Department of Health Services
2021 Certification Application for the
BadgerCare Plus and Medicaid SSI HMO Program
For the 2020-2021 Contract Period

Issued September 2020

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1 Certification Application Submission Instructions

1.1 Purpose

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

1.2 Process

Submission deadline:

- For HMOs that have signed the 2020-2021 Contract, please submit this application by **October 30, 2020**. If an extension is needed, please contact your DHS HMO analyst.

HMOs must complete all applicable sections of the certification application. Recertifying HMOs using "see response from previous certification application" is not sufficient. Uncompleted forms, outdated or incomplete information may result in delayed certification. Applications must be submitted electronically to the HMO's SFTP file, with an email notification to the DHS contract monitor. Please do not use the HMO's ID (6900xxxx) in the file name.

Please indicate clearly where the information can be found to meet certification requirements. DHS will consider a requirement unmet if it is not clearly indicated.

1.3 Naming Convention

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

HMOs should embed each document submission in the corresponding section of the Word document. HMOs that use the same policy and procedure document to answer multiple questions may supply the document once. The HMO must clearly indicate where each question can be found within the document. If DHS is unable to open the embedded documents, the HMO must provide the attachment in another format.

HMOs must use the following naming convention:

- Section 8.1 – Subcontracts – Provider Contracts/Policies and Procedures – [*Formal Name of Document*]
- Section 8.2 – Subcontracts – Group Contracts – [*Formal Name of Document*]

2 Administrative

2.1 HMO Information

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

Has the following information changed in the past 6 months? If yes, please provide updated documentation.

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

☐ Yes ☐ No

2.2 HMO Organization Charts and Data Sheets

Has information on organizational charts and data sheets changed in the past 6 months? If yes, please provide updated copies.

☐ Yes ☐ No

2.3 Ownership and Controlling Interest

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

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

Specifically: "Controlling interest or ownership" means that a person:

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

Has the HMO ownership or controlling interest changed in the last six months? If yes, your analyst will collect the updated information via email. Please note that ownership and controlling interest disclosures are due within in 35 days of any changes in ownership, as required by HMO Contract and federal law.

☐ Yes ☐ No

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

☐ Yes ☐ No

2.4 Department Checklist

DHS USE ONLY			Administrative
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	2.1 Has HMO information changed in last six months?
☐	☐	☐	2.1.1 If yes, has the HMO provided documentation?
☐	☐	☐	2.2 Has HMO organizational chart information changed?
☐	☐	☐	2.2.2 If yes, has the HMO provided documentation?
☐	☐	☐	2.3 Has HMO Ownership and Controlling Interest changed in the last six months?
☐	☐	☐	2.3.2 If yes, has the HMO provided documentation?

3 Service Area

HMOs are required to submit provider network files weekly, and the data will be reviewed for annual network analysis as well as any requested changes in service areas. Please make sure all provider information is up to date. The specifications for the file are defined in 3.3 below. Please contact your DHS contract monitor if you have any questions regarding your network review.

3.1 Distance Requirements

HMOs are required to meet the following distance requirements for selected services:

a. **Primary Care Access**

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

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

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties must have a mental health or substance abuse provider within 35 miles and a 60 minute drive from any member. All other counties must have a least one mental health provider within the boundary of the county.

c. **Dental Care Access**

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties that covers dental services must have a dental provider within a 35 mile distance from any member residing in regions 1-4 and a 25 mile distance from any member residing in regions 5 and 6.

d. **Hospitals**

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties must include a non-specialized hospital within a 20 miles and 30 minute drive from any member. All other counties must have a least one hospital within the boundary of the county.

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

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties must have Urgent Care Centers or Walk-In centers or clinics within 20 miles and a 30 minute drive from any member residing in the HMO service area. All other counties must be within 35 miles and a 60 minute drive from any member. At least one urgent care center with extended hours must be in each HMO certified county, unless there is no urgent care center with extended hours in the county.

f. **OB/GYN Providers**

HMOs in Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, and Waukesha counties must have an OB/GYN provider within 20 miles of any member residing in these counties. All other counties must have an OB/GYN provider within 30 miles of any member. Additionally, there must be at least one OB/GYN provider in each HMO certified county.

The HMO must submit policies and procedures describing the process to ensure the provider network meets distance and drive time requirements for primary care, mental health and substance abuse, dental

care, hospitals, OB/GYN and urgent care centers/walk-in clinics. The policy and procedures must include the HMO's plan to monitor compliance with these standards and how the HMO corrects for deficiencies.

3.2 Provider to Member Ratios

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

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

Please submit their policies and procedures to ensure the provider network for these counties meet the standards for primary care, dental care, and access to psychiatrists. The policy and procedure must include the HMO's plan to monitor compliance with these standards and how the HMO corrects for deficiencies if these ratios fall out of compliance.

3.3 Department Checklist

DHS USE ONLY			Service Area
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	3.1 Policies and procedures describing the process to ensure the provider network meets distance and drive time requirements for primary care, mental health and substance abuse, dental care, hospitals, OB/GYN and urgent care centers/walk-in clinics, how the HMO monitors and addresses deficiencies.
☐	☐	☐	3.2 Policies and procedures describing the process to ensure the provider network meets the standards for primary care, dental care, and access to psychiatry, including the plan to monitor compliance with these standards and how the HMO corrects for deficiencies if these ratios are not met.

HMO Provider Networks

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

CFR 438.206, CFR 438.207, CFR 438.208, CFR 438.68

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

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

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

3.5 Protocols/Standards to Ensure Access

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

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

    Training should include clinical and communication issues and the role of care coordinators.

