2024-2025 BadgerCare Plus and Medicaid SSI HMO Contract

Substantive Changes effective 1/1/2024

Article I – Definitions and Acronyms

- Removing terms no longer used in the contract
- Adding definitions from existing Appeal and Grievance Guide and Communications and Marketing Guide
- Adding definition for Electronic Visit Verification, SSI Care Management, Functionally Equivalent, Telehealth, Potentially Preventable Readmission, Waste, and Care Management Service Referral

Article II – Enrollment and Disenrollment

- Removing exemptions for SSI waiver program opt-out and FQHC (Article II.C.)
- Removing exemptions for transplants no longer considered experimental (liver, heart, lung, heart-lung, pancreas, pancreas-kidney) (Article II.C.)
- Clarifying HMO responsibility to report member changes in circumstance with process for how to report (Article II.B.2.)

Article III – Care Management

- Clarifying member screens must be completed at least every twelve months instead of annually (Article III.C.)
- Adding requirement for HMOs to train customer care staff to identify screen results that must be reported to the care management team (Article III.B.)
- Adding required screen completion benchmarks (Article III.B. and C.)
- Adding expectation for HMOs to track referral follow up and results (Article III.A.)
- Adding requirement for HMOs to discuss screening results with the member (Article III.C.)
- Clarifying requirement for member permission to share/discuss care plan with providers (Article III.C.)

Article IV – Services

- Adding coverage of routine services associated with qualifying clinical trials (Article IV.M)
- Clarifying EVV requirements now that EVV implementation is complete (Article IV.E.10)
- Adding HMO responsibility to cover transplants no longer considered experimental (liver, heart, lung, heart-lung, pancreas, pancreas-kidney) (Article IV.E.5.)
- Clarifying HealthCheck requirements (Article IV.G.)
- Clarifying types of transportation HMOs must cover (Article IV.D. and E.)
- Updating HMO MOU requirements with residential substance use disorder Hub and Spoke providers to encourage MOUs with providers in the HMO service area but require MOUs if the HMO and provider have co-enrolled members. (Article IV.K.)
- Removing tramadol from the pharmacy lock-in requirements to only reference controlled substances (Article IV.E.9.)
- Adding requirement for medical necessity of in lieu of services to be documented in a member’s medical record (Article IV.C.)

- Clarifying HMO expectations when the HMO subcontracts with a dental benefits administrator, including requirements to survey in-network dental providers. (Article IV.E.)
- Updating references from “face-to-face” to “in-person” (Article IV.H. and Article III.C.)
- Removing annual report for OB Medical Home evaluations (Article IV.H.)

Article V – Provider Network and Access Requirements

- Removing provider network adequacy standards from the contract. The contract now links to the standards published on ForwardHealth (Article V.F.)
- Removing duplicate provide directory requirements (Article V.H.)
- Updating provider network file submission from weekly to monthly and adding requirement to include provider taxonomy. (Article V.E.)
- Clarifying expectations for using telehealth in network adequacy evaluations (Article V.G.)

Article VI – Marketing and Member Materials

- Incorporating the existing HMO and PIHP Member Communications, Outreach, and Marketing Guide into the contract
- Changes from the existing Comms Guide:
    - Removing definitions of “outreach” and “outreach materials” and terms no longer used in the contract language
    - Clarifying requirements for including taglines in written materials
    - Updating prevalent non-English languages in each rate region
    - Combined existing contract, comms guide, and federal requirements for provider directory distribution and contents
    - Removed requirement for the Department to consult the Medical Care Advisory Committee to review marketing materials
    - Clarified HMO responsibility to refer individuals to the ADRC for options and enrollment counseling
    - Removed requirement for HMOs to submit annual communication and outreach plan
    - Removed requirement to contact the Department grievance expert to review member notices
    - Removed requirement for HMOs to resubmit approved materials once a year
    - Clarifying HMO limits on sharing email addresses
    - Extended public health emergency unwinding provisions to the end of 2024

Article VII – Member Rights and Responsibilities

- Clarifying HMO responsibility to comply with Wis. Stat. § 609.24 regarding continuing care with providers who leave the HMOs network (Article VII.F.8 and 9)
- Clarifying that provider appeal log must include any provider claim appeals processed by subcontractors. (Article VII.B.)
- Clarifying that the HMO advocate can delegate tasks to appropriate plan staff (Article VII.A.)

Article VIII – Provider Appeals

- Adding required timeline for HMOs to complete the reconsideration process (Article VIII.B.)

