Department of Health Services
Initial HMO Certification Application for the BadgerCare Plus and Medicaid SSI HMO Program For the 2022-2023 Contract Period

Contents

1 Certification Application Submission Instructions

1.1 Purpose

This document is to provide instruction on the HMO Certification Application (Certification); detailing process and submission requirements the Department needs to review prior to signing the HMO Contract for BadgerCare Plus and Medicaid SSI (Contract). Materials, formats, and additional instruction necessary for certification to serve BadgerCare Plus and/or Medicaid SSI members under the HMO program are enclosed.

HMOs that are not currently contracted with DHS and are applying for initial certification and contracting should use this comprehensive certification application. Certification, system testing, and full readiness review is a lengthy process that should begin at least eight months prior to the desired contracting date. Please contact DHSDMSHMO@dhs.wisconsin.gov for questions about this process.

1.2 Process

Submission deadline for new plans: April 1st of the year prior to the desired January 1st start date.

If you need an extension to submit specific sections, please contact DHSDMSHMO@dhs.wisconsin.gov.

HMOs must complete all applicable sections of the certification application. Using a response of "see response from previous section" is not sufficient. Incomplete forms, outdated or incomplete information may result in delayed certification. Applications must be submitted electronically. Please contact DHSDMSHMO@dhs.wisconsin.gov for submission instructions.

Please indicate clearly where the information can be found to meet certification requirements. The contract monitor will consider a requirement unmet if it is not clearly indicated. The signature page must be signed and dated by the HMO's authorized agent responsible for applying for certification and must be submitted electronically with the application.

1.3 Naming Convention

In order for more efficient review and to organize information for Certification, please use DHS standardized naming convention.

- Section 6.1 – Subcontracts – Provider Contracts/Policies and Procedures – [*Formal Name of Document*]
- Section 6.2 – Subcontracts – Group Contracts – [*Formal Name of Document*]

HMOs should embed each document submission in the corresponding section of the Word document. HMOs that use the same policy and procedure document to answer multiple questions may supply this document once. HMOs must clearly indicate where responses to the inquires can be found in the materials submitted. For example, if a response is on page 13 of a submitted policy and procedure document, highlighting that section and/or noting specifically "see page 13 paragraph 3" would be expected. See example below. If DHS is unable to open the embedded documents, the HMO must provide the attachment in another format.

HMO Response
Please see embedded document: Section 6 – Care Management - Information Sharing – Question 1 - Care Coordination and Care Management Services - page 3, first bullet point in section C.  Section_6_Care_Management_Information_Sharin

2 Administrative

2.1 HMO Information

HMOs are required to update any information in this section that changes during the two-year contract period as soon as practicably possible.

Please provide documentation for the following:

- Official HMO Name
- Contract Administrator
- Physical Address
- Payee Information
- Tax Identification Number (TIN)
- OCI Wisconsin Certification Certificate

2.2 HMO Organization Charts

Provide a copy of the organizational chart.

2.3 HMO Data Sheet

Complete the HMO's contact information data sheet. The template is provided here:

HMO Name Data Sheet - Updated MM

2.4 All HMOs must submit the following: Accreditation Status

1. If accredited by a nationally recognized accrediting body (i.e. AAAHC, NCQA, URAC), the HMO must submit letter from accrediting body, year of accreditation, and line of business for which it obtained accreditation.
2. If the HMO is not, then please submit an attestation ensuring solvency standards compliance with 42 CFR 438.116.

2.5 Ownership and Controlling Interest

Pursuant to 42 CFR 438.602(c), federal law requires DHS to obtain HMO Ownership and Controlling Interest information.

CMS defines "Controlling Interest" as owners, creditors, controlling officers, administrators, mortgage interest holders, employees or stockholders with holdings of 5 percent or greater or outstanding stock, or holders with such position or relationship who may have a bearing on the operation or administration of a medical service-related business. Specifically, "Controlling interest or ownership" means that a person:

1. Possesses a direct or indirect interest in 5 percent or more of the issued shares of stock in a corporate identity;
2. Is the owner of an interest of 5 percent or more in any mortgage, deed of trust, note, or other secured obligation;
3. Is an officer or director of the corporation; or
4. Is a partner of the partnership

Please provide HMO ownership or controlling interest information. Please contact DHSDMSHMO@dhs.wisconsin.gov for the most recent template and submission instructions.

Please note that ownership and controlling interest disclosures are due within in 35 days of any changes in ownership, as required by the Contract and federal law.

Has the HMO (including any employee, vendors, or providers with whom the HMO has a controlling interest) or any person having a controlling interest in the HMO ever been convicted of a crime related to, or been terminated from, a federally-assisted or state-assisted medical program?

☐Yes ☐ No

2.6 Department Checklist

DHS USE ONLY			Administrative
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	2.1 Provide HMO Information.
☐	☐	☐	2.2 Provide organizational chart.
☐	☐	☐	2.3 Provide data sheet.
☐	☐	☐	2.4.1 HMO must submit a letter showing the year of accreditation, and line of business for which it obtained accreditation.
☐	☐	☐	2.4.2 If not accredited by a nationally recognized accrediting body, the HMO must submit an attestation ensuring they are compliant with 42 CFR 438.116
☐	☐	☐	2.5 Provide Ownership and Controlling Interest information.

3 Service Area

HMOs are required to submit provider network files weekly. All provider information is expected to be up to date. The specifications for the file are defined on the ForwardHealth website; select Managed Care Organization, Encounters and Reporting, HMO Provider Network reporting.

Please provide mapping and documentation proving your provider network meets the provider network adequacy requirements as stated in the Contract.

3.1 Distance Requirements

Please provide policy and procedure documentation describing the HMO's process that ensures the provider network meets the following distance and drive time requirements for selected services:

a. **Primary Care Access**

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties must have a certified primary care provider within 20 miles and a 30 minute drive from any member. All other counties must have a provider within 30 miles and 60 minute drive from any member. At least one PCP must be in each HMO certified county unless there is no such provider in the county.

b. **Mental Health and Substance Abuse Access to Care**

HMOs must have a mental health or substance abuse provider within 35 miles and a 60 minute drive from any member. At least one mental health and substance abuse provider must be in each HMO certified county unless there is no such provider in the county.

c. **Dental Care Access**

HMOs in Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties (Regions 5 and 6) must have a dental provider within 25 miles, a 30 minute drive, and at least one provider within the boundary of the county. All other regions that cover dental services must have a dental provider within a 35 mile distance from any member residing the certified county. At least one dental provider must be in each HMO certified county unless there is no Medicaid enrolled provider in that county.

d. **Hospitals**

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties must include a non-specialized hospital within a 20 miles and 30 minute drive from any member. All other counties must be within 35 miles and a 60 minute drive from any member. At least one hospital must be in each HMO certified county unless there is no hospital in the county.

e. **Urgent Care Centers or Walk-In Clinics**

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties must have Urgent Care Centers or Walk-In centers or clinics within 20 miles and a 30 minute drive from any member residing in the HMO service area. All other counties must be within 35 miles and a 60 minute drive from any member. At least one urgent care center with extended hours must be in each HMO certified county unless there is no urgent care center with extended hours in the county. In the event where there are no urgent care centers with extended hours in the county, DHS will also consider telehealth services if the HMO can provide evidence that e-prescribing, diagnosis, and referral services are being provided.

f. **OB/GYN Access**

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties must have an OB/GYN provider within a 20 miles and 30 minute drive from any member. All other counties must have an OB/GYN provider within 30 miles and 60 minute drive from any

member. At least one OB/GYN provider must be in each HMO certified county must be in each HMO certified county unless there is no such provider in the county.

3.2 Provider to Member Ratios

A. HMOs in Regions 5 and 6 are required to meet the following provider to member ratios for selected provider types:

Provider Type	Provider to Member Ratio
Primary Care Provider	1:100
Dentist	1:1,600
Psychiatrist	1:900

Please submit policies and procedures to ensure the provider network for these counties meet the standards for primary care, dental care, and access to psychiatrists. The policy and procedure must include the HMO's plan to monitor compliance with these standards and how the HMO corrects for deficiencies if these ratios fall out of compliance. The Managed Care Rate Regions can be found on the ForwardHealth website here.

3.3 Department Checklist

DHS USE ONLY			Service Area
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
			3. Mapping and documentation proving provider network adequacy is met has been provided.
☐	☐	☐	3.1 Policies and procedures describing the process to ensure the provider network meets distance and drive time requirements for primary care, mental health and substance abuse, dental care, hospitals, OB/GYN and urgent care centers/walk-in clinics.
☐	☐	☐	3.2 Policies and procedures describing the process to ensure the provider network meets the standards for primary care, dental care, and access to psychiatry, including the plan to monitor compliance with these standards and how the HMO corrects for deficiencies if these ratios are not met.
☐	☐	☐	3.2.A Provide documentation describing how the weekly provider network and facility files will be audited and/or monitored to ensure continuous data accuracy.

4 Availability of Services, Assurances of Adequate Capacity of Services, Network Adequacy Standards, Coordination and Continuity of Care

CFR 438.206, CFR 438.207, CFR 438.208, CFR 438.68

Per the Contract, HMOs must provide medical services to its members, in the same terms of timeliness, amount, duration, and scope, as services to commercial members within the area served by the HMO.

1. Provide policies and procedures to monitor network adequacy, identify access to care issues, and evaluate the capacity of the HMOs network.
2. Provide information about the persons within the organization evaluating network adequacy, frequency of the evaluation, as well as data or analysis related to network adequacy in the last year.

4.1 Use of BadgerCare Plus and/or Medicaid SSI Enrolled Providers

The HMO must provide policies and procedures to ensure the use of only WI Medicaid-enrolled providers for the provision of covered services (except in emergency situations).

4.2 Protocols/Standards to Ensure Access

- The HMO must have written protocols to ensure members have access to screening, diagnosis and referral and appropriate treatment for those conditions and services covered under the Contract. The HMO's protocols must include training and information for network providers, to promote and develop provider skills in responding to the needs of persons with:

    - limited English proficiency,
    - mental disabilities,
    - physical disabilities, and
    - developmental disabilities.

  Training should include clinical and communication issues and the role of care coordinators.
- For members with special health care needs, the HMO must provide policies and procedures to allow members to directly access a specialist, as appropriate.

4.3 Primary Care Assignment

HMOs must have policies and procedures in place to assign members to a primary care provider, a primary care clinic, or a specialist when appropriate based on the health care needs of the member.

HMOs must provide their primary care assignment policies and procedures to the Department for review which includes a description of the following:

1. The processes and procedures to allow members to have choice of providers before assignment.
2. The communication plan to inform members about their primary care provider options, the primary care assignment process, and their rights to change primary care providers after assignment.
3. Describe the process to assist members in getting a primary care visit as part of the primary care assignment process.
4. How the primary care assignment process takes into account members' health care needs and how members with chronic conditions (including, but not limited to, diabetes, asthma, COPD, congestive heart failure, and behavioral health) are identified (including clinical guidelines and other tools used).
5. How the HMO ensures that PCPs provide culturally sensitive care for members.
6. Policies and procedures for members that want to change their assigned primary care provider.
7. Processes and procedures to ensure coordination of care and information sharing between the primary care provider and the specialists, including pharmacy data.
8. Processes and procedures for ensuring patient-centered care and that a comprehensive treatment plan is developed between members and their primary care provider.
9. Processes and procedures HMOs use to evaluate the effectiveness of their primary care assignment strategies.
10. Policies and procedures related to protecting members' privacy when coordinating their care and services with other providers.
11. Results and analysis from internal monitoring and improvement efforts related to care coordination and follow-up, assessment and care planning.

4.4 Waiting times

Article V(C) of the Contract defines standards for access to care which includes:

- Waiting times for care at facilities;
- Waiting times for appointments;
- Statements that providers' hours of operation do not discriminate against BadgerCare Plus and/or Medicaid SSI members; and
- Whether or not provider(s) speak the member's language.

HMOs shall submit policies and procedures for:

1. Waiting times for care at facilities and appointments for the following provider specialties: primary care, mental health, and dental
2. Communication plan for educating primary care, mental health, and dental providers on these waiting times.
3. Processes and procedures to monitor provider compliance with the waiting times and processes to correct for deficiencies if the waiting time standards are not being met.

4.5 Urgent Care Access

Per Article V(E)(5) of the Contract, HMOs are required to provide to the Department:

a. Policies and procedures to make urgent care available to members during extended office hours (such as from 5p-7p during weekdays and open during weekends).
b. As part of the policy and procedures, the communication plan to educate members on adequate use of urgent care vs. emergency department and the availability of urgent care.