- For members with special health care needs, the HMO must provide policies and procedures to allow members to directly access a specialist, as appropriate.

3.6 Primary Care Assignment

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

Please describe what percent of your enrollment has a chosen or assigned PCP on file?

- BadgerCare Plus membership: Enter %
- Medicaid SSI membership: Enter %

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

a. The processes and procedures to allow members to have choice of providers before assignment.
b. The communication plan to inform members about their primary care provider options, the primary care assignment process, and their rights to change primary care providers after assignment.
c. Describe the process to assist members in getting a primary care visit as part of the primary care assignment process.
d. How the primary care assignment process takes into account members' health care needs and how members with chronic conditions (including, but not limited to, diabetes, asthma, COPD, congestive heart failure, and behavioral health) are identified (including clinical guidelines and other tools used).
e. How the HMO ensures that PCPs provide culturally sensitive care for members.

f. Policies and procedures for members that want to change their assigned primary care provider.
g. Processes and procedures to ensure coordination of care and information sharing between the primary care provider and the specialists, including pharmacy data.
h. Processes and procedures for ensuring patient-centered care and that a comprehensive treatment plan is developed between members and their primary care provider.
i. Processes and procedures HMOs use to evaluate the effectiveness of their primary care assignment strategies, including methods to identify when a member is utilizing a PCP other than their assigned PCP and updating the PCP designation accordingly.
j. Policies and procedures related to protecting members' privacy when coordinating their care and services with other providers.
k. Results and analysis from internal monitoring and improvement efforts related to care coordination and follow-up, assessment and care planning.

3.7 Waiting Times

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

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

HMOs shall submit policies and procedures for:

- Waiting times for care at facilities and appointments for the following provider specialties: primary care, mental health, and dental.
    - For mental health access in your network, please share any standards and available data about wait times, broken out by initial appointment (intake or screening appointment) vs. treatment appointment.
- Communication plan for educating primary care, mental health, and dental providers on these waiting times.
- Processes and procedures to monitor provider compliance with the waiting times and processes to correct for deficiencies if the waiting time standards are not being met.

3.8 Urgent Care Access

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

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

3.9 Access to Women's Health Specialists

HMOs are required to provide to the Department policies and procedures to make women's health specialists available to members and the waiting times for care.

3.10 Second Medical Opinions

HMOs are required to provide policies and procedures that:

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

3.11 Moral or Religious Objections to Care

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

3.12 Transition of Care

a. HMOs are required to provide policies and procedures to ensure well-managed member continuity of care, including a 90 day continuity of care during transitions of care for each of the HMOs member as defined in Article VII (F).

b. HMOs should submit descriptions and/or documentation on how they provide transitions of care to members:

- How the HMO currently works with in-network and out-of-network hospitals to assist with discharge planning and transitions to other settings.
- How the HMO ensures providers, both in and out-of-network, are made aware of the process to request authorizations for post-stabilization care or authorizations for transfers/discharges to other facilities.
- The HMO's clinical guidelines or prior authorization criteria for determining medical necessity for skilled nursing facility/nursing home admissions.

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

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

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

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

3.14 Access to Indian Health Providers

- For Indian members enrolled in the HMO, the HMO must ensure access to an Indian Health Care Provider (IHCP), when available. The HMO must have sufficient IHCPs within its network to ensure timely access to services for Indian members.
- Indian members of the HMO may receive primary care services from an IHCP provider, as long as the provider agrees to serve in the HMO network as a PCP and has capacity for additional patients. If no such provider is contracted, the HMO must allow the member to see the IHCP out-of-network. If an

Indian member receives services through an out-of-network IHCP, the HMO must allow the out-of-network IHCP to refer the Indian member to a provider within the HMO network for additional care.

- If timely access to an IHCP cannot be ensured, the HMO may allow Indian members to access out-of-state IHCPs or the member may choose to disenroll from the HMO.
- The HMO must pay all IHCPs, whether within network or not, at a minimum, the full Medicaid fee-for-service payment rate for provision of services or items to Indian members.
- Indian members are exempt from payment of fees, co-payments, or premiums for services provided by an IHCP.
- HMOs are required to provide to the Department:
    - Policies and procedures to ensure timely access to IHCPs for Indian members.
    - Policies and procedures to allow Indian members to receive primary care services from an IHCP provider, as long as the provider agrees to serve as a PCP within the HMO network and has capacity for additional patients. Include the provisions to allow the member to see the IHCP out-of-network if no provider is contracted and allow the out-of-network IHCP to refer the Indian member to contracted provider for additional care.
    - Policy and procedure allowing Indian member to access out-of-state IHCPs or disenroll from the HMO if timely access to an IHCP cannot be ensured.
    - Policy and procedure to pay all IHCPs, in network or not, at a minimum, the full Medicaid fee-for-service payment rate for provision of services or items to Indian members.
    - Policy and procedures that exempt Indian members from payment of fees, co-payments, or premiums for services provided by an IHCP.

3.15 Optional Service Coverage: Chiropractic Coverage

(Please check one)

☐ HMO elects to cover chiropractic services.
☐ HMO elects not to cover chiropractic services.
☐ Mix of the above depending on the county. The counties where the HMO provides chiropractic services are as follows: Click here to enter text.

3.16 Optional Service Coverage: Dental Coverage

(Check all that apply)

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

- If the HMO subcontracts with a dental benefits administrator (DBA), please identify it:
Click here to enter text.

3.17 Optional Service Coverage: Additional Services

The HMO does not charge copays for:

☐ BadgerCare Plus ☐ Medicaid SSI

☐ This HMO offers free cooking and nutrition classes.

☐ This HMO offers free weight loss or exercise classes.

