

HMO and PIHP Communication, Outreach, and Marketing Guide

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CHANGE SUMMARY

Change Date	Changed By	Description of Change	Version
4/10/2020	Kari Brock	Distribution of Final 2020 Guide	1.0

1. PURPOSE

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 herein.

This guide provides detailed policies and contractual requirements, including procedures for obtaining approval of member and non-member communication, outreach and informational materials from Wisconsin Department of Health Services (the Department) for managed care programs including these contracts:

- BadgerCare Plus, Medicaid SSI Health Maintenance Organization (HMO), Article VI and Addendum II of the BadgerCare Plus and Medicaid SSI Contract, January 1, 2020 – December 31, 2020
- Dual Eligible Special Needs Plans (D-SNPs), Agreement between the Wisconsin Department of Health and Medicare Advantage Health Plan, January 1, 2020 – December 31, 2021
- Prepaid Inpatient Health Plan (PIHPs)
 - Care4Kids, Foster Care Medical Home Contract, January 1, 2020 – December 31, 2021, Article VI and Addendum I
 - Children Come First, Contract for Services Between Department of Health Services and Dane County, July 1, 2015 – June 30, 2020
 - Wraparound Milwaukee, Department of Health Services and Milwaukee County, July 1, 2015 – June 30, 2020

Long Term Care Managed Care Organizations are out of scope for this guide.

The Member Communication and Marketing Policies and Procedures guide should be reviewed by Health Plans prior to submitting documents to the Department for review, as it provides guidance for submission and review standards. Materials that do not meet standards defined in this document will not be approved by the Department.

The Department encourages Health Plans to perform outreach to newly enrolled members, to provide health education, and information to members and/or to the general community, and to participate in community events, to engage with the BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, Wraparound Milwaukee and D-SNP populations.

2. DEFINITIONS

Agent: An entity that solicits and/or conducts marketing or research on behalf of a Health Plan and/or takes or transmits any applications for insurance coverage.

Application: A form completed by a potential member to determine eligibility for the BadgerCare Plus or Medicaid SSI Program. Eligibility may only be determined by county income maintenance (IM) agencies or tribal agencies.

Common areas: Any area in a provider’s facilities that is accessible to the general public. Common areas include, without limitation, reception areas, waiting rooms, hallways, etc.

Direct mail marketing: Any materials sent to potential members by a Health Plan or its agents through U.S. mail or any other mail service.

D-SNP: a health plan which enrolls beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

Health Plans: Any HMO, Prepaid Inpatient Health Plan (PIHP), D-SNP contracted to provide Medicaid managed care to Wisconsin BadgerCare Plus, Medicaid SSI, Care4Kids, Children Comes First, and Wraparound Milwaukee members.

Incentives: Any form of financial compensation, including material items, travel or transportation reimbursement, child care services, etc., offered to members or potential members.

Marketing policy: Policy that governs acceptable and prohibited promotional activities for Health Plans participating in BadgerCare Plus and/or SSI Medicaid programs, Care4Kids, Children Comes First, Wraparound Milwaukee.

Marketplace: The federal Health Insurance Marketplace (also called the “Exchange”), that offers standardized health insurance plans to individuals, families, and small businesses.

Outreach: Working in the community or developing materials to share information about the Medicaid program and managed care with families or individuals that may be eligible for Medicaid programs.

Paid advertising: Otherwise known as paid media, includes, but is not limited to, the airing of campaign messages—or advertisements—by purchasing space in media outlets,

such as television and radio stations, newspapers, magazines, web sites, online search optimization and/or ad placement, bus advertisements, and outdoor billboards.

Qualified Health Plan: As established by the Affordable Care Act (ACA), an insurance plan that is certified by the Marketplace and meets ACA requirements such as coverage of essential health benefits.

3. FEDERAL POLICY

Medicaid Managed Care Requirements

3.1 42 CFR § 438.10

In accordance with 42 CFR § 438.10, the HMO or PIHP must adhere to the following requirements.

3.1.1 Basic Rules

3.1.1.1 Each HMO or PIHP must provide all information in this section to members and potential members as described.

3.1.1.2 Definitions

3.1.1.2.1 For consistency, each HMO or PIHP must use the following terms as defined in Article II of the Contract: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.

3.1.1.3 Member information required in 42 CFR § 438.10 may not be provided electronically by the HMO or PIHP unless all of the following are met:

3.1.1.3.1 The format is readily accessible;

3.1.1.3.2 The information is placed in a location on the HMO, or PIHP website that is prominent and readily accessible;

3.1.1.3.3 The information is provided in an electronic form which can be electronically retained and printed;

3.1.1.3.4 The information is consistent with the content and language requirements of 42 CFR § 438.10; and

3.1.1.3.5 The member is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

3.1.1.4 Each HMO or PIHP must have in place mechanisms to help members and potential members understand requirements and benefits of the program.

3.1.2 Language and Format

3.1.2.1 Methodology

3.1.2.1.1 The Department established methodology for identifying the prevalent non- English languages spoken by members and potential members throughout the state. Where applicable, HMOs and PIHPs must provide materials and services in those languages identified in Addendum II.

3.1.2.2 Oral Interpretation Services

3.1.2.2.1 HMOs and PIHPs shall make oral interpretation in any language available to members and potential members.

3.1.2.2.2 Oral interpretation shall be free of charge to members and potential members.

3.1.2.3 Written Translation

3.1.2.3.1 HMOs and PIHPs shall make written translation available in each prevalent language. Examples of prevalent languages for each Rate Region are identified in Addendum II.

3.1.2.4 Auxiliary aids and services

3.1.2.4.1 Auxiliary aids, such as TTY/TDY and American Sign Language (ASL), must be available to members and potential members.

3.1.2.4.2 Auxiliary aids shall be provided to members free of charge.

3.1.2.5 Taglines

3.1.2.5.1 HMOs and PIHPs shall include large print (no smaller than 18 point font) taglines in the prevalent non-English languages in all written materials explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services. See Addendum II for examples.

3.1.2.6 Written Materials

3.1.2.6.1 HMOs and PIHPs shall make its written materials that are critical to obtaining services, including at minimum: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages for the MCO's Rate Region and PIHP Service Area.

- 3.1.2.6.2 Written materials must be made available in alternative formats upon request of the member or potential member at no cost.
- 3.1.2.6.3 All written materials must:
 - 3.1.2.6.3.1 be in easily understood language and format,
 - 3.1.2.6.3.2 using a font size no smaller than 12 point,
 - 3.1.2.6.3.3 be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of the member or potential member with disabilities or limited English proficiency, and
 - 3.1.2.6.3.4 include large print (no smaller than 18 point font) taglines and information on how to request auxiliary aids and services, including materials in alternative formats.
- 3.1.2.6.4 See Addendum II for additional state guidance on written materials, including websites and electronic media.

3.1.3 Notification to Members

- 3.1.3.1 HMOs and PIHPs must notify members and potential members:
 - 3.1.3.1.1 That oral interpretation is available for any language and written translation is available in prevalent languages;
 - 3.1.3.1.2 That auxiliary aids and services are available upon request and at no cost for members with disabilities; and
 - 3.1.3.1.3 How to access oral interpretation and auxiliary aids and services.
 - 3.1.3.1.4 See Addendum II for additional state guidance.
- 3.1.3.2 The HMO and PIHP must make any physician incentive plans available upon request.

3.1.4 Standard Member Handbook

- 3.1.4.1 For consistency, the HMOs and PIHPs must use the state developed Standard Member Handbook (Addendum I). Requirement of the handbook include:
 - 3.1.4.1.1 Timeframe to provide
 - 3.1.4.1.1.1 Within 10 days of final enrollment notification to the HMO or PIHP, the HMO or PIHP shall provide a hardcopy member handbook to new members.
 - 3.1.4.1.1.2 The HMO or PIHP must give members notice of any state-identified significant changes to the information at least 30 days before the intended effective date of the change.
 - 3.1.4.1.2 Handbook Content

- 3.1.4.1.2.1 The content of the member handbook includes information that allows the member to understand how to effectively use the program. This information must include at minimum:
- a. Services covered by the HMO or PIHP
 - b. How and where to access any benefits provided by the state (pharmacy, non-Emergency Medical Transportation, dental (when relevant to the PIHP or HMO Rate Region), chiropractic (when relevant to HMO or PIHP), and cost sharing)
 - i. In the case of counseling or referral services the HMO or PIHP does not covered due to moral or religious objections, the HMO or PIHP must inform the member that the service is not covered by the HMO or PIHP.
 - ii. The HMO or PIHP must inform all members how they can obtain information from the state about how to access the services.
 - c. Benefits and Prior Authorizations
 - i. The handbook must include:
 - The amount, duration and scope of benefits available in sufficient detail to ensure the member understands the benefits they are entitled to.
 - The extent to which, and how, after-hours and emergency coverages are provided, including:
 - What constitutes an emergency medical condition and emergency services
 - The member has a right to use any hospital or other setting for emergency care
 - Prior authorizations are not required for emergency services
 - d. Procedures for obtaining benefits, including prior authorization and referral requirements for specialists and any benefit not provided by the member's primary care provider.
 - e. Any restrictions on the member's freedom of choice of network provider
 - f. How members may obtain benefits, including family planning services and supplies from out-of-network providers.

- i. Including an explanation that the HMO or PIHP cannot require a member to obtain a referral before choosing a family planning provider.
- g. Any copays that are required by the state.
- h. Member rights and responsibilities
- i. How to select and change primary care providers.
- j. The Department developed or approved grievance, appeals, and fair hearings procedures and timeframes. (See Grievance and Appeals Guide for additional information on grievance and appeal requirements) Including the:
 - i. Right to file grievances and appeals
 - ii. Requirements and timeframes for filing a grievance or appeal
 - iii. Availability of assistance in the filing process
 - iv. Right to request a state fair hearing after the HMO or PIHP has made an adverse determination on the members appeal
- k. How to exercise an advanced directive
- l. How to access auxiliary aids and services, including additional information in alternative formats and languages.
- m. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.
- n. How to report suspected fraud or abuse.
- o. Additional the Department requirements. (see Section 5.1.1)

3.1.4.2 Distribution

3.1.4.2.1 The HMO or PIHP must provide the member handbook to members using one or more of the following methods:

- 3.1.4.2.1.1 Mail a printed copy to the member's mailing address,
- 3.1.4.2.1.2 By email after obtaining the member's agreement to receive the information by email,
- 3.1.4.2.1.3 Posted to the HMO's or PIHP's website and advised the member in paper or electronic form that the handbook is availing on the Internet and includes the Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost, or

3.1.4.2.1.4 Providers the information by any other method that can reasonably be expected to result in the member receiving the handbook.

