WISCONSIN SSI MEDICAID MANAGED CARE
CERTIFICATION APPLICATION INSTRUCTIONS

Enclosed are the materials, formats, and additional instructions necessary to apply for certification as a Medicaid SSI Managed Care Organization (MCO) provider with the Wisconsin Medicaid Program. Every item must be completed unless the application form indicates otherwise. If an item was already submitted for the 2004-05 Medicaid and BadgerCare HMO certification and no changes have been made for SSI certification, a statement including the date the information was submitted to the Department will be accepted for that item. Improperly completed forms and incomplete information may result in delayed certification. The application must be typed. It must be signed and dated in ink by the MCO's authorized agent. All signatures must be originals; copies or stamped signatures are not acceptable.

TABLE OF CONTENTS

Page No.

CHECKLIST FOR MCOs COMPLETING THE CERTIFICATION APPLICATION PACKET

Application Item	Due Date	Special Instructions	Is it included? (check off)
A. General Information	January 21, 2005		
B. Reports and Resources	January 21, 2005		
C. MCO Data Sheet, and Technical Data Sheet	January 21, 2005	Complete All	
D. Ownership and Controlling Interest	January 21, 2005		
E. Service Area, Optional Service Coverage, and Enrollment Limit	January 21, 2005		
F. Terms of Reimbursement	January 21, 2005		
G. Access	January 7, 2005	CD or e-mail to: boothc@dhfs.state.wi.us	
G1. Provider Contracts	January 7, 2005	If boiler plate contract language is used, submit copy of contract with list of specific providers.	
G2. Group Contracts (IPAs)	January 7, 2005	Submit all Group/IPA contracts	
G3. Administrative Service Agreements (ASAs)	January 7, 2005	Submit all ASA contracts	
G4. Provider Network Listing	January 7, 2005		
H. MOUs with County 51.42 Agencies		Submit copies of all current MOUs.	
I. Improvement	January 21, 2005		
J. Recipient Grievance Policy and Procedures	January 21, 2005		

Application Item	Due Date	Special Instructions	Is it included? (check off)
K. Provider Appeal Process	January 21, 2005		
L. Advocate Work Plan and Job Description	January 21, 2005		
M. Enrollee Handbook	January 21, 2005		
N. Signature Page	January 21, 2005		
O. Reporting Requirements	January 21, 2005		
P. Encounter Data	January 21, 2005		
Q. Computer and Data Processing System	January 21, 2005		
R. Charge Base Data	January 21, 2005		
S. Fraud and Abuse	January 21, 2005		
T. Translation Policies Procedures	January 7, 2005		

MCO APPLICATION FOR CERTIFICATION
To Be Completed by All MCOs

Enclosed are the materials necessary to apply for certification as an MCO with the Wisconsin Medicaid SSI Program in Milwaukee County. The Wisconsin Medicaid MCO Certification Application must be submitted to the address indicated on the cover memorandum. Every item is required unless indicated otherwise by the checklist. Improperly completed forms, outdated or incomplete information may result in delayed certification. The application must be typed. It must be signed and dated in ink.

The application must be completed and signed by the MCO's authorized agent responsible for applying for certification. All information submitted must be accurate and complete.

The correct "physical address" and "payee address" must be indicated. The physical address, or work address, is the MCO's corporate address. If the MCO's mailing address is a post office box, you must also include a street address or county fire response number, if available, or enclose directions for locating your office. The physical address will be used for mailing all correspondence (i.e., contract issues, program information, recertification materials, etc.), but will not be used for mailing reimbursement for services. Please indicate the complete, nine-digit zip codes. You must report any address changes promptly, noting whether the physical address is to be changed, the payee address is to be changed, or both.

The payee address will be used only for mailing checks, 1099 tax forms, and Remittance and Status reports (i.e., detailed list of paid, pending, denied claims and other financial transaction information). Remittance and Status reports are produced in paper and electronic formats. Electronic format reports cannot be sent to post office box addresses. If the MCO wishes to receive an electronic format Remittance and Status report, and the payee address is a post office box, you must also include a street address or county fire response number, if available. The payee name and the federal employer identification number (FEIN) must match those recorded and on file with the Internal Revenue Service (IRS). Please indicate the complete, nine-digit zip code. You must report any changes to this address promptly, noting whether the payee address is to be changed, the physical address is to be changed, or both.

A. General Information

Applicant MCO Name –Medicaid requires a **Wisconsin Health Maintenance Organization (HMO)** license for MCO certification. The applicant name must match the name on the license. This name must be the name used on all documents for the Wisconsin Medicaid program.

Applicant MCO Name:_____

Physical Address - Indicate the address where the MCO's primary office is located. **Do not use a billing service address.** This is the address used for mailing Medicaid publications/information.

Physical Address: _____

(Attention To: i.e., Department or Individual):_____

_____

(Street): _____

(City):_____ **(State):**_____ **(Zip):** _____

(County):_____ **(Contact Person):**_____

(Telephone Number): _____

Payee Name – Enter the name to whom checks are payable. MCOs reporting income to the IRS under an employer identification number (EIN) must indicate the name associated with the EIN and enter the name exactly as it is recorded with the IRS.