☐ This HMO offers discounts on massage therapy and acupuncture.

☐ Other: Click here to enter text.

3.18 "In Lieu of" Services

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

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

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

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

3.19 Department Checklist

DHS USE ONLY			Provider Network – Availability of Services, Assurances of Adequate Capacity and Services, Network Adequacy Standards
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
			3.4 Use of BadgerCare Plus and/or Medicaid SSI Enrolled Providers
☐	☐	☐	HMO provided policies and procedures to ensure the use of Medicaid enrolled providers for the provision of covered services.
			3.5 Protocols/Standards to Ensure Access
☐	☐	☐	HMO provided written protocols to ensure members have access to screening, diagnosis and referral and appropriate treatment for those conditions and services.
Met	**Not Met**	**NA**	
			3.6 Primary Care Assignment
☐	☐	☐	3.6.1 The HMO described the percentage of its BadgerCare Plus and/or Medicaid SSI membership that has selected or was assigned a PCP.
☐	☐	☐	a. Processes and procedures allow members to have choice of providers before assignment.
☐	☐	☐	b. The communication plan to inform members about their primary care provider options, the primary care assignment process, and their rights to change primary care providers after assignment.
☐	☐	☐	c. A description of the process to assist members in getting a primary care visit as part of the primary care assignment process.
☐	☐	☐	d. The primary care assignment process takes into account members' health care needs and describe how members with chronic conditions are identified (including clinical guidelines and other tools used).

☐	☐	☐	e. How the HMO ensures PCPs provide culturally sensitive care for members.
☐	☐	☐	f. The procedures to follow when members want to change their assigned primary care provider and how the HMO updates the PCP based on member utilization data and/or provider feedback.
☐	☐	☐	g. Processes and procedures ensure coordination of care and information sharing between the primary care provider and the specialists, including pharmacy data.
☐	☐	☐	h. Processes and procedures for ensuring patient-centered care and that a comprehensive treatment plan is developed between members and their primary care provider.
☐	☐	☐	j. Procedures related to protecting members' privacy when coordinating their care and services with other providers.
☐	☐	☐	k. Results and analysis from internal monitoring and improvement efforts related to care coordination and follow-up, assessment and care planning.
			3.7 Waiting times
☐	☐	☐	Provide written standards for waiting times at facilities and appointments for primary care, mental health (both initial screening and treatment appointments), and dental.
☐	☐	☐	Communication plan is present for educating primary care, mental health, and dental providers on these waiting times.
☐	☐	☐	Processes and procedures monitor provider compliance with the waiting times and processes are developed to correct for deficiencies if the waiting standards are not being met.
			3.8 Urgent Care Access
☐	☐	☐	Policies and procedures make urgent care available to members during extended office hours.
			3.9 Access to Women's Health Specialists
☐	☐	☐	Policies and procedures are in place for access to women's health specialists.
			3.10 Second Medical Opinions
☐	☐	☐	Policies and procedures are in place for Second Medical Opinions
			3.11 Moral or Religious Objections to Care
☐	☐	☐	Policies and procedures detail communication with the Department, Enrollment Specialist, and member when a provider in network refuses to provide a service based on moral or religious objections.
			3.12 Transition of Care
☐	☐	☐	a. Policies and procedures to ensure well-managed member continuity of care as laid out in in Article VII (F).
☐	☐	☐	b. How the HMO ensures providers, both in and out-of-network, are made aware of the process to request authorizations for post-stabilization care or authorizations for transfers/discharges to other facilities.
			3.13 HMO Referrals to Out-of-Network Providers for Services
☐	☐	☐	Policies and procedures on HMO referrals to Out-of-Network Provider for Services.
			3.14 Access to Indian Health Providers
☐	☐	☐	3.14.1 Policies and Procedures for access to Indian Health Providers

☐	☐	☐	a. HMO provided policies and procedures to monitor network adequacy, identify access to care issues, and evaluate the capacity of their network.
☐	☐	☐	b. HMO provided information about the persons within the organization evaluating network adequacy, frequency of the evaluation, as well as data or analysis related to network adequacy in the last year.
			3.15 Optional Service Coverage: Chiropractic Coverage
☐	☐	☐	Chiropractic Coverage
			3.16 Optional Service Coverage: Dental Coverage
☐	☐	☐	Dental Services
			3.17 Optional Service Coverage: Additional Services
☐	☐	☐	Additional Services
			3.18 "In Lieu of" Services
☐	☐	☐	

4 Quality Improvement and Accreditation

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

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

4.1 All HMOs must submit the following: Accreditation Status

a. If accredited by a nationally recognized accrediting body (i.e. AAAHC, NCQA, URAC), the HMO must submit letter from accrediting body, year of accreditation, and line of business for which it obtained accreditation.

b. If the HMO is not, then please submit an attestation ensuring solvency standards compliance with 42 CFR 438.116.

4.2 QAPI Program

- Quality program description, areas of focus, and provider performance monitoring
- QAPI committee structure and position descriptions
- Frequency of QAPI meetings and provide copies of the most recent QAPI meeting minutes
- Most recent annual QAPI work plan and QAPI annual report including:
  - Annual plan to meet its Pay-for-Performance (P4P) goals and submit NCQA audited P4P results to the Department on time;
  - Annual Performance Improvement Projects (PIPs) topic selection, implementation, monitoring, and final report submission to the Department and MetaStar.
- Evaluation of the QAPI program to determine if the HMO is meeting its goals.

- Data and related documentation which shows monitoring of:
    - Quality of care and services in clinical and non-clinical areas;
    - Member satisfaction;
    - Access to providers and verification that services members needed were provided.