3.1.5 Provider Directory

3.1.5.1 Distribution

3.1.5.1.1 HMO's or PIHP's must make the provide directory available in paper form upon request

3.1.5.1.1.1 Must be updated at least monthly

3.1.5.1.2 Electric Format

3.1.5.1.2.1 Must be updates no later than 30 days after receiving updated provider information

3.1.5.1.2.2 Available on the HMO's or PIHP's website in a machine readable file and format

3.1.5.2 HMOs or PIHPs are required to list the following information about network providers:

3.1.5.2.1 Provider's name and any group affiliation

3.1.5.2.2 Street address(es)

3.1.5.2.3 Telephone number(s)

3.1.5.2.4 Website URL, as appropriate

3.1.5.2.5 Specialty, as appropriate

3.1.5.2.6 If the provider is accepting new patients

3.1.5.2.7 Cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the providers office, and whether the provider has completed cultural competence training

3.1.5.2.8 Accommodations for people with physical disabilities, including offices, exam rooms, and equipment.

3.1.5.3 Provider type required in the directory include:

3.1.5.3.1 Physicians, including specialists

3.1.5.3.2 Hospitals

3.1.5.3.3 Pharmacies

3.1.5.3.4 Behavioral health providers

3.1.5.3.5 Long term services and supports providers, as appropriate

3.2 42 CFR Part 438.104

3.2.6 [42 CFR 438.104](#) requires contracted HMOs providing Medicaid coverage to Medicaid members to comply with the following requirements:

3.2.6.1 Marketing materials mean materials that:

3.2.6.1.1 Are produced in any medium, by or on behalf of an HMO or PIHP, and

3.2.6.1.2 Can reasonably be interpreted as intended to market the HMO or PIHP to potential members.

3.2.6.2 Provide that the contracted HMO or PIHP –

3.2.6.2.1 Does not distribute any marketing materials without first obtaining State approval;

3.2.6.2.2 Distributes the materials to its entire service area as indicated in the Contract;

3.2.6.2.3 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;

3.2.6.2.4 Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance (see Addendums II and III for additional state guidance, including examples); and

3.2.6.2.5 Does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

3.2.6.3 Specify the methods by which the entity assures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the State agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that –

3.2.6.3.1 The beneficiary must enroll in the HMO in order to obtain benefits or in order not to lose benefits; or

3.2.6.3.2 The MCO or PIHP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the federal or state government, or similar entity.

3.2.6.4 State agency review. In reviewing the marketing materials submitted by the entity, the State must consult with the Medical Care Advisory Committee established under 42 CFR §431.12 or an advisory committee with similar membership.

3.2.6.5 See Addendums II and III for additional state guidance, including examples of marketing.

3.3 Medicare Marketing Guidelines

3.3.1 D-SNP Plans must comply with the Medicare Marketing Guidelines defined in 42 CFR §:

3.3.1.1 [417.428](#),

3.3.1.2 [422.2268](#),

3.3.1.3 [423.2268](#).

4. STATE POLICY

4.1 Basic Rules

4.1.1 Health Plans are required to distribute member communication materials to managed care members. Member and non-member communication materials must adhere to the following guidelines:

- 4.1.1.1 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.
- 4.1.1.2 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.
- 4.1.1.3 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.
- 4.1.1.4 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.
- 4.1.1.5 Document all actions and results for any language access services provided to members and be available to the Department upon request.
- 4.1.1.6 Designate a staff person to be responsible for the administration of language access services and auxiliary aids and services.
- 4.1.1.7 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.

4.1.2 Member Communication and Outreach Plan

- 4.1.2.1 The member communication and outreach plan must describe the Health Plan's timeline and process for distributing outreach and member

communication materials, including materials posted to the Health Plan or PIHP Program's website or distributed electronically.

- 4.1.2.2 The Health Plan must also specify the format of its member communication and outreach materials (mailings, radio, TV, billboards, etc.) and its target population or intended audience. The communication plan must include mechanisms to ensure members and potential members understand the requirements and benefits of the Health Plan.
- 4.1.2.3 Health Plans must document in the member communication and outreach plan all member information (which does not contain Protected Health Information) provided electronically to members who provided an email.
- 4.1.2.4 See Addendum III for additional state guidance, including a sample format of the Member and Outreach Communication Plan.
- 4.1.2.5 See Addendum V for state guidance on DHS review and approval of the Member and Outreach Communication Plan, including a template plan.

4.2 Review of Member Communication, Education, Outreach, and Service Expansion Materials

4.2.1 All communication originating from the Health Plans or their providers relating to BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and Wraparound Milwaukee, must be approved by the Department prior to publication or display. See Addendums for additional guidance, including examples for submissions and checklists.

- 4.2.1.1 The Department will review and either approve, approve with modifications, or disapprove all member communication materials and outreach materials within 10 business days, except Member Handbooks, which will be reviewed within 30 days. If the Health Plan does not receive a response from the Department within the prescribed time frame, the Health Plan should contact the Managed Care Section Chief in the Bureau of Benefits Management. A response will be prepared within two business days of this contact.
- 4.2.1.2 Time-sensitive member communication and outreach materials must be clearly marked time-sensitive by the Health Plan and will be approved, approved with modifications, or disapproved by the Department within three business days. The Department reserves the right to determine whether the materials are indeed time-sensitive. If the Health Plan does not receive a response from the Department within three business days, the Health Plan

must contact the Managed Care Section Chief in the Bureau of Benefits Management. A response will be prepared within one business day of this contact.

- 4.2.1.3 The Department will not approve any materials that are confusing, fraudulent or misleading, or that do not accurately reflect the scope, philosophy, or covered benefits of the BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and/or Wraparound Milwaukee programs.
- 4.2.1.4 The Health Plan must correct any problems and errors the Department identifies. The Health Plan agrees to comply with Ins. [6.07](#) and [3.27](#), Wis. Adm. Code, and practices consistent with the Balanced Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [42 U.S.C. 1396v(d)(2)].
- 4.2.1.5 Educational materials prepared by the Health Plan or by their contracted providers and sent to the Health Plan's entire membership (i.e. Medicare, BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, Wraparound Milwaukee, and commercial members) do not require the Department's approval, unless there is specific mention of BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and/or Wraparound Milwaukee. Educational materials prepared by outside entities (i.e. American Cancer Society etc.) do not require the Department's approval.

4.3 Allowed Member Communication and Outreach Practices

4.3.1 Member communication materials should be designed to provide the members with clear and concise information about the Health Plan's program, the Health Plan's network, and the BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and/or Wraparound Milwaukee program. All member communication materials must be written at a sixth-grade comprehension level. An HMO serving members in at least one county in an HMO Rate Region must make its written materials critical to obtaining services available in at least the top three non-English languages for that HMO Rate Region. The Department will determine every three years the non-English languages spoken by members and potential members by Health Plan Rate Region.

- 4.3.1.1 Health Plans may provide information about enrollment, including renewals, in BadgerCare Plus/SSI programs. Health Plans must direct potential members to:
 - 4.3.1.1.1 Apply online at the ACCESS website: www.access.wisconsin.gov
 - 4.3.1.1.2 Complete the online form at:
www.dhs.wisconsin.gov/forms/F1/F10182.pdf;
 - 4.3.1.1.3 Call ForwardHealth Member Services at 1-800-362-3002;

- 4.3.1.1.4 Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.
- 4.3.1.1.5 For Medicaid SSI information please direct members or potential members to:
- 4.3.1.1.6 The Department Link - <https://www.dhs.wisconsin.gov/ddb/apply.htm>
- 4.3.1.1.7 Social Security Administration Resources – How to apply for Medicaid SSI:
 - 4.3.1.1.7.1.1 <https://www.ssa.gov/disabilityssi/>
 - 4.3.1.1.7.1.2 <https://www.ssa.gov/ssi/text-apply-ussi.htm>
- 4.3.1.2 Health Plans may use their logos and names on materials.
- 4.3.1.3 Provide health messaging and other materials to improve health literacy.
- 4.3.1.4 Provide plan information to educate members and potential members.
- 4.3.1.5 Health Plan distributed outreach materials, should be distributed to its entire service area.
- 4.3.2** Health Plans may use results, rankings, and quality metrics in their marketing materials and are permitted to include the Department, national quality organizations’, or other external quality organizations’ results in member marketing.
 - 4.3.2.1 Eligible Health Plan marketing activities include member and non-member written communications, websites, and other marketing media. Quality in Health Plan marketing activities is limited to health, service delivery, or member experience topics only.
 - 4.3.2.2 Health Plans may only reference their own quality results, rankings, metrics, etc. in their marketing materials.
 - 4.3.2.3 Health Plans must state the measure used for the result, ranking, or score, and the source(s) of the result, ranking, or score in any quality based marketing.
 - 4.3.2.4 The Health Plan must submit quality data and/or supporting quality documentation with the marketing materials to validate the Health Plan quality claims. It is the responsibility of the Health Plan to supply the data and/or supporting quality documentation to the Department for all measures. Quality data submitted must be from the most recent available year, and may not be more than 36 months old.
 - 4.3.2.5 Health Plans must include in their quality related marketing submission to the Department the exact quality statement to be used in marketing, quality data to

support the statement, and any additional supporting documentation to verify Health Plan quality claims.

4.3.2.6 Health Plans must comply with any restrictions on use of national quality measures or quality measures external to the Department by relevant external authorities. Where the Department marketing policy conflicts with national or external quality organizations' policy on permitted use of quality results, the Department will defer to the national or external quality organizations' policy unless explicit written permission has been granted by the external quality organization.

4.3.2.7 See Addendum II for additional state guidance, including examples.

4.4 Prohibited Activities

4.4.1 Health Plans are prohibited from marketing to an individual potentially eligible for BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and/or Wraparound Milwaukee. Health Plans are prohibited from marketing to recipients of BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and/or Wraparound Milwaukee members who are not the Health Plan's members.

4.4.2 Health Plans are prohibited from¹:

4.4.2.1 Direct and indirect cold calls, either door-to-door or via telephone with potential members. (See Addendum II and III for additional state guidance, including examples)

4.4.2.2 Practices that seek to influence enrollment in conjunction with the sale of any other insurance product.

4.4.2.3 Offer of material or financial gain to potential members as an inducement to enroll.

4.4.2.4 Materials which contain the assertion that the client must enroll in the Health Plan in order to obtain benefits or avoid losing benefits.

4.4.2.5 Practices that are discriminatory.

4.4.2.6 Activities that could mislead, confuse, or defraud members or potential members or otherwise misrepresent the Health Plan, its marketing representatives, the Department, or CMS.

¹ These are examples and not an exhaustive list of allowed and prohibited practices.

- 4.4.2.7 Materials that contain false information.
 - 4.4.2.8 Practices that are reasonably expected to have the effect of denying or discouraging enrollment.
 - 4.4.2.9 Use the ForwardHealth or BadgerCare Plus logos and/or names with any paid or non-paid mass media and advertising, even if used in conjunction with health messaging. This includes using the logo on member policy cards.
 - 4.4.2.10 Use paid advertising, including mass media, that does not primarily focus on providing public health messages or improving health literacy. (See Addendums II and III for additional state guidance, including examples.)
 - 4.4.2.11 Participate in any activity that interferes with a potential member's ability to seek out enrollment or plan information on his or her own terms; this includes marketing through unsolicited contacts.
 - 4.4.2.12 Solicit to non-members to enroll with a specific Health Plan. Non-members must seek out plan information.
 - 4.4.2.13 Portray competitors in a negative manner or encourage members to disenroll from competing Health Plans.
 - 4.4.2.14 Perform any other activity deemed by the Department as inappropriate or outside the scope and philosophy of the BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and/or Wraparound Milwaukee programs.
- 4.4.3** For additional details and examples of allowed and prohibited activities, please refer to the Addendums attached to this guide.
- 4.4.4** D-SNP plans are prohibited from using the BadgerCare Plus logo/name or the SSI Managed Care name in any marketing or member outreach materials. D-SNP plans are not allowed to conduct any marketing and member outreach activities that have not been previously approved by the Department and/or CMS.
- 4.5 Policies Related to Medicaid Managed Care Program Providers**
- 4.5.1** Providers may educate and inform their patients about the Health Plan's with which they contract.
 - 4.5.2** Providers may inform their patients of the benefits, services, and specialty care services offered through the Health Plan in which they participate.
 - 4.5.3** Providers may give a member contact information for a particular Health Plan, but only at the member's request.