4.6 Telehealth Services

a. HMOs are required to provide policies and procedures that are consistent with ForwardHealth policies and Wisconsin Statute Wis. Stat. § 49.45(61). The HMO may not impose additional restrictions for telehealth services that are not similarly required for in person services and must officer members like services in physical locations in addition to telehealth services.
b. HMOs are required to provide policies and procedures for internal monitoring and telehealth utilization.

4.7 Access to Women's Health Specialists

HMOs are required to provide to the Department policies and procedures to make women's health specialists available to members and the waiting times meet the requirements stated in the contract.

4.8 Second Medical Opinions

HMOs are required to provide policies and procedures that:

- Allow providers to advise or advocate on behalf of a member.
- Provide to members, upon request, second medical opinions from a qualified provider in-network or out-of-network if needed.

4.9 Moral or Religious Objections to Care

a. HMOs are required to notify the Department, the Enrollment Specialist, and the member of any moral or religious objections to provide care.
b. HMOs are required to provide to the Department its policies and procedures for communication with the Department, Enrollment Specialist, and member whenever a provider in network refuses to provide a service based on moral or religious objections.
c. Include a list of any providers that refuse to provide a service based on moral or religious objections.

4.10 Transition of Care

1. HMOs are required to provide policies and procedures to ensure well-managed member continuity of care, including a 90 day continuity of care during transitions of care for each of the HMOs member as defined in Article VII (F).
2. HMOs should submit descriptions and/or documentation on how they provide transitions of care to members:
    - How the HMO currently works with in-network and out-of-network hospitals to assist with discharge planning and transitions to other settings.
    - How the HMO ensures providers, both in and out-of-network, are made aware of the process to request authorizations for post-stabilization care or authorizations for transfers/discharges to other facilities.
    - The HMO's clinical guidelines or prior authorization criteria for determining medical necessity for skilled nursing facility/nursing home admissions.

4.11 HMO Referrals to Out-of-Network Providers for Services

HMOs must provide adequate and timely coverage of services provided out-of-network when the medical service is not available within the HMO network. The HMO must:

- Coordinate with out-of-network providers for payment and to ensure the cost to the member is no greater than if the services are furnished within the network;
- Use processes, strategies, or evidentiary standard to determine access to out-of-network providers for mental health or substance abuse disorder benefits that are no more stringent than those for out-of-network providers for medical benefits in the same classification;
- Ensure emergency services provided out-of-network do not have a cost to the member greater than if the emergency services are provided in network.

HMOs are required to provide to the Department policies and procedures to provide members referrals to out-of-network providers for services if the service is not available within the HMO network.

4.12 Access to Indian Health Providers

- For Indian members enrolled in the HMO, the HMO must ensure access to an Indian Health Care Provider (IHCP), when available. The HMO must have sufficient IHCPs within its network to ensure timely access to services for Indian members.
- Indian members of the HMO may receive primary care services from an IHCP provider, as long as the provider agrees to serve in the HMO network as a PCP and has capacity for additional patients. If no such provider is contracted, the HMO must allow the member to see the IHCP out-of-network. If an Indian member receives services through an out-of-network IHCP, the HMO must allow the out-of-network IHCP to refer the Indian member to a provider within the HMO network for additional care.
- If timely access to an IHCP cannot be ensured, the HMO may allow Indian members to access out-of-state IHCPs or the member may choose to disenroll from the HMO.
- The HMO must pay all IHCPs, whether within network or not, at a minimum, the full Medicaid fee-for-service payment rate for provision of services or items to Indian members.
- Indian members are exempt from payment of fees, co-payments, or premiums for services provided by an IHCP.
- HMOs are required to provide to the Department:
    1. Policies and procedures to ensure timely access to IHCPs for Indian members.
    2. Policies and procedures to allow Indian members to receive primary care services from an IHCP provider, as long as the provider agrees to serve as a PCP within the HMO network and has capacity for additional patients. Include the provisions to allow the member to see

the IHCP out-of-network if no provider is contracted and allow the out-of-network IHCP to refer the Indian member to contracted provider for additional care.

3. Policy and procedure allowing Indian member to access out-of-state IHCPs or disenroll from the HMO if timely access to an IHCP cannot be ensured.
4. Policy and procedure to pay all IHCPs, in network or not, at a minimum, the full Medicaid fee-for-service payment rate for provision of services or items to Indian members.
5. Policy and procedures that exempt Indian members from payment of fees, co-payments, or premiums for services provided by an IHCP.

4.13 Optional Service Coverage: Chiropractic Coverage

(Please check one)

☐ HMO elects to cover chiropractic services.

☐ HMO elects not to cover chiropractic services.

☐ Mix of the above depending on the county. The counties where the HMO provides chiropractic services are as follows: Click here to enter text.

4.14 Optional Service Coverage: Dental Coverage in regions 1-4

(Check all that apply)

☐ HMO elects to cover dental services for BadgerCare Plus members in regions 1-4.
Counties: Click here to enter text.

☐ HMO elects to cover dental services for Medicaid SSI members in regions 1-4.
Counties: Click here to enter text.
If the HMO subcontracts with a dental benefits administrator (DBA), please identify it:
Click here to enter text.

Note: Dental coverage is required in regions 5-6.

4.15 Optional Service Coverage: Additional Services

☐ The HMO does not charge copays for:
☐ BadgerCare Plus ☐ Medicaid SSI

☐ This HMO offers free cooking and nutrition classes.

☐ This HMO offers free weight loss or exercise classes.

☐ This HMO offers discounts on massage therapy and acupuncture.

☐ Other: Click here to enter text.

4.16 "In Lieu of" Services

In lieu of services can be covered by HMOs on a voluntary basis as follows:

- The Department determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan;
- The member is not required by the HMO to use the alternative service or setting, and
- The approved in lieu of services are identified in the HMO contract and will be provided at the option of the HMO.

☐ Please describe and list any "in lieu of" services your HMO provides:
Click here to enter text.

☐ Our HMO does not provide any "in lieu of services"

4.17 Department Checklist

DHS USE ONLY			Provider Network – Availability of Services, Assurances of Adequate Capacity and Services, Network Adequacy Standards
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	4.0.1 HMO provided policies and procedures to monitor network adequacy, identify access to care issues, and evaluate the capacity of their network.
☐	☐	☐	4.0.2 HMO provided information about the persons within the organization evaluating network adequacy, frequency of the evaluation, as well as data or analysis related to network adequacy in the last year.
☐	☐	☐	4.1 HMO provided policies and procedures to ensure the use of Medicaid enrolled providers for the provision of covered services.
☐	☐	☐	4.2 HMO provided written protocols to ensure members have access to screening, diagnosis and referral and appropriate treatment for those conditions and services.
☐	☐	☐	4.3.1 Processes and procedures allow members to have choice of providers before assignment.
☐	☐	☐	4.3.2 The communication plan to inform members about their primary care provider options, the primary care assignment process, and their rights to change primary care providers after assignment.
☐	☐	☐	4.3.3 A description of the process to assist members in getting a primary care visit as part of the primary care assignment process.
☐	☐	☐	4.3.4 The primary care assignment process takes into account members' health care needs and describe how members with chronic conditions are identified (including clinical guidelines and other tools used).
☐	☐	☐	4.3.5 How the HMO ensures PCPs provide culturally sensitive care for members.
☐	☐	☐	4.3.6 The procedures to follow when members want to change their assigned primary care provider and how the HMO updates the PCP based on member utilization data and/or provider feedback.
☐	☐	☐	4.3.7 Processes and procedures ensure coordination of care and information sharing between the primary care provider and the specialists, including pharmacy data.
☐	☐	☐	4.3.8 Processes and procedures for ensuring patient-centered care and that a comprehensive treatment plan is developed between members and their primary care provider.
☐	☐	☐	4.3.9 Processes and procedures HMOs use to evaluate the effectiveness of their primary care assignment strategies.
☐	☐	☐	4.3.10 Procedures related to protecting members' privacy when coordinating their care and services with other providers.
☐	☐	☐	4.3.11 Results and analysis from internal monitoring and improvement efforts related to care coordination and follow-up, assessment and care planning.
☐	☐	☐	4.4.1 Provide written standards for waiting times as specified in the contract.

☐	☐	☐	4.4.2 Communication plan is present for educating primary care, mental health, and dental providers on these waiting times.
☐	☐	☐	4.4.3 Processes and procedures monitor provider compliance with the waiting times and processes are developed to correct for deficiencies if the waiting standards are not being met.
☐	☐	☐	4.5 Policies and procedures make urgent care available to members during extended office hours, including the communication plan to educate members on adequate use of urgent care vs. emergency department and the availability of urgent care.
☐	☐	☐	4.6.1 Policies and procedures are in place for telehealth services.
☐	☐	☐	4.6.2 Policies and procedures are in place for internal monitoring of telehealth utilization
☐	☐	☐	4.7 Policies and procedures are in place for access to women's health specialists.
☐	☐	☐	4.8 Policies and procedures are in place for Second Medical Opinions
☐	☐	☐	4.9 Policies and procedures detail communication with the Department, Enrollment Specialist, and member when a provider in network refuses to provide a service based on moral or religious objections.
☐	☐	☐	4.10.1 Policies and procedures to ensure well-managed member continuity of care as laid out in in Article VII (F).
☐	☐	☐	4.10.2 How the HMO ensures providers, both in and out-of-network, are made aware of the process to request authorizations for post-stabilization care or authorizations for transfers/discharges to other facilities.
☐	☐	☐	4.11 Policies and procedures on HMO referrals to Out-of-Network Provider for Services.
☐	☐	☐	4.12 Policies and Procedures for access to Indian Health Providers
☐	☐	☐	4.13 Optional Service Coverage: Chiropractic Coverage
☐	☐	☐	4.14 Optional Service Coverage: Dental Services
☐	☐	☐	4.15 Optional Service Coverage: Additional Services
☐	☐	☐	4.16 HMO indicates which "in lieu of" services are provided, if any.

5 Mental Health Parity

HMOs must complete a mental health parity analysis to demonstrate compliance with the mental health parity rule.

1. Mapping medical/surgical (M/S), mental health (MH), and substance use disorder (SUD) benefits to each classification.
2. Analyzing financial requirements (FR) and quantitative treatment limitations (QTL) applied to MH and SUD benefits in each classification.
3. Evaluating aggregate lifetime and annual dollar limits (AL/ADL) applied to MH and SUD benefits.
4. Identifying and test each non-quantitative treatment limitations (NGTL) applied to MH to SUD benefits in each classification.
5. Assessing compliance for availability of information.

HMOs shall reference the Mental Health Parity Toolkit for detailed instructions:
https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf

Please provide documentation to show compliance for the following:

5.1 Mapping

1. Create two tables comparing (1) all covered medical/surgical benefits to mental health benefits by classification, and (2) all medical/surgical benefits to substance use disorder benefits by classification
2. List at three MH/SA benefit in the same classification as available M/S benefits

Additional guidance is found in Section 4 of the Mental Health Parity Toolkit

5.2 Compliance

- Assess if the following requirements have been met by the HMO:
  - Medical necessity determinations for MH/SUD benefits are made available to members and affected ForwardHealth providers upon request
  - Reasons for payment denial for MH/SUD benefits made available to members

See Section 9 of the MH Parity Toolkit for additional instructions to completing the analysis

5.3 Department Checklist

DHS USE ONLY			Mental Health Parity
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	5.1.1 HMO provided tables comparing all covered m/s benefits to mental health benefits by classification and all m/s benefits to substance use disorder benefits by classification.
☐	☐	☐	5.1.2 HMO provided list of MH/SA benefit in the same classification as available M/S benefits
☐	☐	☐	5.2 HMO provided methodology, data sources, and specific percentages for analysis
☐	☐	☐	5.3 HMO provided documentation that the HMO has met the requirements for ○ medical necessity determinations are made available to members and affected ForwardHealth provider upon request ○ reasons for payment denials for MH/SUD benefits made available to members

6 Subcontracts and Memoranda of Understanding (MOUs)

CFR 438.206

1. HMOs must submit a list of all subcontractors and organizations with which there is a MOU/agreement/contract currently in effect.

2. List any of those subcontractors or organizations that are located outside the United States and the functions/duties they perform for your BadgerCare Plus and/or Medicaid SSI program.

DHS may request that HMOs submit specific contracts for review.