4.3 Clinical Practice Guidelines

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

4.4 Utilization Management

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

- Medical record review tools
    - Policies and procedures related to medical record review including instructions;
    - Medical record review results (including numerators and denominators and analysis for prior twelve months;
    - Documentation related to any resulting improvement efforts;
    - Policies and procedures for other methods used to assess and improve quality of care.
- Adverse Actions
    - Policies and procedures on notification of adverse actions and timeliness of decisions;
    - Persons authorized to make denial decisions based on medical necessity;
    - UM criteria conformity with applicable HMO clinical practice guidelines and inter-rater reliability.
- Policies for processing expedited and urgent authorization requests.
- Description of the utilization management practices used by HMOs on emergency and post-stabilization services.
    - Instructional materials for members related to use of emergency services.
- UM committee meeting minutes for prior six months.

4.5 Members with Special Health Care Needs

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

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

4.6 Telephone Triage

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

4.7 Department Checklist

DHS USE ONLY			Quality Improvement and Accreditation
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
			4.1 Accreditation Status
☐	☐	☐	a. HMO must submit a letter showing the year of accreditation, and line of business for which it obtained accreditation. b. If not accredited by a nationally recognized accrediting body, the HMO must submit an attestation ensuring they are compliant with 42 CFR 438.116
			4.2 QAPI Program
☐	☐	☐	QAPI program description, including description of program monitoring and oversight, committees, position descriptions and FTE staffing data.
☐	☐	☐	Must include the most recent QAPI program and most recent annual QAPI report.
☐	☐	☐	Frequency of QAPI meetings and provide copies of the most recent QAPI meeting minutes.
☐	☐	☐	Must show most recent annual QAPI work plan. The work plan must include P4P and PIP information.
☐	☐	☐	Evaluation of the effectiveness of the QAPI program.
☐	☐	☐	Data and related documentation to monitor quality of care, member satisfaction, and access to care and verification that services members needed were provided.
			4.3 Clinical Practice Guidelines
☐	☐	☐	Description and sample of the clinical evidence based practice guidelines used by the HMO for utilization management, member education on health and disease management, coverage of services and other areas to which the guidelines may apply. These guidelines must meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of providers in the particular field • Consider the needs of the HMO members • Are adopted in consultation with contracting health care professionals • Are reviewed and updated periodically as appropriate
☐	☐	☐	Policies and procedures that show how the HMO and its in-network providers are adopting the clinical guidelines and how the HMO makes those guidelines available to their providers and members.
			4.4 Utilization Management
☐	☐	☐	Medical record review tools.
☐	☐	☐	Notification of adverse actions, timeliness of decisions, persons authorized to make denial decisions based on medical necessity, UM criteria conformity with applicable HMO clinical proactive guidelines and inter-rater reliability.
☐	☐	☐	Policies for processing expedited and urgent authorization request.
☐	☐	☐	Description of the utilization management guidelines for emergency and post-stabilization services. • Instructional materials for members on appropriate utilization of emergency services.

☐	☐	☐	UM committee minutes for last six months.
			4.5 Members with Special Health Care Needs
☐	☐	☐	Policy and procedures for identification of members with special health care needs assessment and delivery
☐	☐	☐	Policy and procedures for coordination of care for pregnant and post-partum women, members with chronic conditions or high-cost members.
			4.6 Telephone Triage
☐	☐	☐	Policy and procedure including clinical protocols in use, clinical credentials required for staff and a copy of annual evaluation of the clinical appropriateness of decisions made through the system. This applies only to nurse lines where clinical advice is provided by phone. If no such system is in operation, please provide written rationale.

5 Reporting and Data Administration

The Department requires the HMOs to meet security, data, claims and encounter processing, computer system, and reporting standards outlined in the 2018-2019 BadgerCare Plus and Medicaid SSI Contract, sections XI.D.5.g-h, XII.A, XII.C-F, XII.I, XIV.A-B, XV.D.1-2, XV.D.11, XVI.F, XVI.I-N, Addendum IV.F-H, and Addendum VI.

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

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

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

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

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

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

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

   Does the HMO have written policies and procedures for?

Standard	*Yes (Check One)*	*No (Check One)*

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

Does the HMO have written training materials for?

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

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

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

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

Standard	*HMO FTE*	*Subcontractor FTE*
Data Security and Privacy		
Secure SFTP Use		
Secure ForwardHealth Portal Use		

Data Retention – 10 Years for All Instances Cited in the HMO Contract		
Distribution of Access Payments as Described in Article XVI		
Encounter Based Payments and Ad Hoc Cash Transactions Processing		
Annual Financial Template Completion		

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

1. Describe the system hardware and software, the technical resources that will be used, and the name of the agency or organization (e.g., HMO, outside vendor, etc.) responsible for the following:

    a. Claims processing
    b. Monitoring enrollment and disenrollment
    c. Non-encounter data reporting (e.g., Neonatal ICU patient care data)
    d. Encounter data reporting.

2. The BadgerCare Plus and Medicaid SSI HMO contract requires the HMO to only use providers enrolled in the Wisconsin Medicaid program when rendering services to Wisconsin Medicaid members. The HMOs must work with providers utilized in emergencies or out of area situations to ensure their enrollment as a Wisconsin Medicaid Certified provider.

    a. Describe how the HMO currently updates its provider file with Wisconsin Medicaid provider IDs and NPI numbers.
    b. Describe how the HMO ensures that, when new providers are added to the HMO network, they are appropriately enrolled in the Wisconsin BadgerCare Plus and/or Medicaid SSI program and have a valid NPI (or Medicaid assigned non-NPI for atypical providers).