- 4.5.4** Providers are allowed to assist potentially eligible individuals with enrollment in the Medicaid managed care program by helping them:
- 4.5.4.1 Apply online at the Access website: www.access.wisconsin.gov;
 - 4.5.4.2 Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf;
or
 - 4.5.4.3 Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm
- 4.5.5** Providers are allowed to assist potentially eligible individuals with the BadgerCare Plus express enrollment process, as described on the ForwardHealth Portal at www.forwardhealth.wi.gov, if they qualify.
- 4.5.6** Providers are allowed to refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at 1-800-291-2002.
- 4.5.7** Health Plans are allowed to conduct orientations, health fairs, or community baby showers for their members in a private setting at a provider's office.
- 4.5.8** D-SNP plans are allowed to have agreements with providers in connection with plan marketing activities as long as the activity is consistent with Medicare regulations. D-SNP plans may use providers/and or facilities to distribute plan marketing materials as long as the provider and/or the facility distributes marketing materials for all plans with which the provider participates.
- 4.5.9** Providers are prohibited from recommending one HMO over another HMO, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO.
- 4.5.10** Per the Medicare Marketing Guidelines, providers participating in D-SNP plans must remain neutral when assisting members with enrollment decisions to ensure that providers do not appear to be a D-SNP plan agent.
- 4.5.11** Health Plans are required to inform all providers in their network of the policies contained within this Section.

4.6 Other Medicaid and Medicare Programs

4.6.1 Health Plans are allowed to provide general information to Medicaid managed care members about the following programs, if they participate:

4.6.1.1 Family Care

4.6.1.2 Program of All-Inclusive Care for the Elderly (PACE)

4.6.1.3 Family Care Partnership

4.6.2 Health Plans are prohibited from marketing these programs to current Medicaid managed care program members to entice enrollment.

4.6.3 If a Health Plan receives approval from the Department to partner with a Family Care MCO for care management purposes, the review of any materials to members impacted by these arrangements are not subject to the expedited review process and could take longer than ten business days. The review of these materials will be performed jointly by DHS staff that monitors the BadgerCare Plus and Medicaid SSI HMOs as well as Long Term Care staff that monitors Family Care MCOs.

4.7 Qualified Health Plans and Medicaid HMOs

4.7.1 HMOs are allowed to inform their current BadgerCare Plus or Medicaid SSI members transitioning to the Marketplace that they may apply for coverage, compare plans, and enroll in the Marketplace and that the HMO is a participating QHP in the Marketplace. Likewise, HMOs are allowed to inform their Marketplace members that they may be eligible for BadgerCare Plus or Medicaid SSI and direct them to the appropriate resources.

4.7.2 HMOs are allowed to participate in community-wide outreach and marketing activities surrounding Marketplace participation.

4.7.3 HMOs are prohibited from asserting that a member must enroll in the HMO's QHP in order to obtain benefits or avoid losing benefits.

4.7.4 HMOs are prohibited from direct marketing (e.g., telephone calls, mailings, home visits) their specific marketplace plan to non-members. Non-members include parents who have children enrolled with a particular BadgerCare Plus HMO.

4.7.5 If an HMO has information on its website about the Marketplace or about transitioning BadgerCare Plus and/or Medicaid SSI members, it should include a link to the following DHS website: <https://www.dhs.wisconsin.gov/guide/wigov.htm>

4.8 The Health Plan Agreement to Abide by Member Communication/Informing Criteria

4.8.1 The Health Plan agrees to engage only in member communication and outreach activities and distribute only those materials that are pre-approved in writing. The Health Plans that fails to abide by these requirements may be subject to sanctions. In determining any sanctions, the Department will take into consideration any past unfair member communication, or marketing practices, the nature of the current problem, and the specific implications on the health and well-being of members. In the event that the Health Plan's affiliated provider fails to abide by these requirements, the Department will evaluate if it was reasonable for the Health Plan to have had knowledge of the member communication or marketing issue and the Health Plan's ability to adequately monitor ongoing future member communication or marketing activities of the subcontractors.

4.8.2 Any Health Plan that engages in marketing or that distributes materials without prior approval by the Department may be subject to:

4.8.2.1 Immediate retraction of materials

4.8.2.2 Sanctions detailed in Article XIV, Section C of the Contract.

4.9 Reproduction/Distribution of Materials

4.9.1 Health Plans may reproduce and distribute (at their own expense) information or documents sent to the Health Plan from the Department that contains information the Health Plan-affiliated providers must have in order to fully implement the Contract.

4.10 Health Plan Identification (ID) Cards

4.10.1 The Health Plan may issue its own Health Plan ID cards. The Health Plan may not deny services to a member solely for failure to present the Health Plan issued ID card. The ForwardHealth cards will always determine the Health Plan enrollment, even where the Health Plan issues Health Plan ID cards.

4.11 Certification Application

4.11.1 As part of the certification application, the Health Plan must submit the policies and procedures for language access services and auxiliary aids and services. For interpreters, a list of interpreters the Health Plan uses, and the language spoken by each interpreter must be included as part of the certification application. The Health Plan must also submit, as part of certification, its policy on provision of auxiliary aids and services for hearing-impaired members. The policy must include a description of the Health Plan's process for assessing the preferred method of communication of each hearing-impaired member. The Health Plan must offer each hearing-impaired or vision-impaired member the type of auxiliary aid(s) s/he prefers in order to access program

services and benefits. Once the hearing-impaired or vision-impaired member identifies the type of auxiliary aid(s) s/he prefers, a less effective form of communication may not be used. For example, a person who can most effectively communicate in sign language may not be required to communicate using hand written notes. For members with visual impairment, the Health Plan must include its policy on providing materials in Braille, larger fonts, or other alternatives.

4.12 Supplemental Contact Information and Email

4.12.1 Use of Phone Numbers

- 4.12.1.1 Health Plans are allowed to use additional telephone numbers included on the Supplemental Demographic Information Report for members enrolled in the Health Plan. All requirements regarding telephone communications included within this guide apply for all telephone numbers provided by the member.

- 4.12.1.2 If provided, Health Plans should always use the member's preferred contact method, preferred contact time, and preferred contact telephone number when first attempting to reach the member by telephone. If the Health Plan is unable to speak with the member but is able to leave a message, the Health Plan must not seek to speak with the member directly by contacting multiple telephone numbers provided or leaving multiple messages on different telephone lines. When leaving a message, personal health information (PHI) must not be included in the message.

4.12.2 Email Communication

- 4.12.2.1 Personal Health Information (PHI) must not be included in email communication from the Health Plan to a member. To protect the member's privacy and confidentiality, email communications that contain PHI require a secure portal log-in to view the information. To assure the member, the Health Plan must inform the member that the Health Plan will never request personally identifiable information via email. Rather, Health Plans will request members to log-in to a secure portal to update or provide personally identifiable information.

- 4.12.2.2 For example, a general health and wellness newsletter that is sent via email does not require a secure portal; however, any communication specific to an individual's diagnosis or health condition will require the member to access the information through a secure portal. This could include general information or survey targeting treatment or care for an individual's diagnosis or health condition.

4.12.2.3 Health Plans are prohibited from sending emails to members (or their authorized representative) that are not currently enrolled in their Health Plan. Depending on who has provided an email address, there may be differences in the type of information a Health Plan can communicate over email to an enrolled member.

4.12.3 Email Content

4.12.3.1 Within the email, the Health Plan must use clear subject lines. Subject lines must accurately reflect the content of the message. The message must provide a valid physical postal address. The message must also provide a clear and conspicuous explanation of how the member can choose to stop receiving emails from the Health Plan in the future. The Health Plan cannot sell or transfer email addresses, even in the form of a mailing list.

4.12.4 Subscribing to Emails

4.12.4.1 The Health Plan can ask for the member's email address for purposes of subscribing to the Health Plan's electronic communications for the Health Plan's records. The Health Plan must explicitly indicate the type of information that will be communicated electronically and how to unsubscribe to emails from the Health Plan before requesting a member's email address. The Health Plan cannot require a member to sign up for email subscription in order to get information about the Health Plan.

4.12.5 Text Message Notifications

4.12.5.1 The Health Plan must request consent from the member to use his or her phone number for text messages or text notifications. When collecting consent from the member to send text messages or text notifications, the Health Plan must indicate the type of information that may be communicated through text messaging and how to unsubscribe from text messages from the Health Plan. The Health Plan cannot require a member to sign up for a text subscription to get information about the health plan.

4.12.6 Unsubscribing from Emails or Text Messages

4.12.6.1 The Health Plan must inform the member on how and where to unsubscribe from receiving email communications or text messages from the Health Plan.

4.12.6.2 Email address will continue to be shared with the Health Plan until the member updates his or her information in ACCESS. In order to prevent the member's email address from being shared with the Health Plan, the member must update their MyACCESS account or contact the IM agency. After

creating or logging into their MyACCESS account, the member can choose to update or remove their email address and stop sharing their email address under the “Manage My Email” feature. Any changes made to email address should appear on the next Supplemental Demographic Report for Health Plans.

5. MEMBER HANDBOOK, PROVIDER DIRECTORY, EDUCATION AND OUTREACH FOR NEWLY ENROLLED MEMBERS

5.1 General Requirements

5.1.1 The member handbook shall be written at a sixth-grade reading comprehension level. In addition to the requirements in Section 4, the Health Plans must include information on these Standard Member Handbook requirements. See Addendum I template:

5.1.1.1 The telephone number that can be used for assistance in obtaining emergency care or for prior authorization for urgent care.

5.1.1.2 Location of facilities.

5.1.1.3 Hours of service.

5.1.1.4 HealthCheck.

5.1.1.5 Contracted providers' telephone numbers and whether the provider is accepting new "members." Additionally, include languages spoken by the provider.

5.1.1.6 SSI Comprehensive assessments (for Medicaid SSI members only).

5.1.2 Health Plans must post their current BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and/or Wraparound Milwaukee member handbook and provider directory on their website following the requirements of 42 CFR § 438.10(g) and (h). Annually, Health Plans must notify all members that these materials are available online and can be mailed hard copy upon request.

5.1.3 With Department approval, Health Plans may send member handbooks, provider directories, newsletters, and other new member information (which does not contain Protected Health Information) electronically to members that provide an e-mail address to the Health Plan, provided the Health Plan meets the timeframes regarding distribution of member handbooks. Health Plans may also choose to send the annual materials electronically to members that have provided an e-mail address.

5.1.4 Notification about the availability of the member handbook and provider directory must be mailed to each case head, but Health Plans may choose to mail to each individual member.

- 5.1.4.1 As needed, the Health Plan must provide periodic updates to the handbook and notify members of changes to the information listed above. The Health Plan must provide members at least a 30 day notice, in writing, of any significant changes to the handbook before the intended effective date of the change. Such changes must be approved by the Department prior to printing. The Health Plan must work with the Department to review these changes in accordance with the timeline established in Article VI, A.2.
- 5.1.4.2 When the Health Plan reprints their member handbooks, they must include all of the changes to the standard language as specified in this Guide and Contract.
- 5.1.4.3 The member handbook (or other substitute member information approved by the Department that explains the Health Plan's services and how to use the Health Plan) must be made available upon request within a reasonable timeframe in the three prevalent languages for each rate region. The handbook must tell members how to obtain a copy of the handbook in those languages. The Department will translate the standard handbook language into the three prevalent languages for each rate region. The Health Plan may use the translated standard handbook language as appropriate in its service area. However, the Health Plan must have local resources review the final handbook language to ensure that the appropriate dialect(s) is/are used in the standard translation. The Health Plan must also arrange for translation into any other dialects appropriate for its members. The Health Plan also must arrange for the member handbook to be provided in braille, larger fonts or be orally translated for its visually limited members.
- 5.1.4.4 At a minimum, the Health Plans must include the information provided in the Standard Member Handbook language (Addendum I). The Health Plan may create member handbook language that is simpler than the standard language, but the language must be approved by the Department. The Health Plan must also independently arrange for the translation of any non-standard language.
- 5.1.4.5 The Health Plan must submit their member handbook for review and approval no more than 60 days after the effective date of the Contract.
- 5.1.4.6 Any exceptions to the standard language must be approved in advance by the Department, and will be approved only for exceptional reasons. If the standard language changes during the course of the Contract period, due to changes in federal or state laws, rules or regulations, the Health Plan must

insert the new language into the member handbooks as of the effective date of any such change and notify members of the changes.