Payee Name: _____

Group Name or Attention To – Enter an additional name (e.g., business, group, and agency) that should be printed on checks and Remittance and Status Reports (payment/denial report).

Group Name or Attention To (Optional):_____

_____

Payee's Address – Indicate where checks and Remittance and Status Reports (payment/denial report), and other financial information should be mailed. **If the MCO wishes to receive the Remittance and Status report in electronic format the Payee's address cannot be a P.O. Box number. A paper copy of the Remittance and Status report is always produced, but an electronic version is optional.**

Payee Address: _____
(Street)

(City):_____ **(State):**_____ **(Zip):** _____

Taxpayer Identification Number (TIN) – Enter the TIN that should be used to report income to the IRS. The number must be the TIN of the payee name and match what is recorded with the IRS.

Taxpayer Identification Number: _____

Wisconsin HMO License Number: _____

Effective Date: _____

B. Reports and Resources

Listed on the following pages are the multiple reports and resources that the Department of Health and Family Services (DHFS) produces for use by Medicaid MCOs. Please indicate the person and address where the report/resource should be mailed, and the format of the report/resource preferred by the MCO.

All certified MCOs will receive copies of the resources listed according to the frequency indicated.

DHFS Report/Resource for MCOs	MCO Person and Address to Send Report/Resource	Report/Resource Preferred Format
INITIAL & FINAL MCO ENROLLMENT TAPES (Initial produced roughly 12 days prior to capitation month; final produced on the last day of prior capitation month)	(Attention to: i.e., Department or individual) _____ (Street) _____ (City) _____ (State) (Zip) _____ (Phone Number)	☐ Paper ☐ Open Reel Tape 1600 BPI ☐ Open Reel Tape 6250 BPI ☐ 3480 Tape Cartridge ☐ 3490 Tape Cartridge ☐ Electronic File Transfer (MCOs can choose multiple formats, though only one electronic format)
PAYEE ADDRESS for PAPER REMITTANCE & STATUS REPORT (Weekly; sent with check)	(Attention to: i.e., Department or individual) _____ (Street) _____ (City) _____ (State) (Zip) _____ (Phone Number)	
REMITTANCE & STATUS REPORT – ELECTRONIC FORMAT (Weekly)	(Attention to: i.e., Department or individual) _____ (Street) _____ (City) _____ (State) (Zip) _____ (Phone Number)	☐ Open Reel Tape 1600 BPI ☐ Open Reel Tape 6250 BPI ☐ 3480 Tape Cartridge ☐ 3490 Tape Cartridge ☐ CD ☐ Electronic File Transfer (MCOs can choose only one electronic format)

DHFS Report/Resource for MCOs	MCO Person and Address to Send Report/Resource	Report/Resource Preferred Format
MAXIMUM ALLOWABLE FEE REPORT (Quarterly)	(Attention to: i.e., Department or individual) _____ (Street) _____ (City) _____ (State) (Zip) _____ (Phone Number)	☐ Paper ☐ Open Reel Tape 1600 BPI ☐ Open Reel Tape 6250 BPI ☐ 3480 Tape Cartridge ☐ Electronic Bulletin Board ☐ CD (MCOs can choose multiple formats, though only one electronic format)
PROCEDURE CODE MASTER FILE (Upon request)	(Attention to: i.e., Department or individual) _____ (Street) _____ (City) _____ (State) (Zip) _____ (Phone Number)	☐ Open Reel Tape 1600 BPI ☐ Open Reel Tape 6250 BPI ☐ 3480 Tape Cartridge (MCOs can choose only one electronic format)
COORDINATION OF BENEFITS CARRIER CODE LIST (Monthly)	(Attention to: i.e., Department or individual) _____ (Street) _____ (City) _____ (State) (Zip) _____ (Phone Number)	Paper is only option

DHFS Report/Resource for MCOs	MCO Person and Address to Send Report/Resource	Report/Resource Preferred Format
COORDINATION OF BENEFITS EXTRACT TAPE (Monthly)	(Attention to: i.e., Department or individual) _____ (Street) _____ (City) _____ (State) (Zip) _____ (Phone Number)	☐ Paper ☐ CD ☐ Open Reel Tape 1600 BPI ☐ Open Reel Tape 6250 BPI ☐ 3480 Tape Cartridge (MCOs can choose multiple formats, though only one electronic format)
MEDICAID PROVIDER HANDBOOKS, MEDICAID UPDATES, & OTHER MEDICAID BILLING MATERIALS (As changes are made)	(Attention to: i.e., Department or individual) _____ (Street) _____ (City) _____ (State) (Zip) _____ (Phone Number)	Provider handbooks are available on CD. Provider handbooks and updates are available on the website. Paper is the only option for other materials.
PRIOR AUTHORIZATION GUIDELINES (As changes are made)	Updates will be sent to the designated Contract Administrator for each MCO	At this time, paper is the only option

C. General Information and MCO Data Sheet

The "Applicant MCO Name" must be the name that is used on all other documents for the Wisconsin Medicaid program. The Medicaid program requires a **Wisconsin HMO license**, so the applicant name must match the name on the license.