3. The HMO may submit encounter data to the department from third party vendors who pay and process claims on the HMO's behalf (e.g., behavioral health benefits manager and dental benefits administrator).

    a. Identify any third party vendors, the services provided, and the type of services (e.g., inpatient, behavioral health, etc.) provided.
    b. Describe how the HMO obtains the required data from the third party vendors, how often (e.g., monthly), and the timeliness of the data (i.e., how soon after the date of service is the data transmitted to the HMO, and subsequently to the department as encounters).
    c. Describe how the HMO ensures accuracy of data (through audit or other means).

4. Describe quality control measures of HMO information systems for both claim and encounter processing.

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

b. What processes are in place to identify and inform staff of any system performance problems?
c. Provide a summary document of your system's current disaster recovery program.

5. Describe the HMO's system's ability to provide data necessary to monitor program performance relative to Pay-for-Performance (P4P).

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

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

8. Describe the process used to convert provider claims to encounters.

   a. What is the process to submit the converted claims as encounters on a monthly basis?
   b. How does the HMO monitor and verify that at least 90% of adjudicated clean claims are submitted as encounters within 90 days, 99% within 150 days, and 100% within 240 days?

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

10. Provide a list of the ForwardHealth reports found on the Comprehensive HMO Report Matrix currently being used by your HMO.

    - A link to the Comprehensive HMO Report Matrix is below: https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage

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

5.1 Department Checklist

DHS USE ONLY			Reporting and Data Administration
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	Data Security and Privacy
☐	☐	☐	Secure SFTP Use
☐	☐	☐	Secure ForwardHealth Portal Use
☐	☐	☐	Data Retention – 10 Years for All Instances Cited in the HMO Contract
☐	☐	☐	Distribution of Access Payments as Described in Article XVI
☐	☐	☐	Encounter Based Payments and Ad Hoc Cash Transactions Processing
☐	☐	☐	Annual Financial Template Completion
☐	☐	☐	System and Technical Resources

☐	☐	☐	Provider Updates
☐	☐	☐	Encounter Third Party Vendors
☐	☐	☐	Claims/Encounters Quality Control
☐	☐	☐	P4P Data
☐	☐	☐	Method for allocating Administrative Expenses
☐	☐	☐	Claims Adjudication Timeliness
☐	☐	☐	Encounter Conversion and Submission Timeliness
☐	☐	☐	Wis. Stats., Ch. 20.927 The HMO does not submit Medicaid encounters for an abortion except with a signed physician certification on file that it is medically necessary to save the life of the woman or in a case of sexual assault or incest; or to prevent grave, long-lasting physical health damage to the woman due to a medical condition existing prior to the abortion.
☐	☐	☐	Wis. Stats., Ch. 253.107 The HMO does not submit Medicaid encounters for an abortion if the probable post fertilization age of the unborn child is 20 or more weeks unless because of a medical emergency, defined as: a condition, in a physician's reasonable medical judgment, that so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a 24-hour delay in performance or inducement of an abortion will create serious risk of substantial and irreversible impairment of one or more of the woman's major bodily functions.
☐	☐	☐	42 CFR 441 Subpart E-Abortions The HMO does not submit Medicaid encounters for expenses related to an abortion unless it has on file the physician’s certification that the life of the mother would be endangered if the fetus were carried to term, including the name and address of the patient.
☐	☐	☐	42 CFR 441 Subpart F-Sterilizations The HMO does submit Medicaid encounters for expenses related to sterilization only if the individual is mentally competent, at least 21 years old at the time consent is obtained, has voluntarily given informed consent; and there is at least 30 days, but not more than 180 days, between the date of informed consent and the date of the sterilization (refer to Subpart F for exceptions).
☐	☐	☐	42 CFR 441 Subpart F-Sterilizations The HMO does not submit Medicaid encounters for expenses related to sterilization by hysterectomy if it was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.
☐	☐	☐	42 CFR 441 Subpart F-Sterilizations The HMO does submit Medicaid encounters for expenses related to sterilization by hysterectomy, except with the restrictions immediately above, only if the person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing;

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

6 Care Management System and Continuity of Care

6.1 Care Management Requirements for All Members

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

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

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

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

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

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

6.2 Care Management Requirements for BadgerCare Plus Members

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

a. An initial screen(s) the HMO utilizes for the BadgerCare Plus population.

b. A description of the staff conducting the member screens including titles, credentials, and qualifications.

- HMOs must include how many FTEs conduct the member screens.
    - The HMO must also indicate the average number BadgerCare Plus members they serve per month.
- HMOs serving both BadgerCare Plus and SSI populations must describe whether or not the same staff conducts these screens and SSI Care Management member outreach processes.
    - If the same staff conducts both outreach processes, the HMO must include how many FTEs they have employed with the average numbers of both BadgerCare Plus and SSI members they serve per month.

c. Policies and procedures to conduct member outreach for the completion of the member screens including:

- A description of the process to engage members to complete the screen with methods of outreach (phone calls and mailings) and timeline of outreach.
- A description of their processes to identify and engage hard-to-reach members to complete the screen including the methods and timeline of outreach (i.e., phone calls and mailings).
- A description of their processes to engage members that initially refused to complete the screen including the methods and timeline of additional member outreach (i.e., phone calls and mailings).
- A description of the process to capture the responses to the screen.

d. Policies and procedures to prioritize members for additional assessments and care management interventions based on the member's responses to the screen.

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

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

6.3 SSI Care Management Practices (SSI HMOs only)

HMOs that contract with the Department to provide covered services to the SSI population must describe how they will meet the care management requirements defined in Article III, Section B of the 2020-2021 BadgerCare Plus and Medicaid SSI HMO contract. Your submission must include:

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

- An organization chart with the names and positions of the HMO's care management staff.
- Position descriptions with the names, credentials, duties, and caseload of each care management staff member.
    - Include in this section how many FTEs the HMO has and the average number of members served per month.