6.1 Contract Templates

CFR 438.214

HMOs shall submit contract templates currently used for each of the following subcontract types:

- Key provider types including physicians, group contracts, and facilities
- Independent Practice Association Contract (IPA)
- Administrative Services Agreement (ASA)
- MOU/MOA arrangements

At a minimum, templates should have the following information:

- Name of the subcontractor
- Complete address
- Type of services provided

Please indicate which, if any, of the above subcontract types **DO NOT** apply to your HMO (e.g. if you do not use an IPA, note "NA" for that type):

6.2 Policy and Procedure

1. HMOs must submit policy and procedures for:
   - Delegation
   - Provider Selection, Credentialing and Re-credentialing
2. At a minimum, policies should include:
   1. Pre-delegation evaluation of prospective subcontractor's ability to perform;
   2. Monitoring activities and reporting requirements;
   3. Corrective actions when problems are identified;
   4. Provisions for termination of delegation; and
   5. Provisions for retention by the HMO of the right to make final selection decisions about practitioners and providers credentialed or re-credentialed by a delegate.
   6. Provider selection policies and procedures ensuring non-discrimination of providers and verification that providers excluded from participation in federal health care programs are not part of the HMO's BadgerCare Plus or Medicaid SSI provider network.
   7. Results and analysis from internal monitoring related to provider selection and retention including provider termination for quality issues, appeal procedures and reporting to entities as required by law (DHS, National Practitioner Data Bank, Department of Safety and Professional Services).
   8. Policies and procedures on credentialing and recredentialing of practitioners and institutional providers (hospital, nursing home, home health agency, hospices, and free-standing ambulatory surgical centers) including:
   9. Initial credentialing;
   10. Recredentialing.
   11. How the HMO monitors that the credentialling process is complete within 90 days after receipt of all necessary documents.

6.1 Department Checklist

DHS USE ONLY			Subcontracts
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	6.0.1 Provide list of all subcontractors and organizations with which there is a signed agreement/MOU currently in effect.
☐	☐	☐	6.0.2 Provide a response to identify any subcontractors/organizations used that are located outside the United States and their responsibilities.
☐	☐	☐	6.1.1 Provide contract templates - IPAs
☐	☐	☐	6.1.2 Provide contract templates - ASAs
☐	☐	☐	6.1.3 Provide contract templates - MOUs
			6.2.1 Provide policy and procedure governing delegation and provider selection, credentialing and re-credentialing
☐	☐	☐	6.2.2.1 Pre-delegation evaluation of prospective subcontractor's ability to perform
☐	☐	☐	6.2.2.2 Monitoring activities and reporting requirements
☐	☐	☐	6.2.2.3 Corrective actions when problems are identified
☐	☐	☐	6.2.2.4 Provisions for termination of delegation
☐	☐	☐	6.2.2.5 Provisions for retention by the HMO of the right to make final selection decisions about practitioners and providers credentialed or re-credentialed by a delegate
☐	☐	☐	6.2.2.6 Documentation of policies and procedures on provider selection, credentialing and re-credentialing including: • Non-discrimination of providers; • Verification that providers excluded from participation in federal health care programs are not contracted; • Results and analysis on provider selection and retention including provider termination for quality issues, appeal procedures, and reporting to entities as required by law (DHS, NPDB, DSPS); • Credentialing and re-credentialing for practitioner and institutional provider (hospital, nursing home, home health agency, hospice, and free-standing ambulatory surgical centers).
☐	☐	☐	6.2.2.7 How the HMO monitors completion of the credentialling process.

7 Member Rights & Advocates

CFR 438.100 and 438.10

HMOs are required to educate members, network providers and organization staff of the rights that members are owed under federal and state laws. Through policy and procedure, HMOs must ensure that all members:

- Receive all medically necessary services covered by BadgerCare Plus and Medicaid SSI and are available to in the same manner to all members.

- Are not discriminated against due to , race, , color, national origin, health status, sex, sexual orientation, gender identity, or disability, .

HMOs shall provide policy and procedure documentation outlining:

1. The process, outreach and frequency of outreach of the materials used to inform members of their rights.
2. How the HMO conveys member rights to providers and subcontracts and ensures these rights are respected, specifically that members are not adversely treated when exercising these rights.
3. Use of restrictive measures and restraints. HMO must show:
   a. Information on committee structure and monitoring
4. Requests for access to medical records and the right to amend those records.
5. Advance directives including:
   a. Any differences between conscientious objections and anything raised by individual physicians.
   b. A description of the range of medical conditions or procedures affected by conscientious objection.
   c. How the HMO updates the member's medical records an advance directive and that it has been executed.
   d. How the HMO ensures there is no discrimination against a member for execution of an advance directive.
6. Attestation that members are not liable for:
   a. HMO debt in the event of insolvency
   b. Covered services provided to the member for whom the State does not pay the HMO or does not pay the provider that furnishes the services under a contractual, referral or other arrangement.
   c. Payments for covered services furnished under a contact, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the HMO covered the services directly.
7. HMOs must also provide a description of staff training procedures on member rights including:
   - Who conducts the training
   - Who is trained
   - Specific training on advance directives

7.1 Member Advocate

The HMO must provide documentation showing:

1. Job description(s) of the HMO Member Advocate position(s) as defined in the Contract Article VII(A)
2. Number of FTEs allocated to the advocate position, broken out by BadgerCare Plus vs. Medicaid SSI, if applicable.
3. Other duties or responsibilities of the advocate position(s) other than those required in the HMO contract.

7.2 Department Checklist

DHS USE ONLY			Member Rights & Advocates
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	7.0.1 Policy and procedures for process, outreach, and frequency of outreach, including availability in other languages.
☐	☐	☐	7.0.2 Policy and procedures on how HMO conveys member rights to providers and subcontractors including how HMO ensures how rights are being respected.

☐	☐	☐	7.0.3 Policy and procedures on the use of restrictive measures and restraints which must include:
☐	☐	☐	7.0.3.1 Information describing committee structure and tracking systems for monitoring.
☐	☐	☐	7.0.3.2 If any restrictive measures have been applied, submit the HMO restrictive measures log for the past 12 months.
☐	☐	☐	7.0.4 Policy and procedures to honor members' request to access their medical records and to amend their records.
☐	☐	☐	7.0.5 Policy and procedures concerning advance directives. This must include the following:
☐	☐	☐	7.0.5.1 Clarify any differences between any HMO conscientious objections and those that may be raised by individual physicians.
☐	☐	☐	7.0.5.2 Describe the range of medical conditions or procedures affected by the conscience objection
☐	☐	☐	7.0.5.3 Document in the individual's medical record whether or not the individual has executed an advance directive.
☐	☐	☐	7.0.5.4 How the HMO ensures there is no discrimination against a member for the execution of an advance directive.
☐	☐	☐	7.0.6.1 Attestation that members are not liable for: HMO debt in the event of insolvency
☐	☐	☐	7.0.6.2 Attestation that members are not liable for: Covered services provided to the member for whom the State does not pay the HMO or does not pay the provider that furnishes the services under a contractual, referral or other arrangement.
☐	☐	☐	7.0.6.3 Attestation that members are not liable for: Payments for covered services furnished under a contact, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the HMO covered the services directly.
			7.0.7 HMO provided a description of staff training procedures on member rights including who conducts the training, who is trained, and specific training on advance directives.
☐	☐	☐	7.1.1 Provide functions and duties of the BC+ and SSI Advocate that includes:
☐	☐	☐	• Investigating and resolving access and cultural sensitivity issues identified by HMO staff, State staff, providers, advocate organizations and enrollees.
☐	☐	☐	• Monitoring formal and informal grievances with the grievance personnel for purpose of identifying trends or specific problem areas of access and care delivery. An ongoing participation in the HMO grievance committee.
☐	☐	☐	• Recommend policy and procedural changes to HMO management including those needed to ensure and/or improve enrollee access to care and enrollee quality of care.
☐	☐	☐	• Act as the primary contact for enrollee advocacy groups. Work with enrollee advocacy groups on an ongoing basis to identify and correct enrollee access barriers.
☐	☐	☐	• Act as the primary contact for local community based organizations. Work with the organizations on an ongoing basis to acquire knowledge and insight regarding the special health care needs of enrollees.

☐	☐	☐	• Participate in the Advocacy Program for Managed Care organized by the Department.
☐	☐	☐	• Ongoing analysis of internal HMO system functions, with HMO staff, as these functions affect enrollee access to medical care and enrollee quality of medical care.
☐	☐	☐	• Requirement that Medicaid SSI Advocate is knowledgeable and has experience working with disabled persons.
☐	☐	☐	7.1.2 The number of FTEs allocated to advocate position.
☐	☐	☐	7.1.3 Additional responsibilities outside those required by the Contract.

8 Member Grievances and Appeals

All Wisconsin Medicaid Health Plans are required to implement and enforce all of the requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F, as contained in the HMO and PIHP Member Grievances and Appeals Guide.

8.1 HMOs must:

1. Submit all member grievance and appeal notification documentation to the Department for review and approval prior to use.
2. Provide policy and procedure documentation outlining their grievance and appeal system and how it operates.
3. Identify a contact person in the Health Plan to receive grievances and appeals and be responsible for routing and processing. Provide the contact person's information to the Department.
4. Provide policy and procedure documentation outlining how members are informed about the existence of the grievance and appeal processes and how to use them.
5. Provide policy and procedure documentation outlining how the HMO attempts to resolve issues and concerns without formal hearings or reviews whenever possible.
6. Provide policy and procedure documentation outlining the HMOs filing requirements, timeframes and procedures, for member grievances, appeals and requests for State fair hearings.
7. Provide policy and procedure for submitting the quarterly grievance and appeal reports as required by the Department.

8.2 Department Checklist

DHS USE ONLY			Member Grievances and Appeals
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	8.1.1 Submit all member grievance and appeal notification documentation to the Department for review and approval prior to use.
☐	☐	☐	8.1.2 Provide policy and procedure documentation outlining their grievance and appeal system and how it operates.
☐	☐	☐	8.1.3 Identify a contact person in the Health Plan to receive grievances and appeals and be responsible for routing and processing. Provide the contact person's information to the Department.

☐	☐	☐	8.1.4 Provide policy and procedure documentation outlining how members are informed about the existence of the grievance and appeal processes and how to use them.
☐	☐	☐	8.4.5 Provide policy and procedure documentation outlining how the HMO attempts to resolve issues and concerns without formal hearings or reviews whenever possible.
			8.1.6 Provide policy and procedure documentation outlining the HMOs filing requirements, timeframes and procedures, for member grievances, appeals and requests for State fair hearings.
☐	☐	☐	8.1.7 Provide policy and procedure for submitting the quarterly grievance and appeal reports as required by the Department.

9 Culturally and Linguistically Appropriate Services (CLAS)

HMOs are required to incorporate the National CLAS standards into organizational practices and the delivery of services with a particular focus on care management services. Below are resources to assist HMOs with implementing CLAS standards and providing staff trainings.

- Think Cultural Health
- U.S. Department of Health and Human Services Office of Minority Health
- A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities.
- Culturally and Linguistically Appropriate Services (CLAS) What, Why and How
- Making CLAS Happen: Six Areas for Action – Massachusetts Division of Public Health resource

9.1 HMOs must:

1. Describe how National CLAS standards have been incorporated into organizational practices and delivery of services.
2. Complete and submit the CLAS pledge.
3. Describe and submit any CLAS-related self-assessments and/or trainings the HMO has previously done or plans to complete in the upcoming calendar year as an organization.
4. Describe and submit any CLAS-related evaluation plan the HMO has previously completed or plans to complete in the upcoming calendar year as an organization.
5. Submit policy statements or other documentation that demonstrates how the HMO addresses members who are low income or members of population groups needing specific culturally and linguistically appropriate services. The documentation should include how this information is communicated to providers and other subcontractors. The HMO must provide documentation that shows how the below has been incorporated in its policies, administration, and service practices:
    a. Recognizing members' beliefs,
    b. Screening members for social risk factors and/or health related social needs,
    c. Partnering with community-based organizations to address members' unmet health related social needs,
    d. Addressing cultural and linguistic differences in a responsive manner,
    e. Fostering in its staff and providers' behaviors that effectively address interpersonal communication styles that respect members' cultural backgrounds,

f. Permitting members to change providers based on the provider's ability to provide culturally and linguistically appropriate services, and
g. Requiring culturally and linguistically appropriate grievance and appeal protocols.

9.2 Department Checklist

DHS USE ONLY			Cultural Competency/Culturally and Linguistically Appropriate Services
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	9.1.1 HMO submitted policies and procedures demonstrating how national CLAS standards have been incorporated into organizational practices and delivery of services.
☐	☐	☐	9.1.2 Submit CLAS pledge
☐	☐	☐	9.1.3 Submit any self-assessments and/or trainings.
☐	☐	☐	9.1.4 Describe and submit CLAS evaluation planning
☐	☐	☐	9.1.5. Submit CLAS Standards

10 Language Access and Format Requirements

HMOs are required to provide language access services (including interpreters, sign language, and auxiliary aids and services) free of charge for members as necessary to ensure availability of effective communication regarding treatment, medical history or health education and/or any other component of the contract.