Applicant MCO Name:_____

Contact name for questions on this application

The "Contact Name" should be the person most knowledgeable about the certification. The address and phone number will be used if there are any questions about the application.

Contact Name:_____

Address:_____

City, State, Zip Code:_____

Phone Number: _____

National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), American Accreditation Program, Inc. (AAP, Inc.), Joint Commission on Accreditation of Health Care Organization (JCAHO), Utilization Review Accreditation Committee (URAC), or any other formally acknowledged accrediting agency.

NOTE: The Centers for Medicare and Medicaid Services (CMS) has recognized the following accrediting bodies: The NCQA, the JCAHO, and the AAAHC. The Department may recognize other accreditation bodies as they may qualify for such recognition. Only MCOs that receive, full unrestricted, non-provisional accreditation from a recognized accreditation body qualifies for the MCO Accreditation Incentive.

(Full or provisional)

Accrediting Agency: _____

Accrediting Status [1]**:** _____

Effective Date:_____

Accrediting Agency: _____

Accrediting Status: _____

Effective Date:_____

[1] **Note:** Accreditation status will not affect certification of an MCO; it may affect the extent of ongoing audits/review of the MCO by the Department, or the frequency of utilization information required.

MCO Data Sheets

MCOs must completely and accurately fill out the MCO Data Sheet (see next page). A name and telephone number is needed for each item. Incomplete forms will be returned. This form is used for administrative purposes. If, during the contract period, any changes are made, the Bureau of Managed Health Care Programs must be notified in writing of the changes and the effective dates. Changes may be submitted via e-mail.

MCO Technical Data Sheets

MCOs are required to completely and accurately fill out the MCO Technical Data Sheet (see page following data sheet). This form is used for administrative purposes. If, during the contract period, any changes are made, the Bureau of Managed Health Care Programs must be notified in writing of the changes and the effective dates. Changes may be submitted via e-mail.

MCO Data Sheet

MCO Name: _____

Mailing Address: _____

_____

Physical Address (Street): _____

_____

(City) (State) (Zip)

Telephone Numbers: _____

Corporate: _____

General Information: _____

Member Services: _____

TDD: _____

FAX: _____

24 Hour: _____

Contact People	Name	Phone Number
Chief Executive Officer:		
E-mail Address:		
Medical Director:		
Contract Administrator:		
E-mail Address:		
Enrollment:		
Finance:		
Fraud and Abuse Compliance Officer		
Quality Improvement:		
Reporting (utilization/survey)		
E-mail Address:		
Grievance:		
MetaStar: (WI Peer Review Org.)		
Systems:		
Claims Processing:		
Provider Relations:		
Marketing:		
HealthCheck:		
Medicaid MCO Advocate: Primary		
Back up:		
E-mail Address:		
Targeted Case Management:		
Birth to Three Contact:		
Encounter Data Reporting:		
A) Primary:		
E-mail Address:		
B) Back up:		

D. Ownership and Controlling Interest Information

Medicaid requires the Ownership and Controlling interest information by Federal law and for administrative purposes. The information must be supplied in the given format. Additional pages should be attached if needed, with the same information in the same format.

Has the MCO (including any employee, vendors, or providers) in whom the MCO has a controlling interest, or any person having a controlling interest in the MCO, since the inception of the Medicare, Medicaid, or Title XX services program, been convicted of a crime related to, or been terminated from, a federal-assisted or state-assisted medical program?

☐ Yes ☐ No

As defined by Medicaid, "Controlling Interest" includes, but is not limited to, all owners, creditors, controlling officers, administrators, mortgage interest holders, employees or stockholders with holdings of 5 percent or greater of 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 entity;*

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 in the partnership.*

List the names and addresses of all persons (individual and/or corporate) who have a controlling interest in the MCO.

Name: _____

Address:_____

City:_____ State: _____ Zip: _____

County:_____ Business Telephone:_____

Home Telephone: _____

Type and percent of controlling interest: _____

_____

_____

_____

List the names and addresses of all vendors of drugs or medical supplies, laboratories, pharmacies, transportation providers, or other providers in which the MCO has a controlling interest or ownership.

Name: _____

Medicaid Provider #:_____

Social Security Number or Federal Tax ID Number (FEIN):_____

_____

Address:_____

City:_____ State: _____ Zip: _____

County:_____ Business Telephone:_____

Home Telephone: _____

Type and percent of controlling interest: _____

_____

_____

_____

_____

Optional: Joint Venture Agreements or Memorandums of Understanding (MOUs)

The Department encourages MCOs seeking SSI-MCO certification to enter into Joint Venture Agreements with counties, public health agencies, or other service providers with experience working with SSI eligibles and individuals with development, mental and physical disabilities. If the MCO enters into a Joint Venture arrangement, a copy of the partnership contract should be attached with the application.