- A description of the HMO staff conducting each of the following care management activities with their names, titles, credentials, and average of members served or caseload:
  - Member Outreach.
  - Screening.
  - Care Plan Development.
  - Care Management Service Delivery (Implementing the Care Plan by delivering services outlined in the Care Plan) – Describe differences in the staff implementing interventions in the Care Plan for high-need Wisconsin Interdisciplinary Care Team (WICT) members vs. non-WICT members.
  - Care Plan Review and Updates.
  - Transitional Care.

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

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

c. Screening: Policies, procedures, and additional documentation to conduct a screening of every SSI Managed Care member within 60 days of enrollment in the HMO including the following:

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

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

- The Care Plan template.
- A description of the process for timely completion of the Care Plan; including:

  - A detailed timeline with a description of the process the HMO utilizes to complete the Care Plan.
  - Modes of contact to develop the Care Plan.
- A description of how the HMO uses the following data sources to develop the Care Plan:
  - Member's needs, issues, and preferences identified in the screening.
  - DHS' reports with prior Medicaid utilization information.
  - Member's medical records.
  - Community agency information based on the member's social determinant needs. For example, if a member needs assistance with housing, the HMO must document that need in the Care Plan and if the member is currently in a homeless shelter, the HMO must reach out to the shelter to obtain information about the stability of the member's current living arrangements.
- Member-centric Care
  - A description of how the HMO engages the member in the development of the Care Plan.
  - A description of how the HMO identifies the member's formal and informal supports.
  - A description of how the HMO defines specific goals appropriate for the member's needs with the member's input.
  - A description of the process the HMO uses to assess the member's readiness to self-manage their care and their willingness to adopt healthy behaviors. Some HMOs may utilize standard tools like the Patient Activation Measures (PAM) to monitor member engagement in their care.
  - A description of how HMO staff documents the member's consent with the Care Plan.
- Medical/Dental/Behavioral Health/Social Determinant Needs
  - A description of the chronic and acute illnesses included in the Care Plan. At a minimum, the HMO must include questions related to diabetes, obesity, heart disease, and respiratory diseases. The HMO must also describe how it analyzes data from the Care Coordination reports, which includes 24 months of encounter data and FFS claims, to identify the member's conditions.
  - A description of how the HMO captures the member's need for medication management in the Care Plan. The HMO must also describe how it analyzes pharmacy data from the Care Coordination reports to assess members' medication management needs.
  - A description of the behavioral health conditions included in the Care Plan. The HMO must also describe how it analyzes data from the Care Coordination reports to identify the member's behavioral health conditions.
  - A description of how the HMO integrates the member's dental care needs into the Care Plan.
  - A description of how the HMO captures the member's needs for additional supports to conduct Activities for Daily Living (including, but not limited to, bathing, dressing, and eating) and Instrumental Activities for Daily Living (including, but not limited to, medication management, money management, and transportation) in the Care Plan.
  - A description of how the HMO captures the member's social determinant needs in the Care Plan.
- Treatment Plan - A description of the process used by the HMO to identify the interventions that will be implemented to address the member's medical, behavioral health, dental and social determinant needs in the Care Plan and their sequence.
- Care Plan Sharing
  - A description of how the Care Plan information is shared with the member and/or legal guardian.
  - A description of how the HMO shares the Care Plan with the member's primary care provider and other specialists as appropriate.
  - A description of how the HMO shares relevant portions of the Care Plan interventions with community agencies and other partners as appropriate and with the member's consent. For example, a member lives in a homeless shelter and may need assistance storing diabetic supplies;

the HMO must share relevant portions of the Care Plan, with the member's consent, with staff from the shelter to help the member store the supplies.

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

- A description of how the HMO ensures continuity of care for new members who were receiving services under fee-for-service.
  - Per Art.VII, Section F. Coordination and Continuation of Care of the HMO Contract, the SSI HMO must:
    - Honor FFS authorizations for therapies at the level authorized by FFS for 90 days.
    - Authorize coverage of services with the member's current providers for the first 90 days of enrollment.
- A description of how the HMO ensures that services delivered address the medical, dental, and behavioral health needs identified in the Care Plan.
- A description of how the HMO will coordinate with community agencies and other resources to address the member's social determinant needs identified in the Care Plan, beyond referrals only.
- A description of how the HMO assesses the member's readiness to change and their level of engagement in meeting their Care Plan goals.
- A description of how the HMO follows-up with the member to determine if the services delivered addressed their needs.

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

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

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

- Policies and procedures to follow-up with members within 5 business days of discharge from an inpatient stay. DHS only provides additional reimbursement for follow-up with members within 5 business days of discharge of inpatient stays.

- A description of how the HMO is notified of a member's ER visit, hospital stay, or Nursing Home Stay.
    - Include a description of the technology used to get that information as well as the timeframe for obtaining it. Specify if information is received real-time.
- A description of how relevant information related to any of these events is integrated with the HMO's needs-stratification process.