10.1 HMOs must submit the following documentation to the Department:

1. Provide a policy and procedure for language access services, and auxiliary aids and services.
2. Describe the criteria for selection of interpreters including evaluation of competency in both English and other languages; and include information about sign language interpreter services and auxiliary aids and services for members with hearing or vision impairments.
3. Describe how emergency and 24/7 interpretation services will be provided. Describe the mechanism for receiving translation services. Provide a statement of availability of translation services for urgent/emergent situations.
4. Describe how the HMO's monitoring mechanism for member satisfaction, and provider compliance of language access services.
5. Provide a list of all materials produced by the HMO that must be translated. Examples include vital medical information such as consent forms and instructions, handbooks, provider network lists, notices of denial, termination or reduction of services notices, outreach materials, satisfaction surveys, grievance/appeal information, other documents that need a response from the enrollee.
6. Describe how the HMO will assess for the preferred method of communication of each member with a hearing impairment, or vision impairment
7. Describe how the hearing or vision impaired members' preference for the type of auxiliary aid(s) is addressed.
8. Provide a list of all interpreters (including languages spoken) and sign language interpreters, used by the HMO and the procedures for updating the list and evaluating the need for additional interpreters.
9. Describe how members are notified of the availability of free interpretation services including the frequency of the notification, and the manner in which members are notified.

10.2 Large Print Tagline

DHS provided HMOs with the following suggested large print tagline translated in the prevalent non-English languages identified across all HMO Rate Regions (and FamilyCare Geographic Service Regions). The large print tagline is provided in a fillable Word Document and PDF and is available for download at:

- https://www.dhs.wisconsin.gov/publications/p02057.docx
- https://www.dhs.wisconsin.gov/publications/p02057.pdf

The HMO Communication and Outreach Guide contains additional information regarding language and format requirements.

1. HMOs must indicate whether it uses State or HMO developed taglines.
2. HMOs must also submit a copy of the taglines used for written (printed) communications to members.

10.3 Department checklist

DHS USE ONLY			Language Access Policies and Procedures
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	10.1.1 Procedures for providers regarding language access services (including interpreters, sign language, and auxiliary aids and services).
☐	☐	☐	10.1.2 Criteria for selection of interpreters including evaluation of competency in English and other languages. Include information about sign language interpreter services and auxiliary aids for members with hearing or vision impairments.
☐	☐	☐	10.1.3 Describe how emergency and 24/7 interpretation services will be provided. Describe the mechanism for receiving translation services. Provide a statement of availability of translation services for urgent/emergent situations.
☐	☐	☐	10.1.4 Describe the HMOs monitoring mechanism for member satisfaction, provider compliance/satisfaction with LEP services,
☐	☐	☐	10.1.5 Provide a list of materials that must be produced by the HMO that must be translated such as: Vital medical information (consent forms, pre/post operation instructions), Handbooks, Provider network lists, Notices of denial, termination or reduction of services, Outreach materials, Satisfaction surveys, Grievance/appeal information, Other documents that need a response from the enrollee, HealthCheck materials, Birth to 3 materials
☐	☐	☐	10.1.6 Describe how the HMO will identify hearing impaired, vision impaired, or LEP members and how they will be served adequately.
☐	☐	☐	10.1.7 Describe how the hearing or vision impaired members' preference for the type of auxiliary aid(s) is addressed.
			10.1.8 Provide a list of all current interpreters used by the HMO. Provide procedures for updating the list and for evaluating interpreters.

☐	☐	☐	10.1.9 Describe how enrollees are notified of the availability of free interpretation services, and the frequency of notifications and manner in which enrollees are notified.
☐	☐	☐	10.2.1 HMO indicated whether it uses State or HMO developed taglines.
☐	☐	☐	10.2.2 HMO submitted a copy of the taglines used for written (printed) communications to members.

11 Provider Appeals Process

HMOs are required to submit written documentation of the provider appeals process, consisting of:

1. For Departmental use: The name, phone number and email of the person(s) within the HMO responsible for receiving, routing and processing appeals. A shared or dedicated email address to receive communication and documents is required.
2. For Providers: The location and description of policies and procedures for adjudicating claims and appeals. Include web address for online Provider resources, ie policy announcements, provider manual or other resources. Resource should include information on timely claim filing, coordination of benefits or other insurance, and recoupment information.
3. Documentation of how providers are advised of their right to appeal to the HMO a payment denial or reduction in payment. This language must include the steps necessary to file an appeal and the contractually approved timeliness guidelines or at minimum 60 days from the date of the denial remittance or explanation of payment.
    1. Samples of all claim remittance advice notices with provider appeal language included. Each page of the remittance must include the date the remittance was processed.
4. Documentation of how providers are advised of their right to appeal to the Department if they disagree with the HMO appeal response. This language must include how to appeal to the Department if the HMO fails to respond to their appeal within 45 days: an appeal to the Department must be received at minimum 60 calendar days from the date of the HMOs appeal response or from the 45 calendar days allowed for the HMO response.
    1. Samples of **all** template notification letters sent to providers as a result of an appeal submitted
5. A description of how the HMO assures that provider appeals pertaining to BadgerCare Plus and Medicaid SSI services are adjudicated using Medicaid (not commercial) policies and procedures.
6. Provide a description of the HMO's appeal process. If the HMO distinguishes between claim reconsiderations and formal appeal, provide the HMOs definition of each. Provide an explanation of timeliness for all requirements of an appeal. Provide an explanation of how providers are informed of these requirements.

11.1 Department Checklist

DHS USE ONLY			Provider Appeals System
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	11.1 For Departmental use: The name, phone number and email or dedicated email address of the person(s) within the HMO responsible for receiving, routing and processing appeals.
☐	☐	☐	11.2 For Providers use: The location (website links) and description of policies and procedures for adjudicating claims and appeals. Include website link for provider resources.

☐	☐	☐	11.3 Location of language of how providers are advised of their right to appeal to the HMO a payment denial or reduction in payment. This language must include contractually approved timeliness guidelines or at minimum 60 days from the date of the denial remittance or explanation of payment.
☐	☐	☐	11.3.1 Sample copy of claim remittance advice notices with claim denial reason and code/explanation. This notice must include: A statement regarding the provider's rights and responsibilities in appealing to the HMO about the HMO's payment/denial determination. Each page of the remittance must include the date the claim was processed.
☐	☐	☐	11.4 Location of language on how providers are advised of their right to appeal to the Department if they disagree with the HMO appeal response.
☐	☐	☐	11.4.1 Samples of all template notification letters sent to providers as a result of an appeal submitted. The language must: • Inform providers that the HMO must respond to their appeal within 45 calendar days of postmark. • Inform providers how to appeal to the Department if the HMO fails to respond to their appeal within 45 days. • Inform providers that an appeal to the Department must be received within 60 calendar days from the date of the HMOs appeal response or from the 45 calendar days allowed for the HMO response.
☐	☐	☐	11.5 Provide a description of how the HMO assures that provider appeals pertaining to BadgerCare Plus and Medicaid SSI services are adjudicated using Medicaid (not commercial) policies and procedures.
☐	☐	☐	11.6 Provide a description of the HMOs appeal process including timeframes. Provide an explanation of how providers are informed of this process.

12 Member Communication, Outreach, and Marketing

All Wisconsin Medicaid Health Plans are required to implement and enforce all of the requirements regarding member outreach and marketing processes, including Title 42 Code of Federal Regulations (CFR) §§ 438.10 and 438.104, as contained in Contract and the HMO and PIHP Communication, Outreach, and Marketing Guide.

12.1 HMO must:

1. Provide marketing policies and procedures to the Department for review.
    - Must indicate how the HMO assures materials are not distributed without first obtaining State approval,
    - Complies with the information requirements of § 438.10 to ensure that, before enrolling, the beneficiary receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll
    - Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance (see Addendums II and III of the HMO and PIHP Communication, Outreach, and Marketing Guide for additional state guidance, including examples); and
    - Does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

2. Provide member communication and marketing policies and procedures to the Department for review.
    - Must be designed to provide clear, concise, and factual information about the Health Plan's plan, the Health Plan's network, and the BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and/or Wraparound Milwaukee programs.
    - Must be primarily focused on providing public health messages, benefit education, care management, accessing services, or improving health literacy for both Medicaid and potential Medicaid members.
    - Use professional language access staff (for language access services and auxiliary aids and services), as needed, where technical, medical, or treatment information or other matters, where impartiality is critical, are to be discussed or where use of a family member or friend, as interpreter is otherwise inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.
    - Maintain a current list of "On Call" interpreters who can provide interpreter services. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act.
    - Document all actions and results for any language access services provided to members and be available to the Department upon request.
    - Designate a staff person to be responsible for the administration of language access services and auxiliary aids and services.
    - HMO and PIHP must notify members of transition of care requirements as defined in 42 CFR § 438.62 and Article VII(F)(8) of the contract.
3. Submit to the Department the HMO's Member Communication and Outreach Plan.

12.2 Department Checklist

DHS USE ONLY			Member Communication, Outreach, and Marketing
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	12.1 Provide marketing policies and procedures to the Department for review.
☐	☐	☐	12.2 Provide member communication and marketing policies and procedures to the Department for review.
☐	☐	☐	12.3 Submit to the Department the HMO's Member Communication and Outreach Plan.

13 Member Handbook and Provider Directory

13.1 Member Handbook

A Member Handbook is required to be sent to each new member upon enrollment to provide members information on where they can get assistance for all the services provided by the HMO including:

- Routine and emergency care
- Member rights
- Member grievance and appeal procedures

1. Per Contract, the HMO is required to submit an updated BadgerCare Plus and Medicaid SSI HMO member handbook to the Department within 60 days of signing the contract.
2. After the Department reviews and approves the member handbook, each HMO must post the member handbook on their website. The HMO must then share a website link with the Department so that the handbook will be listed on the ForwardHealth website as a resource for members.
3. As part of the certification application, each HMO shall submit policies and procedures on providing the member handbook to members that includes:
    - A description of how the HMO will share the member handbook with members (i.e., mail, electronic copy) as well as the timeframe for doing so. The response should address distribution to newly enrolled members as well as members who must receive the updated handbook annually.
    - A description of the process for members to request the handbook in different languages, alternative formats, and oral interpretation. Include how the HMO will comply with the request.

13.2 Provider Directory

1. Per the BadgerCare Plus and Medicaid SSI Contract, HMOs must share a provider directory with members and providers that must be posted on their website and updated per contractual requirements. Each HMO shall submit a copy of their provider directory electronically to the Department for review. The provider directory must include all information specified in the HMO and PIHP Communication, Outreach, and Marketing Guide.
2. HMOs shall submit policies and procedures regarding the provider directory including:
    - A description on how the HMO will share the provider directory with members (i.e., mail or electronic copy) as well as the timeframe for doing so.
    - A description of the process for updating the provider directory and making it available to members and providers.
    - The process for notifying members when a provider contract is terminated, including the template of the written notification sent to members.

13.3 Department Checklist

DHS USE ONLY			Member Handbook and Provider Directory
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	13.1 The HMO submitted a copy of the member handbook for DHS review within 60 days of the contract signature.
☐	☐	☐	13.2 The HMO published the member handbook on its website, and shared a URL with DHS to be added to ForwardHealth.
☐	☐	☐	13.3 The HMO submitted policies and procedures related to the member handbook that included: • A description of the process used by the HMO to make the handbook available to members and the timeframe. • A description of the process for updating the provider directory and making it available to members and providers. • A description of the process used by members to request the handbook in different languages, formats, or oral interpretation. Included how the HMO will comply with the request.

☐	☐	☐	13.2.1 The HMO provided an electronic copy of the provider directory to the Department for review. The directory met all contractual requirements.
☐	☐	☐	13.2.2 The HMO submitted policies and procedures related to the provider directory that included: • A description on how the HMO will share the provider directory with members (i.e., mail or electronic copy) as well as the timeframe for doing so. • A description of the process for updating the provider directory and making it available to members and providers. • The process for notifying members when a provider contract is terminated, including the template of the written notification sent to members.

14 Quality Improvement

Per CFR 438.240, the HMO is required to have an ongoing Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to their members. At a minimum, the HMO QAPI program must comply with the following requirements:

- Conduct Performance Improvement Projects
- Submit performance measurement data
- Have mechanisms in place to detect underutilization and overutilization of services
- Have mechanisms in effect to assess the quality and appropriateness of care furnished to members with special health care needs.

