address in the 2019 Certification Application.
438.236(a)(b)	0/4	0	0	4	Practice guidelines. Certification Application Section 6. Access to Care – Coordination and Continuity of Care requires submission of clinical guidelines used to assist in identifying members with chronic conditions. However, it does not review the HMO's process for establishing practice guidelines. DHS will address in the 2019 Certification Application.
438.236 (c)	0/2	0	0	2	Dissemination of guidelines. Certification Application does not include the dissemination of guidelines to providers, enrollees or potential enrollees. DHS will include this element in the 2019 Certification Application.
438.236(d)	0/1	0	0	1	Application of guidelines. 2019 Certification Application will be strengthened to ensure that HMOs use clinical practice guidelines to make decisions for utilization management, enrollee education, coverage of services.
438.242(a)	0/1	0	1	0	Health information systems.
438.242(b)	0/1	0	1	0	Health information systems.
438.242 (c)(d)	0/2	0	2	0	Health information systems.

Managed Care (MC) Rule Citation	# of MC Rule Elements	MC Rule Elements that are met by HMOs through NCQA Accreditation	Remaining MC Rule Elements Met with Current Certification Application	Remaining Gaps to Address in 2019 HMO Certification Application	Notes
Subpart E					
438.330	2/4	2	0	2	Quality assessment and performance improvement program. Elements (b)(1) and (b)(3) elements are addressed in the 2018-2019 contract, but not included in the current certification process. DHS will include these elements in the 2019 Certification Application.
438.330(c)	0/1	0	1	0	Performance measurement
438.330(d)	1/5	1	4	0	Performance improvement projects
438.330(e)	0/1	0	0	1	Program review by the State. This element is addressed in the contract, but not in the Certification Application. DHS will address in the 2019 Certification Application.

Managed Care (MC) Rule Citation	# of MC Rule Elements	MC Rule Elements that are met by HMOs through NCQA Accreditation	Remaining MC Rule Elements Met with Current Certification Application	Remaining Gaps to Address in 2019 HMO Certification Application	Notes
Subpart F					
438.400	2/4	2	0	2	Statutory basis, definitions, and applicability. Elements are addressed in the 2018-2019 contract in Article IX, but are not included in the 2018 Certification Application. DHS will address these elements in the 2019 Certification Application.
438.402	4/9	4	0	5	Grievance and appeal system. All elements are addressed in the 2018-2019 contract in Article IX, but not all are included in the 2018 Certification Application. DHS will ensure that all elements are addressed in the 2019 Certification Application.
438.404	1/3	1	0	2	Timely and adequate notice of adverse benefit determination. All elements are addressed in the 2018-2019 contract, but not all are included in the 2018 Certification Application. DHS will address all elements in the 2019 Certification Application.
438.406	2/6	2	0	4	Handling of grievances and appeals. All elements are addressed in the 2018-2019 contract in Article IX, but not all are included in the 2018 Certification Application. DHS will ensure that all elements are addressed in the 2019 Certification Application.
438.408	5/9	5	2	2	Resolution and notification: Grievances and appeals. All elements are addressed in the 2018-2019 contract, but the 2018 Certification Application does not review these requirements. DHS will ensure that these elements are addressed in the 2019 Certification Application.
438.410	0/3	0	0	3	Expedited resolution of appeals. NCQA standards do not include references to assurances that providers do not suffer punitive action through their involvement in appeals and does address transfer to the standard process for appeals. All elements are addressed in the contract, but not in the Certification Application. DHS will ensure that the 2019 Certification Application will address all elements in this citation.

438.414	0/1	0	0	1	Information about the grievance and appeal system to providers and subcontractors. NCQA standards do not address this requirement. This element is addressed in the contract, but not included in the 2018 Certification Application. DHS will ensure that the 2019 Certification Application will address this element.
438.416	0/3	0	0	3	Recordkeeping requirements. This standard includes requirements for documentation of complaints and appeals but without regard for the need for state oversight. All elements are addressed in the contract, but not included in the Certification Application. Will include in the 2019 Certification Application.
438.420	0/4	0	1	3	Continuation of benefits while the MCO appeal and the State fair hearing are pending. While the general concepts of these federal requirements are addressed in NCQA standards, specific details, especially those related to criteria for continuation of benefits, are not included. All elements are addressed in the contract, but not included in the Certification Application. DHS will add to the 2019 Certification Application.
438.424	0/2	0	0	2	Services not furnished while the appeal is pending. Elements are addressed in the contract but not in the Certification Application. DHS will add to the 2019 Certification Application.

DHS will work with its EQRO to conduct an abbreviated EQRO review process for NCQA accredited HMOs, in addition to the strengthened 2019-2021 HMO certification application review process.

Questions

If there are any questions about this document, please send an email to:

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