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

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

6.4 Department Checklist

DHS USE ONLY			Care Management System and Continuity of Care
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
			6.1 Care Management Requirements for All Members
☐	☐	☐	**a.** Policy and Procedures to utilize member specific information.
☐	☐	☐	**b.** Policies and Procedures to make best effort to conduct initial screening within 90 days of enrollment.
☐	☐	☐	**c.** Policies and procedures for coordination of Medicaid covered services or medically necessary services to members identified in the initial screen.
☐	☐	☐	**d.** Policies and procedures for identification, assessment and development of treatment service plans and access to specialists.
			6.2 Care Management Requirements BadgerCare Plus
☐	☐	☐	**a.** Initial screen.
☐	☐	☐	**b.** Staff qualifications including titles and credentials that are preforming the screen.
☐	☐	☐	• Include number of FTEs conducting member screens and the average number of members served per month.
☐	☐	☐	• HMOs servicing both BC+ and SSI must outline how many FTEs (if any) are conducting both screening processes and the average number of members served.
	☐	☐	**c.** Member outreach for completion of member screens including
	☐	☐	• Process to engage members to complete ie. Phone calls, mailing, etc and include timeframes.
	☐	☐	• Process to identify and engage “hard-to-reach” members
☐	☐	☐	• Process to engage members who initially refused to complete the screen
☐	☐	☐	**d.** How to prioritize members for additional assessments and care management interventions.
			6.3 SSI Care Management Practices (SSI HMOs Only)
☐	☐	☐	**a. Care Management Staff -** Policies, procedures, position descriptions, and subcontracts of the staff providing care management for SSI members. The documentation must include:
☐	☐	☐	• An organization chart with the names and positions of the HMO’s care manage staff.
☐	☐	☐	• Position descriptions with names, credentials, duties, and caseload.
☐	☐	☐	• Care Management activities including: member outreach, screening, care plan development, service delivery including differences in interventions with WICT vs non-WICT members, care plan review, and transitional care.
☐	☐	☐	**b. Member Outreach -** Policies and Procedures and additional documentation for the following items:
☐	☐	☐	• Outreach activities for SSI members after HMO enrollment including method and timeline.
☐	☐	☐	• How staff handle member refusals and the process to re-engage members that previously refused outreach calls.

☐	☐	☐	**c. Screening -** Policy, procedures, and additional documentation to conduct screening for SSI members within 60 days of HMO Enrollment and include:
☐	☐	☐	• Screening questionnaire for new members
☐	☐	☐	• Screening process indicating how and where staff capture responses.
☐	☐	☐	• Identification of Social Determinants and how staff documents the member's support system.
☐	☐	☐	• Identification of member's perception of their strengths, well-being, health and life goals, and any immediate and long-term concerns the member has.
☐	☐	☐	• Identification of the member's behavioral health conditions and type of follow-up conducted by the HMO.
☐	☐	☐	**d. Care Plan Development –** Policies, procedures, and additional documentation to develop a Care Plan thin 30 days of completion of the screening or within 90 days of HMO enrollment, whichever is sooner.
☐	☐	☐	• The Care Plan template.
☐	☐	☐	• Detailed timeline (including dates) with a description of the process the HMO utilizes to complete the Care Plan and including modes of contact used.
☐	☐	☐	• A description of how the HMO uses data sources to develop the Care Plan
☐	☐	☐	• Member's needs, issues, and preferences identified in the screening.
☐	☐	☐	• DHS' reports with Medicaid utilization information.
☐	☐	☐	• Member's medical records.
☐	☐	☐	• Community agency information based on the member's social determinants needs.
☐	☐	☐	**Member-centric care** • A description of how the HMO engages the member in the development of the Care Plan.
☐	☐	☐	• A description of how the HMO identifies the member's formal and informal supports.
☐	☐	☐	• A description of how the HMO defines specific goals appropriate for the member's needs with the member's input.
☐	☐	☐	• A description of the process the HMO uses to assess the member's readiness to self-manage their care and their willingness to adopt healthy behaviors. Some HMOs may utilize standard tools like the Patient Activation Measures (PAM), but must describe how they use PAM to monitor member engagement.
☐	☐	☐	• A description of how the HMO staff documents member's consent with the Care Plan. To deem this element as "met", the HMO must have a process in place to document the member's verbal consent in their care notes or have a copy of the Care Plan signed by the member accessible through their care notes.
☐	☐	☐	**Medical/Dental/Behavioral Health/Social Determinant Needs** • A description of the chronic and acute illnesses included in the Care Plan. At a minimum, the Care Plan should include

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

			member's social determinant needs identified in the Care Plan, beyond referrals including a process to follow-up on all social determinant needs.
☐	☐	☐	• A description of how the HMO assesses the member's readiness to change and their level of engagement in meeting their Care Plan goals.
☐	☐	☐	• A description of how the HMO follows-up with the member to determine if the services delivered addressed their needs.
☐	☐	☐	**f. Care Plan Review and Update:** Policies, procedures, and additional documentation on how the HMO reviews and updates the member's Care Plan with the following information:
☐	☐	☐	• Policies and procedures with the process and criteria for reviewing an updating the Care Plan with members, at a minimum, once a year including: • The timeline and events that trigger review and updates to the Care Plan.
☐	☐	☐	• Any differences in the process and timing of reviewing and updating the Care Plan for members in different strata from the Needs-Stratification step. The HMO must demonstrate how the Care Plan is reviewed and updated more frequently for WICT members than non-WICT members, as well as differences between the medium and low stratas.
☐	☐	☐	• A description of the process for re-stratifying members after their Care Plan is reviewed/updated.

☐	☐	☐	• A description of the process for sharing the updated Care Plan with:
			  • The member and/or their legal guardian;
			  • The member's primary care provider and relevant providers, as appropriate and with the member's consent, and
			  • Community agencies, as appropriate and with the member's consent.