14.1 QAPI Program

1. Quality program description, areas of focus, and provider performance monitoring
2. QAPI committee structure and position descriptions
3. Frequency of QAPI meetings and provide copies of the most recent QAPI meeting minutes
4. Most recent annual QAPI work plan and QAPI annual report including:
    1. Annual plan to meet its Pay-for-Performance (P4P) goals and submit NCQA audited P4P results to the Department on time;
    2. Annual Performance Improvement Projects (PIPs) topic selection, implementation, monitoring, and final report submission to the Department and MetaStar.
5. Evaluation of the QAPI program to determine if the HMO is meeting its goals.
6. Data and related documentation which shows monitoring of:
    1. Quality of care and services in clinical and non-clinical areas;
    2. Member satisfaction;
    3. Access to providers and verification that services members needed were provided.

14.2 Clinical Practice Guidelines

1. Description of the clinical evidence based practice guidelines used by the HMO for utilization management, member education on health and disease management, coverage of services and other areas to which the guidelines may apply. These guidelines must be compliant with 42 CFR 438.236(b)
2. Policies and procedures related to how the HMO and its providers in-network are adopting the guidelines.

3. Description of the process used by the HMO to make those guidelines available to their providers and members (upon request).

14.3 Utilization Management

A description of the mechanisms in place to detect underutilization and overutilization of services as well as a description of the actions the HMO would undertake to correct that. Policies and procedures governing utilization management (UM) including:

1. Medical record review tools
   a. Policies and procedures related to medical record review including instructions;
   b. Medical record review results (including numerators and denominators and analysis for prior twelve months;
   c. Documentation related to any resulting improvement efforts;
   d. Policies and procedures for other methods used to assess and improve quality of care.

2. Adverse Actions
   a. Policies and procedures on notification of adverse actions and timeliness of decisions;
   b. Persons authorized to make denial decisions based on medical necessity;
   c. UM criteria conformity with applicable HMO clinical practice guidelines and inter-rater reliability.

3. Policies for processing expedited and urgent authorization requests.

4. Description of the utilization management practices used by HMOs on emergency and post-stabilization services.
   a. Instructional materials for members related to use of emergency services.

5. UM committee meeting minutes for prior six months.

14.4 Members with Special Health Care Needs

1. Policies and procedures for identification of members with special health care needs including a needs assessment, care plan development and delivery of care.

2. Pregnant women are members with special health care needs. Submit policies and procedures on continuity and coordination of care, particularly for pregnant and post-partum women (i.e. interconception care), those with chronic conditions, and high-cost members.

14.5 Telephone Triage

Policy and procedure governing telephone triage, clinical protocols in use, clinical credentials required for staff (a description of the minimum credentials required), and copy of annual evaluation of the clinical appropriateness of decisions made through the system. **(Applies only to HMOs using "nurse lines" or other telephone triage demand management systems. If no such system is in operation, please provide written indication).**

14.6 Department Checklist

DHS USE ONLY			Quality Improvement
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	14.1.1 QAPI program description, including description of program monitoring and oversight, committees, position descriptions and FTE staffing data.
☐	☐	☐	14.1.2 QAPI committee structure and position descriptions
☐	☐	☐	14.1.3 Frequency of QAPI meetings and provide copies of the most recent QAPI meeting minutes.
☐	☐	☐	14.1.4 Must show most recent annual QAPI work plan. The work plan must include P4P and PIP information.
☐	☐	☐	14.1.5 Evaluation of the effectiveness of the QAPI program.

☐	☐	☐	14.1.6 Data and related documentation to monitor quality of care, member satisfaction, and access to care and verification that services members needed were provided.
☐	☐	☐	14.2.1 Description and sample of the clinical evidence-based practice guidelines used by the HMO for utilization management, member education on health and disease management, coverage of services and other areas to which the guidelines may apply. These guidelines must meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of providers in the particular field • Consider the needs of the HMO members • Are adopted in consultation with contracting health care professionals • Are reviewed and updated periodically as appropriate
☐	☐	☐	14.2.2 Policies and procedures that show how the HMO and its in-network providers are adopting the clinical guidelines and how the HMO makes those guidelines available to their providers and members.
☐	☐	☐	14.2.3 Description of the process used by the HMO to make those guidelines available to their providers and members (upon request).
☐	☐	☐	14.3.1 Medical record review tools.
☐	☐	☐	14.3.2 Notification of adverse actions, timeliness of decisions, persons authorized to make denial decisions based on medical necessity, UM criteria conformity with applicable HMO clinical proactive guidelines and inter-rater reliability.
☐	☐	☐	14.3.3 Policies for processing expedited and urgent authorization request.
☐	☐	☐	14.3.4 Description of the utilization management guidelines for emergency and post-stabilization services. • Instructional materials for members on appropriate utilization of emergency services.
☐	☐	☐	14.3.5 UM committee minutes for last six months.
☐	☐	☐	14.4.1 Policy and procedures for identification of members with special health care needs assessment and delivery
☐	☐	☐	14.4.2 Policy and procedures for coordination of care for pregnant and post-partum women, members with chronic conditions or high-cost members.
☐	☐	☐	14.5 Policy and procedure including clinical protocols in use, clinical credentials required for staff and a copy of annual evaluation of the clinical appropriateness of decisions made through the system. This applies only to nurse lines where clinical advice is provided by phone. If no such system is in operation, please provide written rationale.

15 Reporting and Data Administration

The Department requires the HMOs to meet security, data, claims and encounter processing, computer system, and reporting standards outlined in the 2020-2021 BadgerCare Plus and Medicaid SSI Contract, sections 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.

1. Indicate if the HMO has written policies, procedures, and training materials that articulate the organization's ability to comply with all applicable reporting and data requirements under the HMO contract.

   If applicable, indicate if the HMO subcontractor contracts include the same requirement to comply with the Department requirements under the HMO contract.

2. Provide the number of HMO and/or subcontractor full-time equivalent (FTE) staff dedicated to supporting the Wisconsin BadgerCare Plus and Medicaid SSI contract requirements for each standard below.

   > FTE Example: The HMO employee spends 20% of her/his time each on data security, data retention, claims processing, encounter processing, and on unrelated activities. The HMO records .2 FTE each for Data Security and Privacy, Data Retention, Claims Processing, and Encounter Processing.

3. For each standard, please indicate if the HMO has written policies/procedures, training materials, and whether or not applicable subcontractors are required to have similar materials.

   For each answer marked with a "Yes", please provide a brief description of the written policies/procedures and how they are maintained as well as any associated staff training. Responses should be limited to one or two paragraphs for each standard. Please do not provide the actual written policy/procedure materials.

   For each answer marked with a "No", the HMO has one year from the signing of the annual contract to develop materials in order to be compliant with this requirement by the second year of the contract.

   Does the HMO have written policies and procedures for?

Standard	*Yes (Check One)*	*No (Check One)*
Data Security and Privacy	☐	☐
Secure SFTP Use	☐	☐
Secure ForwardHealth Portal Use	☐	☐
Data Retention – 10 Years for All Instances Cited in the HMO Contract	☐	☐
Distribution of Access Payments as Described in Article XVI	☐	☐
Encounter Based Payments and Ad Hoc Cash Transactions Processing	☐	☐
Quarterly and Annual Financial Template Completion	☐	☐

   Does the HMO have written training materials for?

Standard	*Yes (Check One)*	*No (Check One)*
Data Security and Privacy	☐	☐
Secure SFTP Use	☐	☐
Secure ForwardHealth Portal Use	☐	☐
Data Retention – 10 Years for All Instances Cited in the HMO Contract	☐	☐
Distribution of Access Payments as Described in Article XVI	☐	☐

Encounter Based Payments and Ad Hoc Cash Transactions Processing	☐	☐
Quarterly and Annual Financial Template Completion	☐	☐

Does the HMO require similar written policy/procedure and training materials for subcontracts on?

Standard	*Yes (Check One)*	*No (Check One)*	*N/A (Check One)*
Data Security and Privacy	☐	☐	☐
Secure SFTP Use	☐	☐	☐
Secure ForwardHealth Portal Use	☐	☐	☐
Data Retention – 10 Years for All Instances Cited in the HMO Contract	☐	☐	☐
Distribution of Access Payments as Described in Article XVI	☐	☐	☐
Encounter Based Payments and Ad Hoc Cash Transactions Processing	☐	☐	☐
Quarterly and Annual Financial Template Completion	☐	☐	☐

Provide the number of HMO and/or subcontractor full-time equivalent (FTE) staff dedicated to supporting the Wisconsin BadgerCare Plus and Medicaid SSI HMO contract requirement.

Standard	*HMO FTE*	*Subcontractor FTE*
Data Security and Privacy		
Secure SFTP Use		
Secure ForwardHealth Portal Use		
Data Retention – 10 Years for All Instances Cited in the HMO Contract		
Distribution of Access Payments as Described in Article XVI		
Encounter Based Payments and Ad Hoc Cash Transactions Processing		
Quarterly and Annual Financial Template Completion		

4. Please provide 2-3 page responses to the following questions. The responses should be clearly labeled to indicate which part of the question is being addressed with each response. The descriptions should include the number of HMO and/or subcontractor full-time equivalent (FTE) staff dedicated to supporting the contract requirements in each section below as well as where the FTE is located geographically.

    1. Describe the system hardware and software, the technical resources that will be used, and the name of the agency or organization (e.g., HMO, outside vendor, etc.) responsible for the following:
        a. Claims processing
        b. Monitoring enrollment and disenrollment
        c. Non-encounter data reporting (e.g., Neonatal ICU patient care data)
        d. Encounter data reporting.

2. The BadgerCare Plus and Medicaid SSI HMO contract requires the HMO to only use providers enrolled in the Wisconsin Medicaid program when rendering services to Wisconsin Medicaid members. The HMOs must work with providers utilized in emergencies or out of area situations to ensure their enrollment as a Wisconsin Medicaid Certified provider.
   - Describe how the HMO currently updates its provider file with Wisconsin Medicaid provider IDs and NPI numbers.
   - Describe how the HMO ensures that, when new providers are added to the HMO network, they are appropriately enrolled in the Wisconsin BadgerCare Plus and/or Medicaid SSI program and have a valid NPI (or Medicaid assigned non-NPI for atypical providers).

3. The HMO may submit encounter data to the department from third party vendors who pay and process claims on the HMO's behalf (e.g., behavioral health benefits manager and dental benefits administrator).
   - Identify any third party vendors, the services provided, and the type of services (e.g., inpatient, behavioral health, etc.) provided.
   - Describe how the HMO obtains the required data from the third party vendors, how often (e.g., monthly), and the timeliness of the data (i.e., how soon after the date of service is the data transmitted to the HMO, and subsequently to the department as encounters).
   - Describe how the HMO ensures accuracy of data (through audit or other means).

4. Describe quality control measures of HMO information systems for both claim and encounter processing.
   - How and how often (daily, etc.) is system performance monitored?
   - What processes are in place to identify and inform staff of any system performance problems?
   - Provide a summary document of your system's current disaster recovery program.

5. Describe your method for allocating administrative expenses to the BadgerCare Plus/SSI programs. The allocation methodology described must be consistent with that used in submitting administrative costs to the Department on the financial template, as required under the rate setting process. Include a description of the methods for allocating between product lines and eligibility categories.

6. Describe how the HMO monitors and verifies that at least 90% of adjudicated clean claims from subcontractors/providers will be paid for covered medically necessary services within 30 days of receipt of a clean claim, 99% within 90 days, and 100% within 180 days of receipt.

7. Describe the process used to convert provider claims to encounters.
   - What is the process to submit the converted claims as encounters on a monthly basis?

8. Describe the process followed to determine that abortion and sterilization services meet requirements of Wis. Stats., Ch. 20.927; Wis. Stats., Ch. 253.107; 42 CFR 441 Subpart E-Abortions, and 42 CFR 441 Subpart F-Sterilizations.

9. Provide a list of the ForwardHealth reports found on the Comprehensive HMO Report Matrix currently being used by your HMO.
   - A link to the Comprehensive HMO Report Matrix is below: https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage

10. Provide a list of HMO/subcontractor staff required to attend the monthly Encounter Technical Work Group. The list should include the staff member's title.