5.2 Additional Education and Outreach Activity Requirements

5.2.1 The Health Plan must perform other education and outreach activities for newly enrolled members.

5.2.1.1 As part of the member communication and outreach plan, the Health Plan shall include activities targeted towards newly enrolled members.

5.2.1.1.1 Newly enrolled members are listed as “ADD-New” on the enrollment reports.

5.2.1.1.2 The plan must identify at least two educational/outreach activities the Health Plan will undertake to tell new members how to access services within the Health Plan network.

5.2.1.1.3 The communication and outreach plan must include the frequency (i.e., weekly, monthly, etc.) of the activities, the person within the Health Plans responsible for the activities, and how the activities will be documented and evaluated for effectiveness.

5.2.1.1.4 See Addendum III for additional state guidance, including a member communication and outreach plan template.

6. ADDENDUMS

6.1 Purpose

To establish policies and provide examples for the use of communication and outreach materials for Health Plans.

6.2 Policy

Pursuant to State Policy, the Department has developed specific guidelines Health Plans must follow when communicating with members and non-members. Health Plans are permitted to use various forms of communication with members and non-members. Federal and State laws do place restrictions on information that can be shared through these forms of communication. As addendums to this communications, outreach, and marketing guide, Health Plans can find examples to the allowed and prohibited activities.

Addendum I Standard Member Handbook

I. STANDARD MEMBER HANDBOOK LANGUAGE FOR BADGERCARE PLUS AND MEDICAID SSI

INTERPRETER SERVICES

[Note to HMO/PIHP: The Member Handbook must contain taglines in at least the top three non-English languages spoken by members in the applicable HMO Rate Region or PIHP Service Area, as well as large print, explaining that written translation or oral interpretation of the document is available to the member free of charge. The non-English tagline is provided in a fillable Word Document and is available for download at:

<https://www.dhs.wisconsin.gov/publications/p02057.docx>

[Insert applicable non-English taglines here].

[Note to HMO/PIHP: The Member Handbook must also include a large print tagline with information on how to request auxiliary aids and services, including the provision of the materials in alternative formats.]

[Name of HMO/PIHP program]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact [Name of entity or of contact at HMO/PIHP] at 1-xxx-xxx-xxxx.

IMPORTANT [HMO/PIHP PROGRAM NAME] TELEPHONE NUMBERS

Customer Service	1-800-xxx-xxxx	[Hours/Days Available]
Emergency Number	1-800-xxx-xxxx	Call 24 hours a day, seven days a week
TDD/TTY	1-800-xxx-xxxx	

WELCOME

Welcome to [HMO/PIHP Program Name]. As a member of [HMO Name/PIHP Program], you should get all your health care from doctors and hospitals in the [HMO Name/PIHP Program] network. See [HMO Name/PIHP Program] Provider Directory for a list of these providers. You may also call our Customer Service Department at 1-800-xxx-xxxx. Providers accepting new patients are marked in the Provider Directory.

USING YOUR FORWARDHEALTH ID CARD

Your ForwardHealth ID card is the card you will use to get your BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, or Wraparound Milwaukee benefits. Your ForwardHealth ID card is different from your HMO/PIHP Program card. Always carry your ForwardHealth ID card with you, and show it every time you go to the doctor or hospital and every time you get a prescription filled. You may have problems getting health care or prescriptions if you do not have your card with you. Also bring any other health insurance cards you may have. This could include any ID card from your HMO/PIHP Program or other service providers.

CHOOSING A PRIMARY CARE PHYSICIAN

When you need care, it is important to call your primary care physician first. It is important to choose a primary care physician to manage all your health care. You can choose a primary care physician from the list of doctors accepting new patients, as marked in the [HMO/PIHP Program Name] Provider Directory. HMO/PIHP doctors are sensitive to the needs of many cultures. To choose a primary care physician or to change primary care physicians, call our Customer Service Department at 1-800-xxx-xxxx. Your primary care physician will help you decide if you need to see another doctor or specialist and, if appropriate, give you a referral. Remember, you must get approval from your primary care physician before you see another doctor.

Women may see a women's health specialist, such as an Obstetrician and Gynecologist (OB/GYN), nurse midwife, or licensed midwife, without a referral in addition to choosing from their primary care physician.

ACCESSING THE CARE YOU NEED

Emergency Care

Emergency care is care that is needed right away. Some examples are:

- Choking
- Convulsions
- Prolonged or repeated seizures
- Serious broken bones
- Severe burns

- Severe pain
- Severe or unusual bleeding
- Suspected heart attack
- Suspected poisoning
- Suspected stroke
- Trouble breathing
- Unconsciousness

If you need emergency care, try to go to a [HMO/PIHP Program Name] provider for help. If your condition cannot wait, go to the nearest provider (hospital, doctor, or clinic). Call 911 or your local police or fire department emergency services if the emergency is very severe and you are unable to get to the nearest provider.

If you must go to a non-[HMO/PIHP Program Name] hospital or provider, call [HMO/PIHP Program Name] at 1-800-xxx-xxxx as soon as you can to tell us what happened.

Remember, hospital emergency rooms are for true emergencies only. Unless you have a true emergency, call your doctor or our 24-hour emergency number at [1-800-xxx-xxxx] before you go to the emergency room. If you do not know if your illness or injury is an emergency, call [Note to HMO/PIHP: Insert applicable instructions here—call clinic, doctor, 24-hour number, nurse line, etc.]. We will tell you where you can get care.

A prior authorization is not required for emergency services.

Urgent Care

Urgent care is care you need sooner than a routine doctor's visit, but it is not emergency care. Some examples are:

- Bruises
- Minor burns
- Minor cuts
- Most broken bones
- Most drug reactions
- Bleeding that is not severe
- Sprains

You must get urgent care from [HMO/PIHP Program Name] doctors unless you first get our approval to see a non-[HMO/PIHP Program Name] doctor. Do not go to a hospital emergency room for urgent care unless you get approval from [HMO/PIHP Program Name] first.

Care When You Are Away From Home

Follow these rules if you need medical care but are too far away from home to go to your regular primary care physician or clinic:

- For true emergencies, go to the nearest hospital, clinic, or doctor. Call [HMO/PIHP Program Name] at 1-800-xxx-xxxx as soon as you can to tell us what happened.
- For urgent or routine care away from home, you must first get approval from us to go to a different doctor, clinic, or hospital. This includes children who are spending time away from home with a parent or relative. Call us at 1-800-xxx-xxxx for approval to go to a different doctor, clinic, or hospital.

Care During Pregnancy and Delivery

If you become pregnant, please let [HMO/PIHP Program Name] and your income maintenance (IM) agency know right away, so you can get the extra care you need. You do not have copayments when you are pregnant.

You must go to a [HMO/PIHP Program Name] hospital to have your baby. Talk to your [HMO/PIHP Program Name] doctor to make sure you know which hospital you are to go to when it is time to have your baby. Do not go out of area to have your baby unless you have [HMO/PIHP Program Name] approval. Your [HMO/PIHP Program Name] doctor knows your history and is the best doctor to help you.

Also, talk to your doctor if you plan to travel in your last month of pregnancy. We want you to have a healthy birth and a good birthing experience, so it may not be a good time for you to be traveling.

WHEN YOU MAY BE BILLED FOR SERVICES

Covered and Noncovered Services

Under BadgerCare Plus, Medicaid SSI, Children Come First, and Wraparound Milwaukee, you do not have to pay for covered services other than required copayments. The amount of your copay cannot be greater than it would have been in fee-for-service. To help ensure that you are not billed for services, you must see a provider in [HMO/PIHP Program Name (excludes C4K)]'s network. The only exception is for emergencies. If you are willing to accept financial responsibility and make a written payment plan with your provider, you may ask for noncovered services. Providers may bill you up to their usual and customary charges for noncovered services.

If you get a bill for a service you did not agree to, please call 1-800-xxx-xxxx.

Copayments

Under BadgerCare Plus and Medicaid SSI, [HMO Name] and its providers and subcontractors may bill you small service fees, called copayments. The following members do not have to pay copayments:

- Nursing home residents
- Pregnant women
- Members younger than 19 years old who are members of a federally recognized tribe
- Members younger than 19 years old with incomes at or below 100 percent of the federal poverty level

Medical Services Received Outside Wisconsin

If you travel outside Wisconsin and need emergency care, health care providers in the area where you travel can treat you and send the bill to [HMO Name/PIHP Program]. You may have copayments for emergency services provided outside Wisconsin.

[HMO Name/PIHP Program] does not cover any services, including emergency services, provided outside the United States, Canada, and Mexico. If you need emergency services while in Canada or Mexico, [HMO Name/PIHP Program] will cover the service only if the doctor's or hospital's bank is in the United States. Other services may be covered with HMO/PIHP approval if the provider has a U.S. bank. Please call [HMO Name/PIHP Program] if you get any emergency services outside the United States.

If you get a bill for services, call our Customer Service Department at 1-800-xxx-xxxx right away.

OTHER INSURANCE

If you have other insurance in addition to [HMO Name/PIHP Program], you must tell your doctor or other health care provider. Your doctor or other health care provider must bill your other insurance before billing [HMO Name/PIHP Program]. If your [HMO Name/PIHP Program] doctor or other health care provider does not accept your other insurance, call the HMO Enrollment Specialist at 1-800-291-2002. The HMO Enrollment Specialist can tell you how to use both insurance plans.

SERVICES COVERED BY [HMO NAME/PIHP Program]

[HMO NAME/PIHP Program] is responsible for providing all medically necessary covered services under BadgerCare Plus and Medicaid SSI. [Note to HMO/PIHP: Information you provide for these sections must be approved by the Department of Health Services.]

Mental Health and Substance Abuse Services

[Note to HMO/PIHP: The language you use in this section may vary based on which plan you are talking about. See the summary of covered services and copayments referenced in Addendum V.]

[HMO Name/PIHP Program] provides mental health and substance abuse (drug and alcohol) services to all members. If you need these services, call [Note to HMO/PIHP: Insert primary care physician, behavioral health manager, customer service, etc., as appropriate]. If you need immediate help, you can call the Crisis Hotline at 1-800-xxx-xxxx or our 24-Hour Nurse Line at 1-800-xxx-xxxx, which is open seven days a week.

All services provided by [HMO Name/PIHP Program] are private.

Family Planning Services

[Note to HMO/PIHP: The language you use in this section may vary based on which plan you are talking about. See the summary of covered services and copayments referenced in Addendum V.]

We provide private family planning services to all members, including minors. If you do not want to talk to your primary care physician about family planning, call our Customer Service Department at 1-800-xxx-xxxx. We will help you choose a [HMO Name/PIHP Program] family planning doctor who is different from your primary care physician.

We encourage you to get family planning services from a [HMO Name/PIHP Program] doctor so that we can better coordinate all your health care. However, you can also go to any family planning clinic that will accept your ForwardHealth ID card, even if the clinic is not part of [HMO Name/PIHP Program].