E. Service Area, Optional Service Coverage and Enrollment Limit Information

For the Medicaid SSI Expansion Program, DHFS defines a service area as a county. MCOs will be expected to coordinate the Medicaid services they provide with the county social services agencies for the disabled including mental health and substance abuse services. MCOs will be required to develop effective working relationships with counties and other agencies that serve disabled populations at the local level. This section of the application contains three sections: service areas, optional service coverage and enrollment limits. Check only one box per section.

1. Service Area

MCOs must indicate their service area. For the purpose of this program, the service area is Milwaukee County.

Certified Service Area (please check one)

☐ MCO is applying for certification for the Medicaid SSI program in Milwaukee County.

2. Optional Service Coverage

Chiropractic (please check one)

☐ MCO elects to cover chiropractic services.

☐ MCO elects not to cover chiropractic services.

Dental

The MCO must cover dental services in Milwaukee County.

3. Enrollment Limit (Please answer both questions)

a) How many enrollees do you anticipate your MCO can take each month for the first six months of the program?

_____

b) What is your MCO's maximum enrollment limit in Milwaukee County?

_____

If you choose to increase or reduce the enrollment limit, please notify the Department in writing. This can be done via e-mail to laughmn@dhfs.state.wi.us.

F. Terms of Reimbursement

The table on the following page provides the per member per month (PMPM) capitation rates for 2004. The PMPM capitation rates are for the current program in Milwaukee County.

MCO capitation rates are developed **annually**. The capitation rates for calendar year 2005, and their actuarial basis, will be communicated to MCOs 30 days prior to implementation of the contract, providing sufficient time for discussion of the rates between the DHFS and MCOs, and for the rates to be incorporated into the MCO contracts. This table is for your information only. Capitation rates for calendar year 2005 will be stratified by age and gender. Rates will vary depending on casemix and enrollee participation on a plan-specific basis.

CY 2004 Age/Gender/CDPS Adjusted Dates Using CY04 YTD Enrolled Months

				Final 2004 Rates
SSI	Dual	<30	Male	$347.24
SSI	Dual	<30	Female	$374.19
SSI	Dual	30 to 39	Male	$405.90
SSI	Dual	30 to 39	Female	$539.09
SSI	Dual	40 to 64	Male	$499.98
SSI	Dual	40 to 64	Female	$644.27
SSI	Dual	65+	Male	$504.74
SSI	Dual	65+	Female	$551.77
SSI	MA Only	<30	Male	$559.57
SSI	MA Only	<30	Female	$602.06
SSI	MA Only	30 to 39	Male	$750.80
SSI	MA Only	30 to 39	Female	$880.07
SSI	MA Only	40 to 64	Male	$999.60
SSI	MA Only	40 to 64	Female	$1,058.03
SSI	MA Only	65+	Male	$1,027.94
SSI	MA Only	65+	Female	$1,200.58
SSI-Related	Dual	<30	Male	$418.50
SSI-Related	Dual	<30	Female	$483.73
SSI-Related	Dual	30 to 39	Male	$523.39
SSI-Related	Dual	30 to 39	Female	$557.30
SSI-Related	Dual	40 to 64	Male	$650.19
SSI-Related	Dual	40 to 64	Female	$704.98
SSI-Related	Dual	65+	Male	$452.42
SSI-Related	Dual	65+	Female	$455.03
SSI-Related	MA Only	<30	Male	$649.78
SSI-Related	MA Only	<30	Female	$670.59
SSI-Related	MA Only	30 to 39	Male	$920.21
SSI-Related	MA Only	30 to 39	Female	$870.05
SSI-Related	MA Only	40 to 64	Male	$1,897.95
SSI-Related	MA Only	40 to 64	Female	$1,458.64
SSI-Related	MA Only	65+	Male	$1,052.38
SSI-Related	MA Only	65+	Female	$863.92

G. Access

Part G of the application contains five sections: Provider Contracts, Group Contracts (IPA's), Administrative Service Agreements (ASAs), Provider Network Listings, Care Management System and Continuity of Care.

1. Provider Contracts: The MCO must provide model subcontracts for all provider types.

2. Group Contracts {Independent Practice Association (IPA) Contracts}:

   An IPA is an intermediate entity with which the MCO contracts. The MCO subcontracts with the IPA and the IPA, in turn, subcontracts with individual providers. Providers continue in their existing individual or group practices. The following entities with which the MCO subcontracts are considered to be IPAs: chiropractic networks, dental organizations, physician services, group physician practices, and mental health gatekeepers.

   For each contracted group (IPA), please submit the following information:

   - IPA contract
   - Name of IPA
   - Complete address of IPA
   - Type of services provided (chiropractic, mental health, physician, etc.)

3. Administrative Services Agreements:

   ASAs are entities with which MCOs contract to provide administrative support. Following is a list of types of ASAs (however this list is not meant to be all-inclusive):

   a) Claims processing
   b) Utilization reporting
   c) Quality improvement
   d) Computer support
   e) Third party liability
   f) Pharmacy Benefits Management Companies.