15.1 Department Checklist

DHS USE ONLY			Reporting and Data Administration
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	15.1 The HMO indicated it has written policies, procedures, and training materials that articulate the organization's ability to comply with all applicable reporting and data requirements under the contract. The HMO indicated if the HMO subcontractor contracts include the same requirement.
☐	☐	☐	15.2 The HMO provided the number of HMO and/or subcontractor full-time equivalent (FTE) staff dedicated to supporting the Wisconsin BadgerCare Plus and Medicaid SSI contract requirements for each standards as indicated.
☐	☐	☐	15.3 The HMO indicated they have written policies and procedures for: • Data Security and Privacy • Secure SFTP Use • Secure ForwardHealth Portal Use • Data Retention – 10 Years for All Instances Cited in the HMO Contract • Distribution of Access Payments as Described in Article XVI • Encounter Based Payments and Ad Hoc Cash Transactions Processing • Quarterly and Annual Financial Template Completion
☐	☐	☐	15.3 The HMO indicated they have written training materials for: • Data Security and Privacy • Secure SFTP Use • Secure ForwardHealth Portal Use • Data Retention – 10 Years for All Instances Cited in the HMO Contract • Distribution of Access Payments as Described in Article XVI • Encounter Based Payments and Ad Hoc Cash Transactions Processing • Quarterly and Annual Financial Template Completion
☐	☐	☐	15.3 The HMO indicated they have similar written policy/procedure and training materials for subcontracts on: • Data Security and Privacy • Secure SFTP Use • Secure ForwardHealth Portal Use • Data Retention – 10 Years for All Instances Cited in the HMO Contract • Distribution of Access Payments as Described in Article XVI • Encounter Based Payments and Ad Hoc Cash Transactions Processing • Quarterly and Annual Financial Template Completion
			15.4.1 The HMO described the system hardware and software, the technical resources that will be used, and the name of the agency

			or organization (e.g., HMO, outside vendor, etc.) responsible for the following: • Claims processing • Monitoring enrollment and disenrollment • Non-encounter data reporting (e.g., Neonatal ICU patient care data) • Encounter data reporting.
			15.5 The HMO Described their method for allocating administrative expenses to the BadgerCare Plus/SSI programs. The allocation methodology described must be consistent with that used in submitting administrative costs to the Department on the financial template, as required under the rate setting process. Include a description of the methods for allocating between product lines and eligibility categories.
			15.6 The HMO described how the HMO monitors and verifies that at least 90% of adjudicated clean claims from subcontractors/providers will be paid for covered medically necessary services within 30 days of receipt of a clean claim, 99% within 90 days, and 100% within 180 days of receipt.
			15.7 The HMO described the process used to convert provider claims to encounters. • What is the process to submit the converted claims as encounters on a monthly basis?
☐	☐	☐	15.8 Wis. Stats., Ch. 20.927 The HMO does not submit Medicaid encounters for an abortion except with a signed physician certification on file that it is medically necessary to save the life of the woman or in a case of sexual assault or incest; or to prevent grave, long-lasting physical health damage to the woman due to a medical condition existing prior to the abortion.
☐	☐	☐	15.8 Wis. Stats., Ch. 253.107 The HMO does not submit Medicaid encounters for an abortion if the probable post fertilization age of the unborn child is 20 or more weeks unless because of a medical emergency, defined as: a condition, in a physician's reasonable medical judgment, that so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a 24-hour delay in performance or inducement of an abortion will create serious risk of substantial and irreversible impairment of one or more of the woman's major bodily functions.
☐	☐	☐	15.8 42 CFR 441 Subpart E-Abortions The HMO does not submit Medicaid encounters for expenses related to an abortion unless it has on file the physician's certification that the life of the mother would be endangered if the fetus were carried to term, including the name and address of the patient.
☐	☐	☐	15.8 42 CFR 441 Subpart F-Sterilizations The HMO does submit Medicaid encounters for expenses related to sterilization only if the individual is mentally competent, at least 21 years old at the time consent is obtained, has voluntarily given informed consent; and there is at least 30 days, but not more than 180 days, between the date of informed consent and the date of the sterilization (refer to Subpart F for exceptions).

☐	☐	☐	15.8 42 CFR 441 Subpart F-Sterilizations The HMO does not submit Medicaid encounters for expenses related to sterilization by hysterectomy if it was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.
☐	☐	☐	15.8 42 CFR 441 Subpart F-Sterilizations The HMO does submit Medicaid encounters for expenses related to sterilization by hysterectomy, except with the restrictions immediately above, only if the person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and the individual or her representative, if any, has signed a written acknowledgment of receipt of that information.
☐	☐	☐	15.8 42 CFR 441 Subpart F-Sterilizations The HMO does submit Medicaid encounters for expenses related to sterilization by hysterectomy, except with the restrictions immediately above, if the physician who performs the hysterectomy certified in writing that the individual was already sterile at the time of the hysterectomy, and states the cause of the sterility; or certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. He or she must also include a description of the nature of the emergency.
☐	☐	☐	15.8 Wis. Stats., Ch. 20.927, 253.107; 42 CFR 441 Subpart E and F The HMO has on file all documentation required for the abortion or sterilization, including but not limited to consent from, an acknowledgement of receipt of hysterectomy information or a physician's certification.
☐	☐	☐	15.9 HMO Report Matrix Identification
☐	☐	☐	15.10 Technical Work Group Attendance

16 Care Management System and Continuity of Care

16.1 Care Management Requirements for All Members

Per Article III, Section A of the HMO contract, the HMO shall submit their care management and care coordination policies, procedures, and additional documentation to the Department. This information shall include the following:

1. **Information Sharing for New Members:** Policies and procedures to utilize member-specific information provided by the Department as described in Article III (A)(1) of the HMO contract.

2. **Screening Requirements:** Policies and procedures to describe how the HMO will make a best effort to conduct an initial screening of each member's needs, within 90 days of HMO enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful.

Please Note: Find additional requirements on timelines, outreach efforts, etc. for BadgerCare Plus and SSI specific populations later in this section. Contractual requirements of this section are located in Article III, Sections B and C of the HMO contract.

3. **Care Coordination Requirements:** Policies and procedures on how the HMO will coordinate and provide Medicaid-covered, medically necessary services to members in accordance with the needs identified in the initial screen as described in Article III (A)(4) of the HMO contract.

4. **Members with Special Needs:** Policies and procedures to describe the identification, assessment, development of treatment service plans, and access to specialists for members with special needs as identified in Article III (A)(5) of the HMO contract.

5. **Participation in Wisconsin Statewide Health Information Network (WISHIN):** Submit documentation showing compliance with the medical record requirements by participating in WISHIN.

16.2 Care Management Requirements for BadgerCare Plus Members

HMOs that contract with the Department to provide covered services to the BadgerCare Plus population must describe how they will meet the care management requirements defined in Article III, Section B of the HMO contract. Your submission must include:

1. An initial screen(s) the HMO utilizes for the BadgerCare Plus population.
2. A description of the staff conducting the member screens including titles, credentials, and qualifications.
    1. HMOs must include how many FTEs conduct the member screens.
        - The HMO must also indicate the average number BadgerCare Plus members they serve per month.
    2. HMOs serving both BadgerCare Plus and SSI populations must describe whether or not the same staff conducts these screens and SSI Care Management member outreach processes.
        - If the same staff conducts both outreach processes, the HMO must include how many FTEs they have employed with the average numbers of both BadgerCare Plus and SSI members they serve per month.
3. Policies and procedures to conduct member outreach for the completion of the member screens including:
    - A description of the process to engage members to complete the screen with methods of outreach (phone calls and mailings) and timeline of outreach.
    - A description of their processes to identify and engage hard-to-reach members to complete the screen including the methods and timeline of outreach (i.e., phone calls and mailings).
    - A description of their processes to engage members that initially refused to complete the screen including the methods and timeline of additional member outreach (i.e., phone calls and mailings).
    - A description of the process to capture the responses to the screen.
4. Policies and procedures to prioritize members for additional assessments and care management interventions based on the member's responses to the screen.
5. Policies and procedures documenting the inclusion of drivers of health and referrals in their screening process.

The HMO shall notify the Department of any changes made to these policies and procedures prior to their implementation.

In order for the screens and other materials submitted by the HMO in this section to be considered proprietary and exempt from public records requests, the HMOs needs to notify the Department upon submission that all of these materials are to be considered as trade secrets per Wis. Stat. 134.90(1)(c).

16.3 SSI Care Management Practices (SSI HMOs only)

HMOs that contract with the Department to provide covered services to the SSI population must describe how they will meet the care management requirements defined in Article III, Section B of the BadgerCare Plus and Medicaid SSI HMO contract. Your submission must include:

1. **Care Management Staff:** Policies, procedures, position descriptions, and subcontracts that describe the staff responsible for providing care management to SSI members. The documentation must include:

    1. An organization chart with the names and positions of the HMO's care management staff.
    2. Position descriptions with the names, credentials, duties, and caseload of each care management staff member.
        - Include in this section how many FTEs the HMO has and the average number of members served per month.
    3. A description of the HMO staff conducting each of the following care management activities with their names, titles, credentials, and average of members served or caseload:
        - Member Outreach.
        - Screening.
        - Care Plan Development.
        - Care Management Service Delivery (Implementing the Care Plan by delivering services outlined in the Care Plan) – Describe differences in the staff implementing interventions in the Care Plan for high-need Wisconsin Interdisciplinary Care Team (WICT) members vs. non-WICT members.
        - Care Plan Review and Updates.
        - Transitional Care.

2. **Member Outreach:** Policies, procedures, and additional documentation to conduct outreach activities for SSI members after their HMO enrollment including the following:

    1. Policies and procedures describing the process used by the HMO to conduct outreach activities for SSI members, including methods of outreach (i.e., phone calls, mailings, videoconference, and home visits) and the timeline and sequence of each outreach activity.
    2. A description of how HMO staff handles member refusals and the process the HMO follows to re-engage members that have previously refused outreach calls or care management, including the timeline of additional outreach.

3. **Screening:** Policies, procedures, and additional documentation to conduct a screening of every SSI Managed Care new or re-enrolled member within 60 days of enrollment in the HMO, as indicated in the contract and current members annually including the following:

    1. The screening questionnaire for new members.
    2. The screening questionnaire for current members if different from above.

3. A description of the screening process including how and where HMO staff capture member responses to the screening.
4. Social Determinants
   a. A description of the social determinants identified in the screening.
   b. A description of how the HMO documents the member's support network (including family and social supports as well as relationships with community resources).
5. Member-centric Care
   - A description of how the screening captures the member's perception of their strengths and well-being.
   - A description of how the staff captures member's health and life goals.
   - A description of how the screening captures any immediate and long-term concerns the member has about their well-being.
6. Behavioral Health
   - A description of the behavioral health conditions that are included in the screening and the type of follow-up conducted by the HMO if a member is identified as potentially having one of those behavioral health conditions.

4. **Care Plan Development:** Policies, procedures, and additional documentation to develop a Care Plan within 30 days of completion of the screening or within 90 days of HMO enrollment, whichever is sooner, including the following:

1. The Care Plan template.
2. A description of the process for timely completion of the Care Plan; including:
   - A detailed timeline with a description of the process the HMO utilizes to complete the Care Plan.
   - Modes of contact to develop the Care Plan.
3. A description of how the HMO uses the following data sources to develop the Care Plan:
   - Member's needs, issues, and preferences identified in the screening.
   - DHS' reports with prior Medicaid utilization information.
   - Member's medical records.
   - Community agency information based on the member's social determinant needs. For example, if a member needs assistance with housing, the HMO must document that need in the Care Plan and if the member is currently in a homeless shelter, the HMO must reach out to the shelter to obtain information about the stability of the member's current living arrangements.
4. Member-centric Care
   - A description of how the HMO engages the member in the development of the Care Plan.
   - A description of how the HMO identifies the member's formal and informal supports.
   - A description of how the HMO defines specific goals appropriate for the member's needs with the member's input.
   - A description of the process the HMO uses to assess the member's readiness to self-manage their care and their willingness to adopt healthy behaviors. Some HMOs may utilize standard tools like the Patient Activation Measures (PAM) to monitor member engagement in their care.

- A description of how HMO staff documents the member's consent with the Care Plan.