Dental Services

[Note to HMO/PIHP: Use the first statement below if you provide dental services. Use the second statement if you do not provide dental services. If you provide dental services in only part of your service area, use both statements and list the appropriate counties with each statement].

[Statement 1]

[HMO Name/PIHP Program] provides all covered dental services. You must go to a [HMO Name/PIHP Program] dentist. See the Provider Directory or call our Customer Service Department at 1-800-xxx-xxxx for the names of our dentists.

As a member of [HMO Name/PIHP Program], you have the right to a routine dental appointment within 90 days of your request either in writing or over the phone to the Customer Service Department.

[Statement 2]

Dental services are a covered benefit for you. You may get covered dental services from a Medicaid-enrolled provider who will accept your ForwardHealth ID card. To find a Medicaid-enrolled provider:

1. Go to www.forwardhealthwi.gov.
2. Click on the Members link or icon in the middle section of the page.
3. Scroll down and click on the Resources tab.
4. Click on the Find a Provider link.
5. Under Program, select BadgerCare Plus.

Or, you can call ForwardHealth Member Services at 1-800-362-3002.

If you have a dental emergency, you have the right to obtain treatment within 24 hours of your request. A dental emergency is a need for immediate dental services to treat severe dental pain, swelling, fever, infection, or injury to the teeth. If you are experiencing a dental emergency:

- If you already have a dentist who is with [HMO Name/C4K]:
 - Call the dentist's office.
 - Tell the dentist's office that you or your child is having a dental emergency.
 - Tell the dentist's office what the exact dental problem is. This may be something like a severe toothache or swollen face.
 - Call us if you need help with getting a ride to or from your dental appointment.
- If you do not currently have a dentist who is with [HMO Name/C4K]:
 - Call [Note to HMO/C4K: insert dental benefits manager or HMO, as appropriate.]. Tell us that you or your child is having a dental emergency. We can help you get dental services.
 - Tell us if you need help with getting a ride to or from the dentist's office.

[Alternative language for HMOs whose dental benefits manager handles appointments for emergencies.]

Call [HMO Name] if you need help with getting a ride to or from the dentist's office. We can help with getting a ride.

For help with a dental emergency, call x-xxx-xxx-xxxx.

Chiropractic Services

[Note to HMO/PIHP: Use the first statement below if you provide chiropractic services. Use the second statement if you do not provide chiropractic services.]

[Statement 1]

[HMO Name/PIHP Program] provides covered chiropractic services for [BadgerCare Plus and Medicaid SSI or Care4Kids] members. You must go to a [HMO Name/PIHP Program] chiropractor. See the Provider Directory or call the Customer Service Department at 1-800-xxx-xxxx for the names of our chiropractors.

[Statement 2]

Chiropractic services are a covered benefit under [BadgerCare Plus and Medicaid SSI and Care4Kids]. You may get covered chiropractic services from a Medicaid-enrolled provider who will accept your ForwardHealth ID card. To find a Medicaid-enrolled provider:

1. Go to www.forwardhealthwi.gov.
2. Click on the Members link or icon in the middle section of the page.
3. Scroll down and click on the Resources tab.
4. Click on the Find a Provider link.
5. Under Program, select BadgerCare Plus.

Or, you can call ForwardHealth Member Services at 1-800-362-3002.

Vision Services

[HMO Name/C4K] provides covered vision services, including eyeglasses; however, some limitations apply. For more information, call our Customer Service Department at 1-800-xxx-xxxx.

Autism Treatment Services

Behavioral treatment services are a covered benefit under [BadgerCare Plus and C4K]. You may get covered autism treatment services from a Medicaid-enrolled provider who will accept your ForwardHealth ID card. To find a Medicaid-enrolled provider:

1. Go to www.forwardhealthwi.gov.
2. Click on the Members link or icon in the middle section of the page.
3. Scroll down and click on the Resources tab.
4. Click on the Find a Provider link.
5. Under Program, select BadgerCare Plus.

Or, you can call ForwardHealth Member Services at 1-800-362-3002.

HealthCheck Services

HealthCheck is a program that covers complete health checkups, including treatment for health problems found during the checkup, for members younger than 21 years old. These checkups are

very important. Doctors need to see those younger than 21 years old for regular checkups, not just when they are sick.

The HealthCheck program has three purposes:

1. To find and treat health problems for those younger than 21 years old.
2. To increase awareness of the special health services for those younger than 21 years old.
3. To make those younger than 21 years old eligible for some health care not otherwise covered.

The HealthCheck checkup includes:

- Age appropriate immunizations (shots)
- Blood and urine lab tests (including blood lead level testing when age appropriate)
- Dental screening and a referral to a dentist beginning at 1 year old
- Health and developmental history
- Hearing screening
- Physical examination
- Vision screening

To schedule a HealthCheck exam or for more information, call our Customer Service Department at 1-800-xxx-xxxx.

If you need a ride to or from a HealthCheck appointment, please call the Department of Health Services (DHS) non-emergency medical transportation (NEMT) manager at 1-866-907-1493 (or TTY 1-800-855-2880) to schedule a ride.

Transportation Services

Non-emergency medical transportation (NEMT) is available through the DHS NEMT manager. The NEMT manager arranges and pays for rides to covered services for members who have no other way to receive a ride. Non-emergency medical transportation can include rides using:

- Public transportation, such as a city bus
- Non-emergency ambulances
- Specialized medical vehicles
- Other types of vehicles, depending on a member's medical and transportation needs

Additionally, if you use your own private vehicle for rides to and from your covered health care appointments, you may be eligible for mileage reimbursement.

You must schedule routine rides at least two business days before your appointment. You can schedule a routine ride by calling the NEMT manager at 1-866-907-1493 (or TTY 711), Monday

through Friday, from 7:00 a.m. until 6:00 p.m. You may also schedule rides for urgent appointments. A ride to an urgent appointment will be provided in three hours or less.

Pharmacy Benefits

You may get a prescription from a [HMO Name/PIHP Program] doctor, specialist, or dentist. You can get covered prescriptions and certain over-the-counter items at any pharmacy that will accept your ForwardHealth ID card.

You may have copayments or limits on covered medications. If you cannot afford your copayments, you can still get your prescriptions.

CARE EVALUATION/HEALTH NEEDS ASSESSMENT (BadgerCare Plus Childless Adults and SSI Managed Care only)

As a member of [HMO Name/PIHP Program], you may be asked to talk with a trained staff member about your health care needs. Your HMO/PIHP Program will contact you within the first 60 days of your being enrolled with [HMO Name/PIHP Program] to schedule a time to talk about your medical history and the care you need. It is very important that you talk with your HMO/PIHP so that you can get the care and services you need. If you have questions or would like to contact [HMO Name/PIHP Program] directly to schedule a time to talk about your health care needs, please call 1-800-xxx-xxxx.

IF YOU MOVE

If you are planning to move, contact your current Income Maintenance (IM) agency. If you move to a different county, you must also contact the IM agency in your new county to update your eligibility for BadgerCare Plus or Medicaid SSI.

If you move out of [HMO Name's/PHIP Program] service area, call the HMO Enrollment Specialist at 1-800-291-2002. The HMO Enrollment Specialist will help you choose a new HMO that serves your new area.

GETTING A SECOND MEDICAL OPINION

If you disagree with your doctor's treatment recommendations, you may be able to get a second medical opinion. Contact your doctor or our Customer Service Department at 1-800-xxx-xxxx for information.

HMO EXEMPTIONS

Generally, you must enroll in an HMO to get health care benefits through BadgerCare Plus and Medicaid SSI. An HMO exemption means you are not required to join an HMO to get your health care benefits. Most exemptions are granted for only a short period of time, primarily to allow you to complete a course of treatment before you are enrolled in an HMO. If you think you

need an exemption from HMO enrollment, call the HMO Enrollment Specialist at 1-800-291-2002 for more information.

GETTING HELP WHEN YOU HAVE QUESTIONS OR PROBLEMS

[HMO Name's/PIHP Program] Member Advocate

[HMO Name/PIHP Program] has a Member Advocate to help you get the care you need. You should contact your Member Advocate for help with any questions about getting health care and solving any problems you may have getting health care from [HMO Name/PIHP Program]. You can reach the Member Advocate at 1-800-xxx-xxxx.

Enrollment Specialist

To get information about what managed care is and other managed care choice counseling, you can contact call the HMO Enrollment Specialist at 1-800-291-2002 for assistance.

External Advocate (for Medicaid SSI Only)

If you have problems getting health care services while you are enrolled with (HMO Name) for Medicaid SSI, call the SSI External Advocate at 1-800-xxx-xxxx.

State of Wisconsin HMO Ombuds Program

The state has designated Ombuds (individuals who provide neutral, confidential and informal assistance) who can help you with any questions or problems you have as an [HMO/PIHP] Program member. The Ombuds can tell you how to get the care you need from your [HMO/PIHP]. The Ombuds can also help you solve problems or complaints you may have about the [HMO/PIHP] program or your [HMO/PIHP]. Call 1-800-760-0001 and ask to talk to an Ombuds.

FILING A GRIEVANCE, OR APPEAL

Grievances

A grievance is any complaint about your HMO/PIHP or health care provider that is not related to a denial, limitation, reduction, or delay in your benefits. Grievance topics include things like the quality of services you were provided, rudeness from a provider or an employee, and not respecting your rights as a member.

We would like to know if you ever have a grievance about your care at [HMO Name/PIHP Provider]. Please call [HMO Name's/PIHP Program's] Member Advocate at 1-800-xxx-xxxx, or write to us at the following address if you have a grievance:

[HMO Name/PIHP Program and Mailing Address]

If you want to talk to someone outside [HMO Name/PIHP Program] about the problem, call the HMO Enrollment Specialist at 1-800-291-2002. The HMO Enrollment Specialist may be able to help you solve the problem or write a formal grievance to [HMO Name/PIHP Program] or to the [BadgerCare Plus, Medicaid SSI, Care4Kids, CCF, or WAM] programs. If you are enrolled in a Medicaid SSI Program, you can also call the SSI External Advocate at 1-800-xxx-xxxx for help with grievances.

The address to file a grievance with the BadgerCare Plus, Medicaid SSI, Care4Kids, CCF and WAM programs is:

BadgerCare Plus and Medicaid SSI
Managed Care Ombuds
P.O. Box 6470
Madison, WI 53716-0470
1-800-760-0001

You may file a grievance at any time. You will not be treated differently from other members because you file a complaint or grievance. Your health care benefits will not be affected.

Appeals

You have the right to appeal if you believe your benefits are wrongly denied, limited, reduced, delayed, or stopped by [HMO Name/PIHP Program]. Your authorized representative or your provider may request an appeal for you if you have given them consent to do so. When requesting an appeal, you must appeal to your [HMO/PIHP Program] first. The request for an appeal must be made no more than 60 days after you receive notice of services being denied, limited, reduced, delayed, or stopped.

If you need help writing a request for an appeal, please call your [HMO/PIHP Program] Advocate at 1-800-xxx-xxxx, the BadgerCare Plus and Medicaid SSI Ombuds at 1-800-760-0001, or the HMO Enrollment Specialist at 1-800-291-2002. If you are enrolled in a Medicaid SSI Program, you can also call the SSI External Advocate at 1-800-xxx-xxxx for help with your appeal.

If you disagree with your [HMO's/PIHP Program's] decision about your appeal, you may request a fair hearing with the Wisconsin Division of Hearing and Appeals. The request for a fair hearing must be made no more than 90 days after your [HMO/PIHP] makes a decision about your appeal.

If you want a fair hearing, send a written request to:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The hearing will be held with an administrative law judge in the county where you live. You have the right to be represented at the hearing, and you can bring a friend for support. If you need a special arrangement for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (hearing impaired).