   For each contracted ASA, please submit the following:

   - Administrative services agreement
   - Name of subcontractor
   - Complete address of subcontractor
   - Type of services provided

4. Provider Network Listings

Federal regulations require states to ensure that Medicaid MCO enrollees have access to all Medicaid covered services. In order to evaluate the adequacy of the MCO's provider network, all MCOs must supply the Department with their provider network details. The Department will review the information submitted to determine whether the MCO has the ability to provide full access to Medicaid covered services. The providers listed must have signed subcontracts with your MCO to provide services to your enrollees. **DO NOT** include providers who only serve your commercial population. **DO NOT** include providers with whom you are in the process of negotiating a contract. You may submit the details on providers with whom you are in the process of negotiating a contract separately, if you believe that it is relevant to your certification.

You must list all individual providers within a clinic. Only individual providers will be considered when your provider network is evaluated. Providers who practice at more than one location should be listed separately for each location. List the FTE percent for each provider at each separate location, and make sure that the total for each provider is not greater than one FTE. Report whether the provider is accepting new Medicaid patients by location.

The data must be provided in a Microsoft Access database. A CD containing the database is included with this certification packet. Save the Access file on the CD to your computer, open the file, and enter the requested information for each provider in your network. When you have finished entering the provider network information, you may send the file back via e-mail (boothc@dhfs.state.wi.us). The subject line of the e-mail should say "Provider Network Database." Or, you may send the file back on the CD through the mail.

A description of each field in the database and what should be entered to be considered complete follows. Incorrect, missing or incomplete data will be returned to the MCO and the certification process will resume only after the corrected information is received from the MCO.

Select Provider Category: There is a drop-down menu with a list of provider categories. Click on the category of the provider, and the blank will automatically fill.

Select Provider Specialty: There is a drop-down menu with an extensive list of provider specialties sorted alphabetically. Scroll through the list and click on the appropriate specialty, and the name of the specialty will fill the blank. If the provider category does not have specialties, select "no specialty."

Pharmacy Name: Enter the name of the pharmacy.

Provider Last Name: Enter the last name of the provider.

Provider First Name: Enter the first name of the provider.

Provider MI (optional): Enter the middle initial of the provider if known.

Provider MA ID: Enter the provider's Medicaid ID number for all providers that are required to have a Medicaid ID number.

Provider Street Address: Enter the street address where the provider practices. Post Office Box numbers cannot be accepted. It is imperative that the address fields are filled in completely and accurately. If the address fields are incomplete, the file will be returned to you. The certification process will not proceed until a file with complete information is submitted.

NOTE: If the provider practices in more than one location, you must make a separate record for each location. Each provider must be recorded in the database at each individual practice location, with the corresponding FTE information included in that field (as described below).

Provider City: Enter the city name of the practice location.

Provider State: Enter the State of the practice location.

Provider Zip: Enter the zip code of the practice location.

Specialty Description (optional field): Use this field to type in any comments you want to submit. This field is also used to enter the name of your MCO if it is not included in the drop-down menu below.

Provider FTE in tenths: Enter the full time equivalent for this provider and this location. For example, if the provider practices at the location half time, enter ".5" in the box. If the provider practices in more than one location, you must make a separate record for each location. Each provider must be recorded in the database at each individual practice location. The total FTE for each provider at all locations cannot total more than one FTE.

MCO Name: There is a drop down menu with the names of several managed care organizations. Click on the name of your MCO and the blank will fill. If your MCO is not included on this list, select "New HMO" in this field and enter the complete, unabbreviated name of the MCO in the Specialty Description optional field above.

Clinic Name: Enter the name of the clinic with which the provider is associated.

Clinic MA ID: Enter the Medicaid ID number of the clinic.

Linguistic/Cultural Specialty: Enter a description of the specialty. For example, "speaks Spanish," "specializes in youth disabilities," etc.

PCP, OB/GYN, Mental Health, AODA, and Dental Providers:

Maximum Number of Enrollees Accepted: Enter the maximum number of Medicaid enrollees this provider will accept at this location.

Provider Accepting New Enrollees: Indicate whether the provider is accepting new Medicaid enrollees at this location.

5. Care Management System and Continuity of Care: All MCOs that contract with the Department to provide Medicaid covered services to the SSI population must describe how they will identify and manage the acute or chronic complex illness, injury or other special health care needs. Your submission must include:

   a) Policies, procedures, position descriptions, subcontracts that describe who is responsible within the MCO to coordinate care for enrolled persons with special needs. By definition, the SSI enrollees have special needs.

   b) A description of how the MCO will identify the need for immediate and ongoing treatment or scheduled services of new enrollees.

   c) A description of how the MCO will initiate, determine the level of care, monitor, and discontinue case management services.

   d) A description of how the MCO will ensure continuity of care for new enrollees who are stable on medications that are not included in its preferred drug list (PDL).

   e) A description of how the MCO will ensure continuity of care for new enrollees receiving personal care services under fee-for-service.

   f) A description of how the MCO will ensure continuity of care for new enrollees receiving therapy services (OT, PT, etc.) under fee-for-service.