5. Medical/Dental/Behavioral Health/Social Determinant Needs
    - A description of the chronic and acute illnesses included in the Care Plan. At a minimum, the HMO must include questions related to diabetes, asthma, COPD, congestive heart failure, and prenatal and post-partum care. The HMO must also describe how it analyzes data from the Care Coordination reports, which includes 24 months of encounter data and FFS claims, to identify the member's conditions.
    - A description of how the HMO captures the member's need for medication management in the Care Plan. The HMO must also describe how it analyzes pharmacy data from the Care Coordination reports to assess members' medication management needs.
    - A description of the behavioral health conditions included in the Care Plan. The HMO must also describe how it analyzes data from the Care Coordination reports to identify the member's behavioral health conditions.
    - A description of how the HMO integrates the member's dental care needs into the Care Plan.
    - A description of how the HMO captures the member's needs for additional supports to conduct Activities for Daily Living (including, but not limited to, bathing, dressing, and eating) and Instrumental Activities for Daily Living (including, but not limited to, medication management, money management, and transportation) in the Care Plan.
    - A description of how the HMO captures the member's social determinant needs in the Care Plan.
6. Treatment Plan - A description of the process used by the HMO to identify the interventions that will be implemented to address the member's medical, behavioral health, dental and social determinant needs in the Care Plan and their sequence.
7. Care Plan Sharing
    - A description of how the Care Plan information is shared with the member and/or legal guardian.
    - A description of how the HMO shares the Care Plan with the member's primary care provider and other specialists as appropriate.
    - A description of how the HMO shares relevant portions of the Care Plan interventions with community agencies and other partners as appropriate and with the member's consent. For example, a member lives in a homeless shelter and may need assistance storing diabetic supplies; the HMO must share relevant portions of the Care Plan, with the member's consent, with staff from the shelter to help the member store the supplies.

5. **Care Management Service Delivery:** Policies, procedures, and additional documentation on how the HMO coordinates delivery of services and implements the interventions defined in the Care Plan including the following:

    1. A description of how the HMO ensures continuity of care for new members who were receiving services under fee-for-service.

- Per Art.VII, Section F. Coordination and Continuation of Care of the HMO Contract, the SSI HMO must:
    - Authorize approved prior authorizations at the utilization level previously authorized for 90 daysAuthorize coverage of state plan approved services with the member's current providers for the first 90 days of enrollment.

2. A description of how the HMO ensures that services delivered address the medical, dental, and behavioral health needs identified in the Care Plan.
3. A description of how the HMO will coordinate with community agencies and other resources to address the member's social determinant needs identified in the Care Plan, beyond referrals only.
4. A description of how the HMO assesses the member's readiness to change and their level of engagement in meeting their Care Plan goals.
5. A description of how the HMO follows-up with the member to determine if the services delivered addressed their needs.

6. Care Plan Review and Update: Policies, procedures, and additional documentation on how the HMO reviews and updates the member's Care Plan with the following information:

- Policies and procedures with the process and criteria for reviewing and updating the Care Plan with members, at a minimum, once a year including:
    - The timeline and events that trigger review and updates to the Care Plan. At a minimum, the HMO must describe how the Care Plan is reviewed and updated after the HMO identifies that a member has a different chronic condition or a member has an ER visit, inpatient stay or Nursing Home stay.
    - Any differences in the process and timing of reviewing and updating the Care Plan for members in different strata from the Needs-stratification step.
    - A description of the process for re-stratifying members after their Care Plan is reviewed/updated.
    - A description of the process for sharing the updated Care Plan with the member and/or their legal guardian, the member's primary care provider and relevant specialists, and community agencies, as appropriate and with the member's consent.

7. Discharge Follow-up/Transitional Care: Policies, procedures, and additional documentation on appropriate discharge planning and transitional care to follow-up with members after they experience transitions between settings of care (e.g., ER visits, hospital stays or nursing home stays) including the following:

1. Policies and procedures to follow-up with members within 5 business days of discharge from an inpatient stay. DHS only provides additional reimbursement for follow-up with members within 5 business days of discharge of inpatient stays.
2. A description of how the HMO is notified of a member's ER visit, hospital stay, or Nursing Home Stay.
    - Include a description of the technology used to get that information as well as the timeframe for obtaining it. Specify if information is received real-time.
3. A description of how relevant information related to any of these events is integrated with the HMO's needs-stratification process.

8. **Wisconsin Interdisciplinary Care Team (WICT):** Policies, procedures, and additional documentation to identify and provide its highest needs members with an intensive, interdisciplinary intervention (WICT) including the following:

    1. Policies or guidelines for determining how, after identifying that a member has high-needs, the HMO evaluates that the member will benefit from a high intensity intervention.
        - Describe how the HMO assesses if the member's needs are actionable, if the member is willing to partner with the WICT and/or are they ready for change.
    2. A diagram of the WICT within the care management structure differentiating between the WICT Core Team and the larger multidisciplinary WICT Team.
    3. A list of WICT staff positions with titles, credentials, number of individuals, and FTE dedicated to the WICT for each position type.
        - Include a ratio of Core staff (those meeting weekly to discuss all WICT members) to WICT population.
        - The ratio should be based on the average number of members on the WICT at a point in time.
        - Use staffing ratios that reflect amount of dedicated individuals and also staff time in FTE. For example, if two individuals each work .5FTE with the WICT Core Team this should be documented as 2 individuals and 1 FTE per X WICT population.
        - If a staff member is managing WICT and non-WICT members, include the FTE time spent with the WICT members only.
    4. The WICT is designed to be a short term, high intensity intervention that stabilizes a member's situation and enables them to more effectively manage their care. A description of the WICT process for intervening rapidly and intensively when needed.
    5. A description of how a WICT team staff will meet at a minimum once a month face-to-face with a member.
    6. Policies and procedures to ensure there is a weekly meeting of the WICT team that includes, at least, two licensed health care professionals to discuss all WICT members.
    7. Policies and procedures to ensure Core WICT staff has ready access to expertise, as needed in consultation, such as physician, pharmacist, etc. This access may be in the form of a larger, multidisciplinary meeting where members are presented and feedback is given to the WICT Core Team.
    8. A description of how the care plan created by the WICT captures:
        - Attainable goals for the member,
        - Clear path for the member to achieve these goals,
        - Assessment of the member's readiness to change and to partner with the WICT, and
        - A plan for the member to transition from the WICT to regular care management that includes goals to be achieved as part of the transition.

16.4 Department Checklist

DHS USE ONLY			Care Management System and Continuity of Care
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	16.1.1 Policy and Procedures to utilize member specific information.
☐	☐	☐	16.1.2 Policies and Procedures to make best effort to conduct initial screening within 90 days of enrollment.

☐	☐	☐	16.1.3 Policies and procedures for coordination of Medicaid covered services or medically necessary services to members identified in the initial screen.
☐	☐	☐	16.1.4 Policies and procedures for identification, assessment and development of treatment service plans and access to specialists.
☐	☐	☐	16.2.1 Initial screen.
☐	☐	☐	16.2.2 Staff qualifications including titles and credentials that are preforming the screen.
☐	☐	☐	16.2.2.1 Include number of FTEs conducting member screens and the average number of members served per month.
☐	☐	☐	16.2.2.2 HMOs servicing both BC+ and SSI must outline how many FTEs (if any) are conducting both screening processes and the average number of members served.
☐	☐	☐	16.2.3 Member outreach for completion of member screens including: • Process to engage members to complete ie. Phone calls, mailing, etc and include timeframes. • Process to identify and engage "hard-to-reach" members • Process to engage members who initially refused to complete the screen
☐	☐	☐	16.2.4 How to prioritize members for additional assessments and care management interventions.
☐	☐	☐	16.2.5 Policies and procedures documenting the inclusion of drivers of health and referrals in their screening process.
☐	☐	☐	16.3.1 Care Management Staff - Policies, procedures, position descriptions, and subcontracts of the staff providing care management for SSI members. The documentation must include:
☐	☐	☐	16.3.1.1 An organization chart with the names and positions of the HMO's care manage staff.
☐	☐	☐	16.3.1.2 Position descriptions with names, credentials, duties, and caseload.
☐	☐	☐	16.3.1.3 Care Management activities including: member outreach, screening, care plan development, service delivery including differences in interventions with WICT vs non-WICT members, care plan review, and transitional care.
☐	☐	☐	16.3.2 Member Outreach - Policies and Procedures and additional documentation for the following items:
☐	☐	☐	16.3.2.1 Outreach activities for SSI members after HMO enrollment including method and timeline.
☐	☐	☐	16.3.2.2 How staff handle member refusals and the process to re-engage members that previously refused outreach calls.
☐	☐	☐	16.3.3 Screening - Policy, procedures, and additional documentation to conduct screening for SSI members within 60 days of HMO Enrollment and include:
☐	☐	☐	16.3.3.1 Screening questionnaire for new members
☐	☐	☐	16.3.3.2 Screening process indicating how and where staff capture responses.
☐	☐	☐	16.3.3.3 Identification of Social Determinants and how staff documents the member's support system.
☐	☐	☐	16.3.3.4 Identification of member's perception of their strengths, well-being, health and life goals, and any immediate and long-term concerns the member has.

☐	☐	☐	16.3.3.5 Identification of the member's behavioral health conditions and type of follow-up conducted by the HMO.
☐	☐	☐	16.4 Care Plan Development – Policies, procedures, and additional documentation to develop a Care Plan thin 30 days of completion of the screening or within 90 days of HMO enrollment, whichever is sooner.
☐	☐	☐	16.4.1 The Care Plan template.
☐	☐	☐	16.4.2 Detailed timeline (including dates) with a description of the process the HMO utilizes to complete the Care Plan and including modes of contact used.
☐	☐	☐	16.4.3 A description of how the HMO uses data sources to develop the Care Plan including: • Member's needs, issues, and preferences identified in the screening. • DHS' reports with Medicaid utilization information. • Member's medical records. • Member's needs, issues, and preferences identified in the screening. • Community agency information based on the member's social determinants needs.
☐	☐	☐	16.4.4 Member-centric care • A description of how the HMO engages the member in the development of the Care Plan. • A description of how the HMO identifies the member's formal and informal supports. • A description of how the HMO defines specific goals appropriate for the member's needs with the member's input. A description of the process the HMO uses to assess the member's readiness to self-manage their care and their willingness to adopt healthy behaviors. Some HMOs may utilize standard tools like the Patient Activation Measures (PAM), but must describe how they use PAM to monitor member engagement. • A description of how the HMO staff documents member's consent with the Care Plan. To deem this element as "met", the HMO must have a process in place to document the member's verbal consent in their care notes or have a copy of the Care Plan signed by the member accessible through their care notes.
☐	☐	☐	16.4.5 Medical/Dental/Behavioral Health/Social Determinant Needs: • A description of the chronic and acute illnesses included in the Care Plan. At a minimum, the Care Plan should include chronic conditions like diabetes, heart disease, respiratory disease, obesity, etc. • A description of how the HMO captures member's needs for medication management in the Care Plan. • A description of the behavioral health conditions included in the Care Plan. • A description of how the HMO integrates the member's dental needs into the Care Plan. • A description of how the HMO captures the member's needs for additional supports to conduct Activities of Daily Living

			(including, but not limited to, bathing, dressing, and eating) and Instrumental Activities of Daily Living (including, but not limited to, money management, and transportation). • A description of how the HMO captures the member's social determinant needs in the Care Plan. At a minimum, the HMO must follow-up with members on the social determinant needs identified in the screening. The HMO must also ask the member about any changes since the screening was conducted related to trauma events, stability of housing, education, access to nutritional food, employment and workforce development. • A description of how the HMO captures the member's social determinant needs in the Care Plan. At a minimum, the HMO must follow-up with members on the social determinant needs identified in the screening. • The HMO must also ask the member about any changes since the screening was conducted related to trauma events, stability of housing, education, access to nutritional food, employment and workforce development.
☐	☐	☐	16.4.6 Treatment Plan – A description of the process used by the HMO to identify the interventions that will be implemented to address the member's medical, behavioral health, dental, and social determinant needs in the Care Plan and their sequence.
☐	☐	☐	16.4.7 Care Plan Sharing • A description of how the Care Plan information is shared with the member and/or legal guardian. • A description of how the HMO shares the Care Plan with the member's PCP and other specialists as appropriate. The HMO must also describe the process for identifying other specialists that receive the Care Plan. • A description of how the HMO shares relevant portions of the Care Plan interventions with community agencies and other partners, as appropriate and with the member's consent.
☐	☐	☐	16.5 Care Management Service Delivery – Policies, procedures, and additional documentation on how the HMO coordinates delivery of services and implements the interventions defined in the Care Plan including:
☐	☐	☐	16.5.1 A description of how the HMO ensures continuity of care for new members who were receiving services under fee-for-service. • The HMO must honor FFS authorizations for therapies at the level authorized by FFS for 90 days. • The HMO must authorize coverage of services with the member's current providers for the first 90 days of enrollment.
☐	☐	☐	16.5.2 A description of how the HMO ensures that services delivered address the medical, dental, and behavioral health needs identified in the Care Plan.
☐	☐	☐	16.5.3 A description of how the HMO will coordinate with community agencies and other resources to address the member's social determinant needs identified in the Care Plan, beyond