If you need help writing a request for a fair hearing, please call either the BadgerCare Plus and Medicaid SSI Ombuds at 1-800-760-0001 or the HMO Enrollment Specialist at 1-800-291-2002. If you are enrolled in a Medicaid SSI Program, you can also call the SSI External Advocate at 1-800-xxx-xxxx for help.

You will not be treated differently from other members because you request a fair hearing. Your health care benefits will not be affected.

You may request to have the disputed services continued while the [HMO/PIHP Program] appeal and State fair hearing process are occurring. The request to continue services must happen within 10 days of receiving the notice that services were denied or changed, or before the effective date of the denial or change in benefits. You may need to pay for the cost of services if the hearing decision is not in your favor.

YOUR RIGHTS

Knowing About Physician Incentive Plan

You have the right to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services you might need. To get this information, call our Customer Service Department at 1-800-xxx-xxxx and request information about our physician payment arrangements.

Knowing Provider Credentials

You have the right to information about our providers including the provider's education, board certification, and recertification. To get this information, call our Customer Service Department at 1-800-xxx-xxxx.

Completing an Advance Directive, Living Will, Or Power Of Attorney For Health Care

You have the right to make decisions about your medical care. You have the right to accept or refuse medical or surgical treatment. You have the right to plan and direct the types of health care you may get in the future if you become unable to express your wishes. You can let your

doctor know about your wishes by completing an advance directive, living will, or power of attorney for health care. Contact your doctor for more information.

You have the right to file a grievance with the DHS Division of Quality Assurance if your advance directive, living will, or power of attorney wishes are not followed. You may request help in filing a grievance.

Transition of Care

If you have moved from ForwardHealth or a BadgerCare Plus HMO to a new BadgerCare Plus HMO, then you have the right to:

- Continue to see your current providers and access your current services for up to 90 days. Please call your HMO upon enrollment to let them know who your provider is. If this provider is still not in the HMO network after 90 days, you will be given a choice of participating providers to make a new choice.
- Receive services that would pose a serious health risk or hospitalization if you did not receive them.

Right to Medical Records

You have the right to ask for copies of your medical records from your provider(s). We can help you get copies of these records. Please call 1-800-xxx-xxxx for help. Please note that you may have to pay to copy your medical records. You may correct inaccurate information in your medical records if your doctor agrees to the correction.

[HMO/PIHP] Moral or Religious Objection

The [HMO/PIHP] will inform members of any covered Medicaid benefits which are not available through the [HMO/PIHP] because of an objection on moral or religious grounds. [HMO Name/PIHP Program] will inform members about how to access those services through the State.

Your Member Rights

- You have the right to have an interpreter with you during any [BadgerCare Plus, Medicaid SSI, C4K, CCF and/or WAM] covered service.
- You have the right to get the information provided in this member handbook in another language or format.
- You have the right to get health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.

- You have the right to get information about treatment options including the right to request a second opinion.
- You have the right to make decisions about your health care.
- You have the right to be treated with dignity and respect.
- You have the right to be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal.
- You have the right to be free to exercise your rights without adverse treatment by the [HMO/PIHP] and its network providers.
- [FOR HMOs ONLY] You may switch HMOs without cause during the first 90 days of [HMO Name] enrollment.
- [FOR HMOs ONLY] You have the right to switch HMOs, without cause, if the State imposes sanctions or temporary management on [HMO Name].

You have the right to receive information from [HMO/PIHP Program Name] regarding any significant changes with [HMO/PIHP Program Name] at least 30 days before the effective date of the change.

- You have the right to disenroll from the [HMO or PIHP Program] if:
 - You move out of the [HMO/PIHP's] service area
 - Your [HMO/PIHP] does not, for moral or religious objections, cover a service you want
 - You need a related service performed at the same time, not all related services are available within the provider network, and your PCP or another provider determines that receiving the services separately could put you at unnecessary risk
 - Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with your care needs.

You have the right to disenroll from [PIHP Program] at any time.

Your Civil Rights

[HMO/PIHP Program Name] provides covered services to all eligible members regardless of the following:

- Age

- Color
- Disability
- National origin
- Race
- Sex

All medically necessary covered services are available and will be provided in the same manner to all members. All persons or organizations connected with [HMO/PIHP Program Name] that refer or recommend members for services shall do so in the same manner for all members.

Fraud and Abuse

If you suspect fraud or abuse of the Medicaid program, you may report it. Please go to www.reportfraud.wisconsin.gov.

Addendum II Written Communication and Marketing

1. Purpose

- a. To provide state guidance, including considerations and examples, for the use of written communication materials by health plans. Written communication may include letters, flyers, websites, electronic media², surveys, direct marketing, and mass media.
- b. To provide a method for Health Plans to gather information relating to currently enrolled health plan members.
- c. To establish uniform standards regarding marketing by Health Plan.
- d. Examples for allowable and prohibited activities related outreach and marketing are outlined below.

2. Language and Format Requirements

- a. The top three prevalent non-English languages for each HMO Rate Region or PIHP Service Area for 2018 through 2020 as established through the American Community Survey data and member self-reported data to identify are:

HMO Rate Region	Non-English Language		
Rate Region 1	Spanish	Hmong	Chinese
Rate Region 2	Spanish	Hmong	Somali
Rate Region 3	Spanish	Hmong	Lao
Rate Region 4	Spanish	Hmong	Chinese
Rate Region 5	Spanish	Chinese	Russian
Rate Region 6	Spanish	Burmese	Hmong

- b. Below are suggested large print (18 point font) tagline translated in the prevalent non-English languages identified across all HMO Rate Regions and PIHP Service Areas (and FamilyCare Geographic Service Regions). The large print tagline is provided in a fillable Word Document and PDF and is available for download at:

- i. <https://www.dhs.wisconsin.gov/publications/p02057.docx>
- ii. <https://www.dhs.wisconsin.gov/publications/p02057.pdf>

Due to the display of some of these languages, Health Plans will need to install the appropriate language fonts (Arabic, Burmese, Laotian, and Somali) in Word to use the fillable Word document. Health Plans may use a different large print tagline as long as it meets the requirements specified in 42 CFR § 438.10.

² Electronic media includes Internet, mobile media, web banners, and social media. Although email is electronic media.

ATTENTION: If you speak [insert language], language assistance services are available to you free of charge. Call [1-xxx-xxx-xxxx] [(TTY: 1-xxx-xxx-xxxx)].

- c. DHS will provide Health Plans with the Member Handbook template language found in Addendum I of this Guide translated in the prevalent non-English languages identified across all HMO Rate Regions and PIHP Service Areas once these translations are available.
- d. DHS is providing Health Plans with the following suggested large print (18 point font) tagline with information on how to request auxiliary aids and services. HMOs may use a different large print tagline as long as it meets the requirements specified in 42 CFR § 438.10.

[Name of HMO/PIHP Program]:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact [Name of entity or of contact at Health Plan] at 1-xxx-xxx-xxxx.

3. Written Communication

	Allowed Activities	Prohibited Activities
Members	<ul style="list-style-type: none"> • Providing letters or brochures that inform members of incentives or rewards programs. • Distributing reminder letters for renewal and directing members to the enrollment center. • Use written materials to provide outreach, and or program and plan information • Use mobile media communications to perform outreach to members only.³ 	<ul style="list-style-type: none"> • Distributing reminder letters that encourage enrollment renewal with a particular BadgerCare Plus or Medicaid SSI HMO. • Distributing materials in an attempt to encourage members from one HMO to enroll in another. • Texting or emailing reminders to renew with a particular HMO.

- ³ Health Plans must have members opt-in for these communications and provide recipients the option to unsubscribe from receiving the communications.

	<ul style="list-style-type: none"> Texting members who have agreed to participate in the Text4Baby program. Emailing members about a new offered benefit or program. Survey current members only. Provide incentives to encourage currently enrolled members to participate in surveys. Contacting members to discuss their satisfaction with a recent service. Contacting members about participating in a research study. 	<ul style="list-style-type: none"> Texting members about programs that they have not opted-into in accordance with State and Federal privacy regulations. Sending out a survey only in English soliciting feedback about the cultural competency of staff.
Non-members	<ul style="list-style-type: none"> Distributing materials that educate the public using health messages. Putting up posters in provider offices that use the Health Plan’s logo, and that include information about local farmers’ markets. Posting a reminder on the Health Plan’s Facebook or Twitter accounts about a free Health Plan-sponsored healthy baby seminar that is open to the public. Purchasing search engine optimization for their Health Plan name or private product offering, such as, “HMO Name A” or “Health Plan Name A High Deductible Health Plan”. 	<ul style="list-style-type: none"> Providing brochures that inform non-members of incentive or reward programs. Door-to-door solicitation, including leaving leaflets at residences or on cars that reference choosing, switching, picking or enrolling in a particular health plan.. Approaching potential members in common areas (distributing brochures at a health fair or educational event to those not specifically seeking plan information). Using a Facebook ad or a web banner to indicate that the health plan is a Medicaid program provider. Renting or purchasing email lists to distribute health plan information. Making unsolicited contacts via telephone or electronic media such as texts, voicemails, and emails, unless the content is focused on health messaging only. Making calls to former members who have disenrolled for the purpose of marketing health plan products. Using any Medicaid terms for search optimization and/or ad placement. Contacting former program members as part of a survey to determine why they disenrolled from the health plan.
Members and Non-members	<ul style="list-style-type: none"> Posting links to MyAccess or a list of county IM numbers for people who are interested in program eligibility. Posting information about a disease management incentive program. Placing the Health Plan’s website on communication materials if the materials contain a general health message. Use social media to provide general health messaging and reminders of events they sponsor or participate in. Post information about health rewards and incentives. 	<ul style="list-style-type: none"> Information that may lead potential Medicaid Managed Care members to believe the Health Plan website has enrollment functionality. Using search optimization technology (using targeted searches to place ads or purchasing key words from internet search engines) to increase the prominence of the Health Plan/PIHP Program in returned search results as related to any and all Medicaid programs. Surveying former members or potential members, as this is seen as marketing through unsolicited contacts.

a. Considerations:

- i. Health Plans are encouraged to include the following information on their websites: service area, links to community resources or partners such as community-based health organizations, local health departments, prenatal care coordination agencies, school-based services, targeted case management agencies, school-based mental health services, and Birth-to-Three Program providers.
- ii. Health Plans must notify DHS if they currently use or intend to use social media (e.g., Facebook, Twitter, etc.). Notification to DHS must include the name of the page, a link, and/or account information. Health Plans are responsible for ensuring that no laws are violated (e.g., the Health Insurance Portability and Accountability Act, or HIPAA).
- iii. The value of incentives used to encourage survey participation may not exceed \$25 per person.

4. Cold Call, Direct Mail Marketing, Mass Media and Paid Programming

	Allowed Activities	Prohibited Activities
Members	<ul style="list-style-type: none"> • Calling a member to provide information about services available through the Health Plan. • Sending a letter to a member about the importance of medication compliance 	<ul style="list-style-type: none"> • Providing members with Medicaid Managed Care health plan information and asking that they distribute to friends and family.
Non-members	<ul style="list-style-type: none"> • Calling individuals who attend a health fair to provide provider network information when they give written permission to do so. 	<ul style="list-style-type: none"> • Calling former members to update them on new benefits offered through the Health Plan. • Renting or purchasing consumer lists to distribute information about the Health Plan. • Conducting telephonic solicitation to potential members, including leaving electronic voicemail messages or text messages, unless an individual has agreed to receive those communications.
Members and non-members	<ul style="list-style-type: none"> • Health Plans are allowed to distribute plan information and to perform outreach about important health topics. • Radio ads reminding listeners to screen for cancer. • Sponsorship of a community event. • Press release announcing a Health Plan will be handing out groceries at a community event. • Health Plans are allowed to use mass media and paid advertising to provide public health messaging to their members and general public. • Health Plans are allowed to use their logo or company name for paid advertising 	<ul style="list-style-type: none"> • Marketing through unsolicited contacts. Cold call or direct mail marketing to Medicaid Managed Care members who are not members of that Health Plan is strictly prohibited. • Making calls or sending mailings to potential members who attended a health fair or Health Plan-organized event, unless the potential member gave express written permission at the event for a follow-up contact. • A billboard advertising a specific Health Plan. • Placing bus decals that have a public health message and reference BadgerCare Plus, Medicaid SSI, or PIHP program. • HMOs may not use BadgerCare Plus logo on HMO clothing.