   g) A description of mechanisms to coordinate services both with the provider network, especially between PCPs and specialists, and with community agencies or providers outside the plan's network. This includes community or social support services, public health clinics, transportation, and mental health or substance abuse services.

   h) A description of when and how the MCO uses specialists as PCPs.

   i) A description of health education programs offered to enrollees, families, or caregivers for ongoing chronic disease management.

   j) A description of the MCO's system for comprehensive assessment at the time of enrollment and how it is updated as care needs change.

   k) A description of the MCO's integration of all processes required to achieve care plan outcomes and to ensure that services provided are effective. This description must include the MCO's plan for handling emergency or urgent care needs, durable medical equipment or supplies needs, home health needs, and coordination of mental health services with community based supportive social or vocational services.

H. Memoranda of Understanding (MOU) with County Boards Created under ss. 51.42, or 51.437

- The MCO must provide the Department with copies of all signed and current MOUs with each County 51.42, or 51.437 agency in the service area. The MOUs must reflect current information.

- The MCO must provide a listing of all other organizations with which there are MOUs, including targeted case management and community based social service organizations.

I. Quality Improvement

The Department encourages the MCO to actively pursue accreditation by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other recognized accrediting body approved by the Department.

The Centers for Medicare and Medicaid Services (CMS) has recognized the following accrediting bodies: The NCQA, the JCAHO, and the Accreditation Association for Ambulatory Health Care (AAAHC). The DHFS may recognize other accreditation bodies as they may qualify for such recognition.

The achievement of full accreditation by a DHCF-approved organization by the MCO will qualify the MCO for the Accreditation Performance Improvement Incentive. MCOs that submitted a completed copy of the Accreditation Standards Incentive Qualification Screen to the Department will be considered for qualification for this incentive. (A copy of the screen and application materials are available upon request.) Qualification for the Accreditation Incentive will result in:

- Submission of biennial recertification information topics in the screen, except information on network providers is not required. However, submission of accreditation and other information as defined by the Department will be required not less than every three years.

- No on-site certification activities related to the quality improvement program that duplicate activities by the accreditation body will be performed by the Department during the period the accreditation is in effect.

- Population health and service performance improvement projects reported for the accrediting body will be deemed acceptable for Medicaid as long as they include Medicaid enrollees. Proposals on the acceptability of MCO-wide performance improvement projects may be submitted for consideration by the Department on a case-by-case basis.

All MCOs regardless of whether they qualify for the Accreditation Performance Improvement Incentive must submit the following documentation to the Department:

- Policy and procedure governing telephone triage, clinical protocols in use, clinical credentials required for staff (not credentials documentation—only a description of the minimum credentials required, for example, "RN with three years of acute experience" etc.)

- Documentation of provider network adequacy with provider data by type and geographic distribution as required in Section G of the certification document.

MCOs that do not qualify for the Accreditation Performance Improvement Incentive must also submit the following documentation to the Department:

- QAPI program description, including description of program monitoring and oversight and most recent annual report.

- Quality program and/or overall MCO organizational chart.

- Most recent annual QAPI work plan.

- Process for developing, adopting, disseminating, and monitoring clinic practice guidelines. Copies of clinical practice guidelines need not be submitted.

- Sample documentation of a performance improvement project **(applies to initial certification only).**

- Standards and policies on access to care, availability of providers and monitoring procedures.

- Documentation on policy and strategy for preventive health services.

- Policies and procedures on continuity and coordination of care, including those related to transfer of medical records for specialty care and/or changes of provider.

- Policies and procedures for identification of enrollees with special health care needs, assessment and linkage to appropriate services.

- Documentation of policy and procedure for practitioner and institutional provider (hospital, nursing home, home health agency, hospices and free-standing ambulatory surgical centers) credentialing and recredentialing. Must include:

    a) Initial credentialing policy and procedure.

    b) Recredentialing policy and procedure.

    c) Policy and procedure governing practitioner and institutional provider termination for quality issues, appeal procedures and reporting to entities as required by law (NPDB).

- Policies governing confidentiality and privacy, including HIPAA compliance, security, transfer, organization, disclosure, completeness and monitoring of medical records.

- Policies governing utilization management, notification of adverse actions, timeliness of decisions, persons authorized to make denial decisions based on medical necessity, UM criteria conformity with applicable MCO clinical proactive guidelines, and inter-rater reliability. Also, clinical information requirements, consultation guidelines, policies for processing expedited and urgent authorization requests. **Do not submit UM criteria**.

- Policy and procedure governing delegation, including sample written agreement. Include polices on:

    a) Pre-delegation evaluation of prospective subcontractor's ability to perform;

    b) Monitoring activities and reporting requirements;

    c) Corrective actions when problems are identified;

    d) Provisions for termination of delegation; and

    e) Provisions for retention by the MCO of the right to make final selection decisions about practitioners and providers credentialed or recredentialed by a delegate.