			referrals including a process to follow-up on all social determinant needs.
☐	☐	☐	16.5.4 A description of how the HMO assesses the member's readiness to change and their level of engagement in meeting their Care Plan goals.
☐	☐	☐	16.5.5 A description of how the HMO follows-up with the member to determine if the services delivered addressed their needs.
☐	☐	☐	16.6.1 Policies and procedures with the process and criteria for reviewing an updating the Care Plan with members, at a minimum, once a year including: • The timeline and events that trigger review and updates to the Care Plan. • Any differences in the process and timing of reviewing and updating the Care Plan for members in different strata from the Needs-Stratification step. The HMO must demonstrate how the Care Plan is reviewed and updated more frequently for WICT members than non-WICT members, as well as differences between the medium and low stratas.
☐	☐	☐	16.6.2 A description of the process for re-stratifying members after their Care Plan is reviewed/updated.
☐	☐	☐	16.6.3 A description of the process for sharing the updated Care Plan with: • The member and/or their legal guardian; • The member's primary care provider and relevant providers, as appropriate and with the member's consent, and • Community agencies, as appropriate and with the member's consent.
☐	☐	☐	16.7 Discharge Follow-up/Transitional Care: Policies, procedures, and additional documentation on appropriate discharge planning and transitional care to follow-up with members after they experience transitions between settings of care (e.g. ER visits, hospital stays or nursing home stays). The documentation must include:
☐	☐	☐	16.7.1 Policies and procedures to follow-up with members within 5 business days of discharge from an inpatient stay.
☐	☐	☐	16.7.2 A description of how the HMO is notified of a member's ER visit, hospital stay or nursing home stay.
☐	☐	☐	16.7.3 A description of how relevant information related to any of these events is integrated with the HMO's needs-stratification process.
☐	☐	☐	**16.8 Wisconsin Interdisciplinary Care Team (WICT):** Provide policies, procedures, and additional documentation to identify and provide its highest needs members with an intensive, interdisciplinary intervention (WICT) including:
☐	☐	☐	16.8.1 Policies or guidelines used to evaluate if a member, once identified as highest needs, will benefit from the WICT intervention.
☐	☐	☐	16.8.2 Diagram of the WICT within the care management structure.

☐	☐	☐	16.8.3 List of WICT staff positions with titles, credentials, number of individuals, and FTE dedicated to the WICT for each position type. a. Ratio of WICT Core Team staff to WICT population at a point in time.
☐	☐	☐	16.8.4 Description of the process for the WICT intervening rapidly and intensively to a member's need when appropriate. Processes must include capability to respond within 24 hours of a trigger event or the element is 'not met'.
☐	☐	☐	16.8.5 Description of the process to ensure a WICT team staff meets at a minimum once a month face-to-face with each member of the WICT.
☐	☐	☐	16.8.6 Policies and procedures to ensure there is a weekly meeting of the WICT that includes, at least, two licensed health care professionals to discuss all WICT members.
☐	☐	☐	16.8.7 Policies and procedures to ensure Core WICT staff has ready access to expertise, as needed in consultation, such as physician, pharmacist, etc.
☐	☐	☐	16.8.8 Description of how the Care Plan created by the WICT captures: • Attainable goals for the member, • Clear path for the member to achieve these goals, o Assessment of the member's readiness to change and to partner with the WICT, and o A plan for the member to transition from the WICT to regular care management.

17 Fraud, Waste, and Abuse Policies and Procedures

The Federal Medicaid Managed Care Rule requires HMOs to have administrative and management procedures to guard against fraud and abuse. Therefore, HMOs must submit the following documentation to the Department:

1. The policies and procedures that describe the following:

1. Designation and work responsibilities of all individuals associated to the compliance officer, identification of dedicated staff responsible for identifying, mitigating and preventing fraud, waste and abuse, and Regulatory Compliance Committee. *Include an organizational chart and a description of the role and duties of each position.*
2. Communication between the compliance officer and the organization's senior management and employees. *Include examples of memos, reports, and/or meeting minutes*.
3. Credentialing process for new and recertifying providers. *Include a description of all related process steps including the required database searches.*
4. Pre-payment strategies. *Include a list of system edits, as well as procedures for manual pre-payment review of claims submitted by the network providers.*
5. Post-payment strategies. *Include a list of data mining strategies and procedures for auditing claims submitted by the network providers. HMOs should also describe in detail any appeal procedures available to providers once audit findings are issued or payments are recouped.*

6. Internal monitoring of the plan's employees. *Internal monitoring should include a risk assessment, as well as any other internal control policies in place.*
7. Prevention, identification, mitigation, and resolution issues pertaining to fraud, waste, and abuse. *Include tools used, procedures followed, and samples of related data reports.*
8. Reporting of fraud, waste, and abuse to the Department's Office of the Inspector General. *Clearly denote where in the process these reports are made and by what mechanism. Identify the activities that occur pre- and post-reporting to OIG. Identify the plan's internal criteria for when to make an external report.*
9. Recovery of overpayments. *Include the process by which overpayments are recovered and documented when the plan identifies the overpayment. ,*
10. Suspension of payments. *Include a clear description of how the plan complies with payment suspensions that stem from an OIG credible allegation of fraud. Be sure to include how the plan responds to OIG notifications.*
11. Evaluation of Special Investigations Unit and compliance program. *Submit the HMOs most recent self-evaluation. Include required benchmarks, plans for correcting deficiencies, and any existing self-imposed plans of correction.*
12. *Submit the HMOs process, including a flow chart, showing how the HMO plans to conduct audits to assist with OIG's audits of the plan's network providers. Include processes, roles, and responsibilities relative to coordinating the scope and sample to avoid duplication, providing claims-level data, and returning overpayments associated with network provider audits to OIG Provide documentation of the plan to be in compliance to respond to those audit findings.* Reporting of providers terminated for cause. *Include the documentation of the reporting process and the responsible party.*
13. Assist as necessary with OIG's audits of the plan's network providers. *Include processes, roles, and responsibilities relative to coordinating the scope and sample to avoid duplication, providing claims-level data, and returning overpayments associated with network provider audits to OIG.*
14. Subcontract must support network provider audits. *Include the excerpt of the subcontract related to participation in network provider audits and potential for the plan's recovery of overpayments.*

2. The training requirements, schedule, and materials related to the following:
   1. Program integrity training for internal personnel including the compliance officer, senior management, and employees for the current calendar year
   2. Program integrity training for network providers for the current calendar year.

17.1 Department checklist

DHS USE ONLY			Fraud and Abuse Policies and Procedures
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	17.1.1 Designation and work responsibilities of all individuals associated to the compliance officer, Special Investigations Unit, and Regulatory Compliance Committee. *Include an organizational chart and a description of the role and duties of each position.*
☐	☐	☐	17.1.2 Communication between the compliance officer and the organization's senior management and employees. *Include examples of memos, reports, and/or meeting minutes*.

☐	☐	☐	17.1.3 Credentialing process for new and recertifying providers. *Include a description of all related process steps including the required database searches.*
☐	☐	☐	17.1.4 Pre-payment strategies. *Include a list of system edits, as well as procedures for manual pre-payment review of claims submitted by the network providers.*
☐	☐	☐	17.1.5 Post-payment strategies. *Include a list of data mining strategies and procedures for auditing claims submitted by the network providers. HMOs should also describe in detail any appeal procedures available to providers once audit findings are issued or payments are recouped.*
☐	☐	☐	17.1.6 Internal monitoring of the plan's employees. *Internal monitoring should include a risk assessment, as well as any other internal control policies in place. .*
☐	☐	☐	17.1.7 Prevention, identification, mitigation, and resolution issues pertaining to fraud, waste, and abuse. *Include tools used, procedures followed, and samples of related data reports.*
☐	☐	☐	17.1.8 Reporting of fraud, waste, and abuse to the Department. *Clearly denote where in the process these reports are made and by what mechanism. Identify the activities that occur pre- and post-reporting to OIG. Identify the plan's internal criteria for when to make an external report.*
☐	☐	☐	17.1.9 Recovery of overpayments. *Include the process by which overpayments are recovered and documented both when the plan identifies the overpayment and when the Department (BBM or OIG) identifies the overpayment.*
☐	☐	☐	17.1.10 Suspension of payments. *Include a clear description of how the plan complies with payment suspensions that stem from an OIG credible allegation of fraud. If the plan's contract with network providers has provisions for payment suspensions independent of a suspension notification from the OIG, include the criteria by which a provider is suspended and the criteria by which a suspension is lifted.*
☐	☐	☐	17.1.11 Evaluation of Special Investigations Unit and compliance program. *Include required benchmarks, plans for correcting deficiencies, and any existing self-imposed plans of correction.*
☐	☐	☐	17.1.12 *Submit the HMOs process, including a flow chart, showing how the HMO plans to conduct audits to assist with OIG's audits of the plan's network providers. Include processes, roles, and responsibilities relative to coordinating the scope and sample to avoid duplication, providing claims-level data, and returning overpayments associated with network provider audits to OIG Provide documentation of the plan to be in compliance to respond to those audit findings.*
☐	☐	☐	17.1.13 Reporting of providers terminated for cause *Include the documentation of the reporting process and the responsible party*
☐	☐	☐	17.1.14 Assist as necessary with OIG's audits of the plan's network providers. *Include processes, roles, and responsibilities relative to coordinating the scope and sample to avoid duplication, providing claims-level data, and returning overpayments associated with network provider audits to OIG*
☐	☐	☐	17.1.15 Subcontract must support network provider audits. *Include the excerpt of the subcontract related to participation in*

			network provider audits and potential for the plan's recovery of overpayments.
☐	☐	☐	17.2.1 Program integrity training for internal personnel including the compliance officer, senior management, and employees.
☐	☐	☐	17.2.2 Program integrity training for network providers.

18 Behavioral Health Services

Per the SUPPORT Act, behavioral health services, including mental health treatment, substance use disorder treatment, and interventions for developmental delays are to be made available to Children's Health Insurance Program (CHIP) populations, which are included in Wisconsin's BadgerCare Plus program. HMOs have the responsibility to ensure the use of age-appropriate validated behavioral health screening and assessment tools for individuals aged 0-18 in primary care settings, according to a surveillance schedule that supports early identification of conditions that affect children's early and long-term development.

Are HMO providers expected to follow a specific periodicity schedule for behavioral health screenings in primary care settings for children?

- Yes, the HMO requires providers to follow a specific periodicity schedule
- Yes, the HMO recommends that providers specific follow a periodicity schedule
- The HMO does not require or recommend a specific periodicity schedule.

Please indicate the required or recommended periodicity schedule, if applicable:

What method(s) does the HMO use to monitor and ensure that providers are following the required or recommended periodicity schedule for behavioral health screenings?

Are HMO providers expected to use specific tools for behavioral health screenings for children? Please indicate below if specific screening tools are required, recommended or available, and where applicable, list the specific tools.

Screening Domains	HMO Screening Tools			Please list the specific tools
	Required	Recommended	Available	
Mental health				
Substance use				
General development				
Autism				
Other:				

What method(s) does the HMO use to monitor and ensure that providers are using the required or recommended tools for behavioral health screenings? (For example, do you perform internal files reviews, audits, or have corrective action plans for providers that are out of compliance)

Please identify any training or clinical practice guidelines that were provided or updated during the past year related to behavioral health screening for children.

Please identify any additional mental health or substance use screening protocols for children that were implemented to address increased behavioral health needs during the pandemic.

DHS USE ONLY			**Behavioral Health and Developmental Screening & Surveillance Services**
Met	**Not Met**	**NA**	**Certification Application Review Criteria**

☐	☐	☐	18. The HMO provided responses to meet the above requirements.

19 Provider Network Participation Denial Reasons

Please provide a list of reasons that the HMO would deny a ForwardHealth-enrolled provider from participation in the HMO's network to deliver contract-covered services to enrolled members.

DHS USE ONLY			Provider Participation Denial Reasons
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	19. The HMO provided responses to the above question.

20 Signature

Applications must have the signature of an authorized representative for the organization. Signatures and signature dates may be in pen or electronic.

HMO Name wishes to provide services and agrees to abide by rules and regulations governing Wisconsin's BadgerCare Plus and Medicaid SSI Programs. As the authorized agent, I hereby certify that the information contained herein is accurate and complete. I further understand and acknowledge that, should information provided to the Department or its fiscal agent as part of the certification process prove to be false or incomplete, any certification granted as a result of that information could be subject to sanctions indicated in DHS 106, Wis. Adm. Code.

Date: Click or tap to enter a date.

Signature of HMO's Authorized Agent: _____

Printed Name of HMO's Authorized Agent: _____