	<ul style="list-style-type: none"> not allowed to reference their Medicaid Health Plans.
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- a. Considerations:
- i. For television and radio advertisements, Health Plans must provide DHS with the scripts and a schedule indicating when the advertisements will be aired, including date and station. If the exact air dates are unknown, the Health Plan can identify the block of advertising time.

5. Supplemental Contact Information and Email

	Member Can Receive	Member Cannot Receive
Primary Person or Case Head (must be 18 years or older)	<ul style="list-style-type: none"> General communications to all HMO enrolled members (e.g., health and wellness newsletters, provider network changes, HMO Member Handbook). Case-level communications (e.g., BadgerCare Plus renewal reminder). Information specific to the children/minors on the case (e.g., appointment reminders, notice of targeted surveys posted to the portal, notice that information is available in the individual’s secure portal). Information intended for this individual (e.g., appointment reminders, notice of targeted surveys posted to the portal, notice that information is available in the individual’s secure portal). 	<ul style="list-style-type: none"> Information intended for other adults on the case (e.g., notice that information is available in the individual’s secure portal).
Other Adults on a health care case (must be over 18)	<ul style="list-style-type: none"> General communications to all HMO enrolled members (e.g., health and wellness newsletters, provider network changes, HMO Member Handbook). Information intended for this individual (e.g., appointment reminders, notice of targeted surveys posted to the portal, notice that information is available in the individual’s secure portal). 	<ul style="list-style-type: none"> Case-level communications (e.g., BadgerCare Plus renewal reminder). Information specific to children/minors on the case. Information intended for other adults on the case (e.g., notice that information is available in the individual’s secure portal).

- a. Considerations:
- i. The Supplemental Demographic Report is intended to provide additional information that is not currently on the Initial and Final Enrollment Rosters and support Health Plans in getting in contact with members. The Supplemental Demographic Report will be provided to Health Plans in the same manner in which they receive their Initial and Final Enrollment Roster. Information on this report should only be used to support communications to enrolled Medicaid members.

6. Quality Specific Messaging

	Allowed Activities	Prohibited Activities
Members and Non-members	<ul style="list-style-type: none"> Using specific quality statements in HMO marketing with verifiable data/results – e.g. “HMO A ranked #2 in immunizations based on the 2018 DHS HMO Report Card”. Charts or figures that illustrate your Health Plan’s rankings, scores, measures, or quality trends. The BadgerCare Plus and Medicaid SSI HMO’s report card or Pay-for-Performance (P4P) results on the HMO’s website. The Medicare Advantage Star Ratings information from CMS. 	<ul style="list-style-type: none"> Unverified or vague quality statements – e.g. “HMO A is #1 in quality”. Referencing other Health Plans and/or their quality ratings by name as part of quality marketing – e.g. “HMO A scored higher than HMO B and HMO C in last year’s poll”. Including other Health Plans’ rankings, scores, and measures in quality charts or figures for comparison. Adding topics to marketing that are unrelated to health, service delivery, or member experience – e.g. “HMO A is highest ranking HMO in environmental sustainability”. Quality statements for which the Health Plan cannot supply DHS with supporting data or documentation. Quality statements prohibited by national rating or external quality organizations– e.g. restrictions on quality measure uses by NCQA policy.

Addendum III Community Outreach and Events

1. Purpose

- a. To provide state guidance, including condensations and examples that pertain to Health Plans’ outreach, education, and marketing activities related to Health Plan-organized events, community events, health fairs, and educational events, rewards/wellness incentives programs, raffles and distribution of any items purchased by Health Plan for distribution to members and potential members.
- b. Examples for allowable and prohibited activities related outreach and marketing are outlined below.

2. Community and Health Events

	Allowed Activities	Prohibited Activities
Members and Non-members	<ul style="list-style-type: none"> • Passing out approved health education or event sponsorship materials with the Health Plan’s logo. • Sponsoring a youth health event, such as a 5K. • Giving away notebooks and pencils to families at back-to-school community events. • Grocery give-away, as long as it meets cost requirements. • Brochures with BadgerCare Plus and Medicaid SSI plan information sought out by attendees. • Health Plans are allowed to work with local partners to sponsor community events. • Having a table tent , table skirt, or banner identifying the Health Plan 	<ul style="list-style-type: none"> • Hanging a banner at a health fair that is subjective rather than factual (e.g., “HMO X has the best quality in Wisconsin”). • Using community events as a means to persuade individuals to enroll in the Health Plan rather than provide basic plan information. • Forcing Health Plan plan information to people walking by and not stopping at the Health Plan’s booth. • Telling non-members about money they could receive from incentive and reward programs. • Providing health plan information to potential members at health events, unless the potential member specifically requests the information.

- a. Considerations:
 - i. The Health Plan must notify DHS of its participation in a community or health event using the Events Form.
 - ii. Participation in community events may be publicized via social media, Health Plan/PIHP Program websites, direct communication with current membership, and/or via press releases.

3. Health Rewards/Wellness Incentives

	Allowed Activities	Prohibited Activities
Members	<ul style="list-style-type: none"> • Providing gift cards for participating in Health Plan health and wellness activities. • Providing healthy food cookbooks and recipes. 	<ul style="list-style-type: none"> • Encouraging members to give away rewards or incentives to non-members. • Offering incentives for renewal or ongoing enrollment in BadgerCare

	<ul style="list-style-type: none"> • Providing treatment-related incentives, such as free nicotine replacement therapy patches. • Offering support to address barriers to participation such as meals, transportation, and childcare. • Solicit for participation in health rewards/wellness incentive programs. • distributing health rewards/wellness incentives to providers for distribution to current members completing approved programs (e.g., diapers for women enrolled in the Obstetric [OB] Medical Home program). 	Plus or Medicaid SSI HMO, or PIHP program.
Non-members	<ul style="list-style-type: none"> • Creating a page within its current website that describes the Health Plan incentive program. 	<ul style="list-style-type: none"> • Advertise health rewards/wellness incentives for BadgerCare Plus or Medicaid SSI, or PIHP Program at health fairs.

a. Considerations:

- i. DHS has not set a maximum value amount on incentives and will review and approve health rewards/wellness incentives on a case-by-case basis.
 - o The value of an incentive to complete a survey shall not exceed \$25.
- ii. Health Plans must provide the option to unsubscribe from health rewards/wellness incentives programs at any point during enrollment.
- iii. Health Plans should prohibit the use of rewards or incentives to be used toward the purchase of items such as alcohol, tobacco products, and firearms.
- iv. The Health Plan may provide information about its rewards and incentives programs to potential members on its website only.

4. Use of Raffles and Nominal Gifts

	Allowed Activities	Prohibited Activities
Members	<ul style="list-style-type: none"> • Offering a limited number of members the chance to have their name drawn to win \$100 worth of free groceries upon completion of a diabetes education and management program. • Provide promotional raffles valued at \$100 or less at community or health events. • Health Plans are allowed to also offer raffles or gifts valued at \$100 or less for specific members-only initiatives, such as participation in a disease management program. Only a few members may receive gifts of high value. • Provide nominal gifts for member participation in focus groups. The 	<ul style="list-style-type: none"> • Using a raffle as a means to persuade members to switch providers or choose a particular provider. • Directing event raffles at potential members only; they must allow for any event attendee to participate.

	amount of the gifts should be reasonable given the amount of participation required and must be preapproved by the Department.	
Non-members	<ul style="list-style-type: none"> Raffling off a kids electric toothbrush for attendees at a pediatric oral health event. Raffling off a fitness tracker at a community health fair. 	<ul style="list-style-type: none"> Offering gift cards to individuals who agree to enroll in or switch to the HMO.

5. Annual Member Communication and Outreach Plan

The Health Plan is required to submit a member communication and outreach plan to the Department annually.

The following sample format is not required and may not be fully inclusive of all needed information; however, it provides a potential template for Health Plans to use when submitting their annual member communication and outreach plan to DHS.

Health Plan Annual Member Communication and Outreach Plan						
	Material/Activity	Frequency/Timeline	Format/Distribution	Audience	Department/Individual Responsible	Notes
1.	New member packets	Monthly within 10 days of receipt of the final 834	Direct mailing and posted on website	Newly enrolled members	Membership Management	
2.	New member outreach calls	Monthly	Outbound calls	Newly enrolled members	Membership Management	
3.	Member incentive programs	Periodically, as needed	Direct mail, posted on website, social media	Existing members	Membership Management	
4.	Disease management programs	Periodically, as needed	Direct mail, posted on website, social media	Existing members	Membership Management	
5.	Prenatal case management and/or medical home information	Ongoing as members are identified	Outbound calls	Identified pregnant members	Care Management	
6.	Community and health events	As identified	Face-to-face interaction, distribution of printed materials	Existing members and non-members	Member advocate, Care management	Intend to offer raffles. Plan to attend minimum of 4 events.
7.	Flu shot clinics	Periodically	Face-to-face interaction, distribution of printed materials	Existing members	Clinical staff	Intend to offer incentives.

8.	Member handbooks, provider directory, member educational materials	As updated and developed	Printed material and posted on website	Existing members	Membership management, provider relations	
9.	D-SNP Communication and Outreach Activities	Periodically	All	Potential members, newly enrolled members, existing members	D-SNP Outreach Staff	

a. Consideration:

- i. DHS encourages Health Plans to establish a schedule for review of developed materials to ensure any documents distributed to members are still accurate and to seek DHS approval as needed, upon review of or as part of the annual member communication and outreach plan submission.

6. Events Spreadsheet

Embedded below is a sample Excel template Health Plans can use for submitting events as part of the annual outreach and communication plan or as updated throughout the year. Health Plans may submit event information in another format if preferred, as long as it includes the information requested in this guide.



HMO Event Spreadsheet.xlsx

Addendum IV Dual Eligible Special Needs Plan

1. Purpose

- a. To provide state guidance, including considerations and examples specific to Dual Eligible Special Needs Plans (D-SNPs).
- b. To provide health plans with guidance from the [Medicare Marketing Guidelines](#).
- c. D-SNP plans must comply with all other requirements, including policy, considerations and examples provided in the COM Guide and all COM Guide Addendums.