J. Recipient Complaint and Grievance System

Please submit written documentation detailing the enrollee complaint and grievance process. The documentation must include and will be evaluated based on the following criteria:

- A definition of a grievance.
- A definition of an appeal.
- A definition of an emergency grievance.
- A description of the formal grievance process including a timeline for handling formal grievances and emergency grievances.
- A description of the process for handling HIPAA privacy complaints.
- The name and phone number of the person(s) responsible for receiving, routing, and processing grievances.
- A description of the process and format used for logging informal grievances.
- A description of the recordkeeping system for formal grievances.
- A description of how enrollees are informed about the grievance process.

- IPA policies and procedures for enrollee grievances and a description of how IPAs notify MCO enrollees of the complaint/grievance process.
- A sample of informal grievance logs.
- A description of how the MCO assures that grievances filed by Medicaid enrollees are adjudicated based on Medicaid rules.
- A description of how the MCO assures that individuals with authority to require the MCO to implement a corrective action are involved in the grievance process.
- Sample copies of denial, termination, and reduction letters to enrollees for medical benefits.
- A description of how enrollees are informed about access to interpreter services during the grievance process.

Please include only documentation that pertains to Medicaid members. If the policies and procedures combine Medicaid and commercial policies, the documents must clearly indicate portions pertaining exclusively to Medicaid or commercial.

K. Provider Appeals System

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

- Samples of remittance advice notices with provider appeal language included.
- Samples of notification letters sent to providers after the appeal determination has been made.
- Policies and procedures for adjudicating provider appeals, showing time lines for adjudication.
- A description of how the MCO assures that provider appeals pertaining to Medicaid services are adjudicated using Medicaid (not commercial) policies and procedures.

L. Medicaid MCO Advocate

The MCO must submit to the Department:

- Job description of the Medicaid MCO Advocate(s).
- The work plan of the Advocate(s) covering the next two years.

In general, the Medicaid MCO standards for advocates are one full time equivalent (FTE) position per MCO. MCOs sharing administrative service functions must have at least one FTE position per MCO. MCOs with high enrollments must have more than one advocate. If the MCO employs less than one FTE, the MCO must submit a justification to the Department explaining why less than one MCO advocate is sufficient. MCO may

contract part of their advocate position to community based advocacy agencies. However, the MCO must maintain a "lead" advocate position within the MCO who is responsible for assuring compliance with the MCO Medicaid Contract.

M. Enrollee Handbook and Marketing Materials

The MCO must submit the following to the Department:

1. Written documentation for plans to outreach to new enrollees. The documentation should include the following:

   - What is the outreach activity?
   - How often the activity will occur?
   - Who will be involved in providing the outreach activity?
   - How will you evaluate the effectiveness?

2. The MCO must include any new or updated versions of enrollee informing documents for approval.

N. Signature

Our MCO wishes to provide services and agrees to abide by rules and regulations governing Wisconsin's Medicaid Program. 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 a part of the Medicaid certification process prove to be false or incomplete, any certification granted as a result of that information could be subject to sanctions indicated in HFS 106, Wis. Adm. Code.

Signature of Applicant – Applications must have the signature of an authorized representative for the organization. ALL signatures and signature dates must be in pen. Photocopied or stamped signatures and dates are not acceptable.

_____

Signature of MCO's Authorized Agent Date of Signature

_____

Typed / Printed Name of MCO's Authorized Agent

O. Reporting and Data Administration

The Department must ensure that MCOs are using Wisconsin Medicaid certified providers when providing services to Medicaid enrollees. The contract between the Department and MCOs requires that MCOs use only providers certified by the Medicaid program when rendering services to Medicaid enrollees, except in emergency situations.

The data submitted by the MCOs will be used to assist in monitoring this requirement. This means that data submitted by the MCO will be edited and reviewed to ensure that a valid Medicaid provider ID is present, except when the service is identified as an emergency service. A missing values indicator (9's) in the field will not be acceptable unless a provider name is indicated in the appropriate field.

1. Describe how the MCO currently updates its provider file with Wisconsin Medicaid provider ID's.

2. The Department currently maintains a list of certified MCOs who have submitted history records with missing or invalid Medicaid provider IDs and/or missing values indicator (9's).

   Describe the circumstances in which your MCO submits encounter data without a valid Medicaid provider ID, substituting a provider number of 99999999. If necessary, describe the steps that you will take to decrease or eliminate the necessity to submit a provider ID number of 999999999 on encounter records.

3. Describe the steps the MCO takes to ensure that when new providers are added to the network, they are appropriately certified in the Wisconsin Medicaid program.

P. Encounter Data from Third Party Vendors

Some of the encounter data you submit to the Department may come from third party vendors who pay and process claims on your behalf (e.g., pharmacy benefits manager).

1. Please identify any third party vendors, the service provided, and the type of encounters (e.g., inpatient, pharmacy, etc.).

2. Please describe how you will obtain the required data from them, how often (e.g., monthly), and the timeliness of the data (i.e., how soon after the date of service will the data be transmitted to you, and subsequently to the Department).