Article IX – Member Grievances and Appeals

- Incorporating the existing HMO and PIHP Grievances and Appeals Guide into the contract
- Changes from the existing Grievance and Appeals Guide:
    - Removing option for members to file grievances with the Department
    - Updated timeframe for HMOs to send notices to members that will be transferred or discharged
    - Clarifying that if written notices are sent to providers the HMO can send the notice by mail or electronically via secure provider portal
    - Clarifying that quarterly grievance and appeal reports must include any member grievance or appeal processed by a subcontractor

Article X – Quality Assessment Performance Improvement (QAPI)

- Clarifying PIP options (Article X.J.)
- Updating NCQA accreditation requirement language to reflect that HMOs must be accredited by 2024, adding requirements for HMOs to report losing accreditation, and clarifying consequences for not meeting these requirements (Article X.I.)
- Adding that the Department may review and audit results of the member satisfaction survey *and* the provider satisfaction survey (Article X.A.)
- Adding requirement for HMOs to cooperate with Department monitoring and evaluation of performance findings, including possibility of corrective action (Article X.B.)
- Adding requirement for HMOs to develop member advisory councils by 2025 (Article X.E.)
- Removing duplicate contract requirements for dental services quality improvement (Article X.H.)
- Removing annual progress reports for dental services quality improvement (Article X.H.)
- Aligning the potentially preventable readmission initiative language with the Quality Guide (Article X.N.)

Article XI – HMO Administration

- Updating clinical laboratory improvement amendment requirements to remove unnecessary citations and sanction for noncompliance (Article XI.C.)
- Clarifying HMO responsibilities to sign MOUs with prenatal care coordination agencies (Article XI.C.)

Article XII – Reports and Data

- Clearly stating requirement for HMOs to meet timely submission deadlines for required reports (Article VII.K.)
- Adding Department ability to request additional reports from HMOs as needed to administer the contract (Article XII.S.)
- Removing duplicate requirement for annual evaluation of QM program. The requirement is in Article X.A. (Article XII.R.)
- Adding requirements for HMOs to use the Department's extrapolation methodologies, prohibiting HMOs from recouping from provider audit findings rooted in the performance errors of HMO employees, and adding requirements for prepay or cost avoidance strategies. (Article XII.M.)

- Clarifying how the Department will provide program integrity technical assistance to HMOs (Article XII.M.4.)
- Adding details for fraud, waste, and abuse strategic plan audits (Article XII.M.5.)
- Adding details to better define suspected fraud, waste, and abuse that HMOs must report to OIG and more clearly defining HMO responsibilities for full investigations (Article XII.M.6.)
- Adding requirement for HMOs to monitor enrollment and capitation discrepancies (Article XII.M.)
- Updating quarterly program integrity reporting requirements to include subcontractor data in the HMO report (Article XII.M.)
- Adding required monthly meetings for HMOs and the Department OIG. (Article XII.M)
- Out of network utilization report must include claims processed by subcontractors (Article XII.Q.)
- Clarifying separate instructions for secure file transfer protocol and the secure ForwardHealth portal (Article XII.A.)
- Clarifying HMO responsibility to certify their required data and report submissions (Article XII.D.)
- Correcting due date of MLR report (Article XII.O.)
- Removing the reporting due date chart. The resource will be available on ForwardHealth (Article XII.K.)

Article XIII – Functions and Duties of the Department

Article XIV – Contractual Relationship

- Updating the timeline HMOs must follow to notify a member of a network provider termination (Article XIV.B.5.)
- Adding Department ability to review HMO compliance with application laws, regulations, and contract if the HMO decertifies another line of Medicaid business (Article XIV.E.)
- Removing CLIA sanctions (Article XIV.D.)
- Adding requirement for HMOs certified in both BadgerCare Plus and SSI Medicaid to align counties served before expanding into a new county (Article XIV.E.)
- Removing references to maximum enrollment levels (Article XIV.D.)

Article XV – Fiscal Components/Provisions

- Removing HMO liability after disenrollment for members hospitalized at the time of disenrollment (Article XV.D.7.)
- Clarifying Health Professional Shortage Area requirements and correct resources for HMOs to use when determining the payments (Article XV.D.5.)
- Adding a timeline for HMOs to report errors in claims processing system and prohibiting an HMO from categorizing claims processing errors in reconsideration or appeal (Article XV.D.)

Article XVI – Payments to the HMO

- Adding cap to related party expenses (Article XVI.M.2.)
- Limiting HMO claims for interpreter services to either administrative expenses or encounter-based payments (Article XVI.N.)

- Updating hospital access payment language to align with current reporting practices and removing hospital access payment forms (Article XVI.I. and J.)

Article XVII – HMO Specific Contract Terms

Addendum I: Memorandum of Understanding

- Removing reference to obsolete memo

Addendum II: HMO Standard Member Handbook

Addendum III: Guidelines for the Coordination of Services Between the HMO, Targeted

Addendum IV: Report Forms and Worksheets

- Removing Hospital Access and Summary Critical Access Hospital Access Payment forms
- Removing attestation form

Addendum V: Benefits and Cost Sharing Information

Addendum VI: Intensive Care Coordination Pilot Program

Addendum VII: Fraud Waste and Abuse Strategic Plans

Addendum VIII: Grievance and Appeal Letters and Templates *New Addendum

Addendum IX: Marketing and Member Materials checklists *New Addendum

Addendum X: HMO Service Area *New Addendum