2. Written Communication

	Allowed Activities	Prohibited Activities
Members	<ul style="list-style-type: none"> D-SNP plans may respond to a question or statement initiated by a member on a public social media forum. 	<ul style="list-style-type: none"> When responding to a question or statement on a public social media forum, the D-SNP may not address subjects beyond the scope of the question or statement.
Non-members	<ul style="list-style-type: none"> Agents/brokers who have a pre-scheduled D-SNP appointment with a potentially eligible member that becomes a “no-show” may leave information at the “no-show” potential enrollee’s residence. Advertising to potential D-SNP members that provides generic messaging for the purpose of brand awareness. Calling former D-SNP members to conduct disenrollment surveys for quality improvement. 	<ul style="list-style-type: none"> D-SNP plans are prohibited from providing cash or other monetary rebates to potential members as raffles or nominal gifts, even if their worth is \$15 or less per person. Requesting email address of potential D-SNP members through referrals from current members.
Member and Non-members	<ul style="list-style-type: none"> Distribute plan information to dual eligible members currently enrolled in their SSI Managed Care program. D-SNP plans are allowed to market through unsolicited contacts via conventional mail and other print media (e.g., advertisements, direct mail). Call BadgerCare Plus or Medicaid SSI members aging-in to Medicare to talk about its D-SNP plan. 	<ul style="list-style-type: none"> Referencing BadgerCare Plus or Medicaid SSI in their website.

- a. Considerations
 - i. If the D-SNP plan includes any reference to Wisconsin Medicaid, the D-SNP plan must submit that information to the Department for review prior to the event.
 - ii. D-SNP plans must maintain a separate section on their website for their D-SNP information, if the plan markets other lines of business, and must submit their website for review to CMS.

3. Cold Call, Direct Mail Marketing, Mass Media and Paid Programming

	Allowed Activities	Prohibited Activities
Members	<ul style="list-style-type: none"> Distribute plan information to dual eligible members currently enrolled in their SSI Managed Care program. D-SNP agents may call their own clients and the D-SNP plan may call current members at any time to discuss plan business 	<ul style="list-style-type: none"> No D-SNP specific examples. Please refer to Addendum II
Non-members	<ul style="list-style-type: none"> Call BadgerCare Plus or Medicaid SSI members aging-in to Medicare to talk about its D-SNP plan. Renting or purchasing mailing lists to distribute information about the D-SNP via direct mail or advertisements. Obtaining names and addresses of potential D-SNP members through referrals from members to mail D-SNP plan information. Calling individuals who have given permission for a D-SNP plan agent to contact them. Returning phone calls or messages from individuals interested in the D-SNP plan. 	<ul style="list-style-type: none"> Requesting phone numbers of potential D-SNP members through referrals from members.

a. Considerations

- i. D-SNP Educational events must be explicitly advertised as “educational,” otherwise they will be considered as a sales/marketing event.

4. Community and Health Events

	Allowed Activities	Prohibited Activities
Members	D-SNP agents may call their own clients and the D-SNP plan may call current members at any time to discuss plan business	<ul style="list-style-type: none"> No D-SNP specific examples. Please refer to Addendum III
Non member	<ul style="list-style-type: none"> Renting or purchasing mailing lists to distribute information about the D-SNP via direct mail or advertisements. Obtaining names and addresses of potential D-SNP members through referrals from members to mail D-SNP plan information. Calling individuals who have given permission for a D-SNP plan agent to contact them. Returning phone calls or messages from individuals interested in the D-SNP plan. 	<ul style="list-style-type: none"> Requesting phone numbers of potential D-SNP members through referrals from members. Educational events cannot be designed to steer or attempt to steer potential members towards a D-SNP plan or include marketing of any kind.
Member and Non-members	<ul style="list-style-type: none"> Educational events designed to inform dual eligible beneficiaries about the D-SNP plan. 	<ul style="list-style-type: none"> Attaching business cards or D-SNP plan/agent contact information to educational materials, unless

	<ul style="list-style-type: none"> D-SNP plans can have marketing/sales events designed to steer or attempt to steer potential members towards a D-SNP plan as long as they are clearly advertised as such and are distinct from educational events. 	<p>requested by the potentially eligible member.</p> <ul style="list-style-type: none"> D-SNP Plans are prohibited from conducting health screenings or other like activities that could give the impression of “cherry picking”.
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a. Considerations

- i. D-SNP plans must submit all sales scripts and presentations with reference to Wisconsin Medicaid to the Department for review prior to the event.

5. Health Rewards/Wellness Incentives

	Allowed Activities	Prohibited Activities
Members	<ul style="list-style-type: none"> No D-SNP specific examples. Please refer to Addendum III 	<ul style="list-style-type: none"> No D-SNP specific examples. Please refer to Addendum III
Non-members	<ul style="list-style-type: none"> Information about rewards and incentives in marketing materials as long as they are provided with information about D-SNP plan benefits and include all information about the rewards and incentives programs offered by the D-SNP plan. 	<ul style="list-style-type: none"> No D-SNP specific examples. Please refer to Addendum III

6. Use of Raffles and Nominal Gifts

	Allowed Activities	Prohibited Activities
Members	<ul style="list-style-type: none"> No D-SNP specific examples. Please refer to Addendum III 	<ul style="list-style-type: none"> No D-SNP specific examples. Please refer to Addendum III
Non-members	<ul style="list-style-type: none"> Raffle nominal gifts⁴ to potential members 	<ul style="list-style-type: none"> D-SNP plans are prohibited from providing cash or other monetary rebates to potential members as raffles or nominal gifts, even if their worth is \$15 or less per person.

⁴ Nominal gifts can be one large gift (e.g., a concert, raffle, drawing) for which the total fair market value must not exceed the nominal per person value based on attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than \$150 (\$15 or less, \$75 aggregate cap, per person, per year for marketing purposes).

Addendum V Submission of Member Communication and Outreach Materials to DHS

1. Purpose

- a. To standardize the material submission and review of health plan member communication, outreach and marketing materials.
- b. DHS will review all Health Plan member communication and outreach materials as defined in the *HMO and PIHP Communication, Outreach and Marketing Guide* and in section 3.06 of the 2020 D-SNP Contract.

2. Guidelines

- a. With each review request submitted to DHS, Health Plans must submit a completed Member Communication/Outreach Material Checklist (below). For requests specific to event participation, Health Plans must submit a completed Events Spreadsheet (Addendum III).
- b. For materials that need additional time for internal DHS review (i.e., materials that need Secretary's Office or Communications Team review), the Managed Care Analyst will notify the Health Plan within three business days of the expected time needed to review the materials. If the Health Plan does not receive a response from DHS within three business days, the Health Plan should contact the Managed Care Compliance Section Chief. A response will be prepared within one business day of this contact.
- c. Materials that can be reviewed by the Managed Care Team and that may be eligible for expedited review include:
 - i. Notifications to members – Letters notifying members of minor changes in the Health Plan provider network. (Exception: Privacy violations or significant changes in the Health Plan provider network, such as major contract terminations, are not eligible for expedited review).
 - ii. Care coordination, wellness program, or disease management information – Materials to educate members on the management of certain conditions.
 - ii. Incentives to members – As long as the incentives are less than \$25, and the material has clear instructions for members or providers to follow in order to qualify for the incentives.
 - iii. Notifications about Health Plan policies and procedures for member grievances (however, the Health Plan must review the BadgerCare Plus and Medicaid SSI, Care4Kids, Children Come First or Wraparound Milwaukee (whichever applies) contract language and consult with DHS's Member Grievances expert on any notifications to members).
- d. The Health Plan must correct any problems and errors DHS identifies. The Health Plan agrees to comply with [Wis. Admin. Code](#) and practices consistent with the

Balanced Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [[42 U.S.C. 1396v\(d\)\(2\)](#)].

- e. The Health Plan must resubmit all approved materials no less than once per year if they will continue to be used. The Department has the discretion to request previously approved documents for re-review at any time.
- f. Because the approval of materials hinges not just on content but also on the Health Plan's intended audience, it is recommended that extra attention be given to the policies and examples within this guide prior to submission of materials

3. Considerations

- a. After materials are approved, Health Plans must provide DHS with final copies.
- b. All new and updated information relating to the Medicaid managed care programs that a Health Plan intends to post on its website must be approved by DHS prior to posting and must be consistent with DHS standards and state law.
- c. Health Plans must also notify DHS when their website is in place and when approved updates are made.
- d. All survey methods must be approved by DHS prior to use and must be translated into the top three (3) prevalent languages by rate region. Health Plans must provide the data obtained through these surveys to DHS upon request.
- e. All efforts to solicit feedback from members and all gift offers must be approved by DHS and must be part of the Health Plan's Quality Assessment/Performance Improvement (QAPI) plan, as specified in appropriate program Contract.
- f. D-SNP outreach materials to be sent to BadgerCare Plus or Medicaid SSI members should be submitted to DHS with a description of the distribution plan.
- g. Health Plans that identify as a QHP and a BadgerCare Plus and/or Medicaid SSI HMO must get approval from DHS prior to distribution of materials.
- h. All raffle items, including a description, declared amount, and number to be disbursed must be submitted to DHS for approval no later than 10 business days prior to the event.
- i. The Health Plan shall submit an initial description of its (or its subcontractors) member communication and outreach plan to the Department for review on the second Friday of January of each calendar year. The Department will review/approve the plans within 30 days. The Health Plan may make changes to its member communication and outreach plan throughout the year. Any significant changes to previously approved member communication or outreach plans must be submitted to the Department for review.

4. Member Communication, Outreach and Marketing Material Checklist

Health Plans must complete the form below and submit it with each review request. DHS will not review any member communication or outreach materials without this form.

Member Communication/Outreach Checklist		
1.	Type of material for review <ul style="list-style-type: none"> If other, please describe 	Choose an item. Click here to enter text.
2.	Target audience	Click here to enter text.
3.	Intended distribution schedule	Click here to enter text.
4.	All materials have been spelling and grammar checked.	<input type="checkbox"/>
5.	All materials are at a 6 th grade or lower reading level. <ul style="list-style-type: none"> Exclude physical addresses, email addresses, phone numbers, TTY from the review. If materials are above a 6th grade reading level, please explain. 	<input type="checkbox"/> Click here to enter text.
6.	All materials include the required language translation text.	<input type="checkbox"/>
7.	All materials use a font size no smaller than 12 point.	<input type="checkbox"/>
8.	All materials include large print (18 point font) taglines in at least the top three prevalent non-English languages in the region.	<input type="checkbox"/>
9.	All materials include large print (18 point font) taglines and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.	<input type="checkbox"/>
10.	All materials include a toll-free phone number for the HMO/PIHP program.	<input type="checkbox"/>
11.	All materials have been inspected by the Health Plan and its Program Advocate and meet all additional requirements in DHS's marketing policy and the Medicaid Program Contract.	<input type="checkbox"/>
12.	D-SNP material(s) complies with the criteria defined in the Medicare Marketing Guidelines, the current D-SNP Contract, and the requirements defined in this guide. <ul style="list-style-type: none"> Has this material been approved by CMS? Include a reference to the specific section of the Medicare Marketing Guidelines that allows the plan to distribute the material. Has this material been approved by the provider (if applicable)? If yes, list provider in provided textbox. 	<input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No Click here to enter text. Click here to enter text.
13.	All materials are being sent to DHS as Microsoft Word documents so staff can use the "Track Changes" feature. DHS will not accept PDFs until the document has final approval.	<input type="checkbox"/>
14.	If an incentive or raffle will be provided, please provide the following: <ul style="list-style-type: none"> Description Declared amount Number to be disbursed 	Click here to enter text. Click here to enter text. Click here to enter text.
15.	If an expedited review is requested, please describe your reason for requesting an expedited review. DHS may deny any request for expedited review. The following materials are not eligible for expedited review: <ul style="list-style-type: none"> Eligibility and enrollment information (i.e., materials that contain information about enrolling in the BadgerCare Plus and Medicaid SSI programs. Media communications (TV and radio ads, press releases) Billboards and posters. Healthy Rewards or wellness incentive programs. Marketplace or Affordable Care Act (ACA) materials, or materials that reference the Marketplace or ACA. Member handbooks. Provider directory and handbook. Materials to members that are receiving care management services through Family Care MCOs. 	Click here to enter text.