Q. Computer and Data Processing System

1. The MCO must prepare a written description that addresses the system hardware and software, the technical resources that will be used and the name of the agency or organization (e.g., MCO, 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

2. Applies only to MCOs not certified and contracting with the Wisconsin Medicaid HMO Program in 2004 and 2005. The MCO must prepare a written description (or provide current documentation) that addresses how the encounter data file will be prepared. The description should begin with the point at which the claim/encounter is adjudicated and finalized in the claims processing system to the point at which the encounter data file will be sent to the Department. Include all automated and manual interventions. Include a brief description of all interfaces between all files, including files provided by the Department (e.g., enrollment data, provider data, etc.) and local MCO files. The description may include a flow chart with a brief written description of each function, data file, query, interface, intervention, etc., that will be required prior to submitting an encounter data file.

3. Applies only to MCOs not certified and contracting with the Wisconsin Medicaid HMO Program in 2004 and 2005. The MCO must also prepare a written description of the following:

   a) Data sources (e.g., claims systems, survey instruments, medical records, etc.) used when acquiring and processing:

      - Performance Improvement Indicators
      - Focus Studies/Performance Improvement Topic Studies
      - Encounter Data

   b) Processes used when tracking and correcting errors. Include a description of any automated and/or manual processes used to track encounter record errors from the time of notification of erred records to final correction of erred record.

4. Describe how the MCO will comply with Wisconsin Medicaid standards for HIPAA compliant transactions as specified in the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products and the 834 Benefit Enrollment and Maintenance Implementation Guides.

5. Quality Control of MCO Information System:

   a) How and how often (daily, etc.) is system performance monitored?

   b) What processes are in place to identify and inform staff of any system performance problems?

   c) Please, briefly describe your system's disaster recovery program.

6. Encounter Data Readiness Questions. Applies only to MCOs not certified and contracting with the Wisconsin Medicaid HMO Program in 2004 and 2005:

a) MCOs must provide all data elements (e.g., place of service code, admission type, etc.) of the encounter record that are required on the encounter data set. Check the appropriate box below, and if necessary, provide required explanation.

☐ All required fields of the encounter record are available from the MCO's administrative database.

☐ MCO's administrative database does not contain all required fields of the encounter record. If this box is checked, please explain how MCO will acquire them prior to the first encounter data submission.

b) MCOs must use ANSI EOB codes at a minimum to identify denied encounters. If the MCO does not use ANSI EOB codes in its claims processing system, describe how the MCO will assign an ANSI EOB code to all denied encounters when submitting the monthly encounter data set. Check the appropriate box, below.

☐ ANSI EOB codes are currently assigned to all adjudicated (paid and denied) encounters.

☐ ANSI EOB codes are assigned only to denied encounters.

☐ MCO does not currently assign any, or only some ANSI EOB codes to adjudicated (paid and denied) encounters. If this box is checked, please explain how MCO will assign them to denied encounters when submitting the monthly encounter data set.

☐ Other. Please explain

c) The Department must verify that the MCO is capable of making consecutive submissions, reversing records and correcting edited records during testing. The MCO will be required to submit, at a minimum, two test submissions from two different process periods (e.g., January process dates and February process dates).

1) Describe how the MCO will ensure that several records from the second submission will reverse records from the first submission.

2) Describe the MCOs approach to reviewing and correcting erred encounter records.

3) Describe how the MCO will submit corrected records from the first submission when submitting the second submission.

d) The record identification number is a unique number that the MCO must assign to each encounter detail record. It is crucial to creating an audit trail that can be used by the MCO and Department to track accepted and erred records. Its function is very similar to the internal control numbers (ICN) or document control numbers (DCN) used by claims processing systems to track claims.

Please describe the record identification number you will be assigning to the encounter record, how it is created, and the methodology used when assigning it to a record.

R. Fraud and Abuse Policies and Procedures

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

1. Submit a compliance plan the includes written procedures, a description and designation of a compliance officer and compliance committee.

2. Describe the training requirements for the Compliance Officer and employees.

3. Describe the enforcement standards and disciplinary guidelines developed by the plan.

4. Describe the plan's internal monitoring and auditing procedures.

5. Describe how the plan will provide a prompt response to detected problems.

6. Provide the name and contact information of the Compliance Officer.

S. Language Access Policies and Procedures

MCOs are required to provide oral and written language access to non-English speaking or limited English proficiency members. MCOs must submit the following documentation to the Department:

1. Provide a description or policy statement regarding the provision of language access services including the effective date of the policy, next review date of the policy, and who the policy affects.

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 for members with hearing impairments.

3. Describe how emergency interpretation services will be provided.

4. Describe the MCO's monitoring mechanism for enrollee satisfaction, and provider compliance.

5. Provide a list of all materials produced by the MCO that must be translated.

6. Describe how the MCO will identify hearing impaired or LEP enrollees.

7. Provide a list of all interpreters used by the MCO and include the procedures for updating the list and evaluating the need for additional interpreters.

8. Describe how enrollees are notified of the availability of free interpretation services including the frequency of the notification, and the manner in which enrollees are notified.