☐	☐	☐	**g. Discharge Follow-up/Transitional Care:** Policies, procedures, and additional documentation on appropriate discharge planning and transitional care to follow-up with members after they experience transitions between settings of care (e.g. ER visits, hospital stays or nursing home stays). The documentation must include:
☐	☐	☐	• Policies and procedures to follow-up with members within 5 business days of discharge from an inpatient stay.
☐	☐	☐	• A description of how the HMO is notified of a member's ER visit, hospital stay or nursing home stay.
☐	☐	☐	• A description of how relevant information related to any of these events is integrated with the HMO's needs-stratification process.
☐	☐	☐	**h. Wisconsin Interdisciplinary Care Team (WICT):** Provide policies, procedures, and additional documentation to identify and provide its highest needs members with an intensive, interdisciplinary intervention (WICT) including:

☐	☐	☐	• Policies or guidelines used to evaluate if a member, once identified as highest needs, will benefit from the WICT intervention.
☐	☐	☐	• Diagram of the WICT within the care management structure.
☐	☐	☐	• List of WICT staff positions with titles, credentials, number of individuals, and FTE dedicated to the WICT for each position type. • Ratio of WICT Core Team staff to WICT population at a point in time.
☐	☐	☐	• Description of the process for the WICT intervening rapidly and intensively to a member's need when appropriate. Processes must include capability to respond within 24 hours of a trigger event or the element is 'not met'.
☐	☐	☐	• Description of the process to ensure a WICT team staff meets at a minimum twice a month face-to-face with each member of the WICT.
☐	☐	☐	• Policies and procedures to ensure there is a weekly meeting of the WICT that includes, at least, two licensed health care professionals to discuss all WICT members.
☐	☐	☐	• Policies and procedures to ensure Core WICT staff has ready access to expertise, as needed in consultation, such as physician, pharmacist, etc.

☐	☐	☐	• Description of how the Care Plan created by the WICT captures:
			  • Attainable goals for the member,
			  • Clear path for the member to achieve these goals,
			  • Assessment of the member's readiness to change and to partner with the WICT, and
			  • A plan for the member to transition from the WICT to regular care management.

7 Fraud, Waste, and Abuse Policies and Procedures

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

a. The policies and procedures that describe the following:
   1. Designation and work responsibilities of all individuals associated to the compliance officer, Special Investigations Unit, and Regulatory Compliance Committee. *Include an organizational chart and a description of the role and duties of each position.*
   2. Communication between the compliance officer and the organization's senior management and employees. *Include examples of memos, reports, and/or meeting minutes*.
   3. Credentialing process for new and recertifying providers. *Include a description of all related process steps including the required database searches.*
   4. Pre-payment strategies. *Include a list of system edits, as well as procedures for manual pre-payment review of claims submitted by the network providers.*

5. Post-payment strategies. *Include a list of data mining strategies and procedures for auditing claims submitted by the network providers. HMOs should also describe in detail any appeal procedures available to providers once audit findings are issued or payments are recouped.*
6. Internal monitoring of the plan's employees. *Internal monitoring should include a risk assessment, as well as any other internal control policies in place.*
7. Prevention, identification, mitigation, and resolution issues pertaining to fraud, waste, and abuse. *Include tools used, procedures followed, and samples of related data reports.*
8. Reporting of fraud, waste, and abuse to the Department's Office of the Inspector General. *Clearly denote where in the process these reports are made and by what mechanism. Identify the activities that occur pre- and post-reporting to OIG. Identify the plan's internal criteria for when to make an external report.*
9. Recovery of overpayments. *Include the process by which overpayments are recovered and documented both when the plan identifies the overpayment, when the Department identifies the overpayment, and when OIG's contracted vendors identify the overpayment.*
10. Suspension of payments. *Include a clear description of how the plan complies with payment suspensions that stem from an OIG credible allegation of fraud. If the plan's contract with network providers has provisions for payment suspensions independent of a suspension notification from the OIG, include the criteria by which a provider is suspended and the criteria by which a suspension is lifted.*
11. Evaluation of Special Investigations Unit and compliance program. *Include required benchmarks, plans for correcting deficiencies, and any existing self-imposed plans of correction.*
12. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis. *Include a sample explanation of benefits (EOB) or other method by which this information is collected.*
13. Reporting of providers terminated for cause. *Include the documentation of the reporting process and the responsible party.*
14. Assist as necessary with OIG's audits of the plan's network providers. *Include processes, roles, and responsibilities relative to coordinating the scope and sample to avoid duplication, providing claims-level data, and returning overpayments associated with network provider audits to OIG.*
15. Subcontract must support network provider audits. *Include the excerpt of the subcontract related to participation in network provider audits and potential for the plan's recovery of overpayments.*

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

7.1 Department checklist

DHS USE ONLY			Fraud and Abuse Policies and Procedures
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	1. Designation and work responsibilities of all individuals associated to the compliance officer, Special Investigations Unit, and Regulatory Compliance Committee. *Include an organizational chart and a description of the role and duties of each position.*

☐	☐	☐	2. Communication between the compliance officer and the organization's senior management and employees. *Include examples of memos, reports, and/or meeting minutes*.
☐	☐	☐	3. Certification Application process for new and recertifying providers. *Include a description of all related process steps including the required database searches.*
☐	☐	☐	4. Pre-payment strategies. *Include a list of system edits, as well as procedures for manual pre-payment review of claims submitted by the network providers.*
☐	☐	☐	5. Post-payment strategies. *Include a list of data mining strategies and procedures for auditing claims submitted by the network providers. HMOs should also describe in detail any appeal procedures available to providers once audit findings are issued or payments are recouped.*
☐	☐	☐	6. Internal monitoring of the plan's employees. *Internal monitoring should include a risk assessment, as well as any other internal control policies in place.* .
☐	☐	☐	7. Prevention, identification, mitigation, and resolution issues pertaining to fraud, waste, and abuse. *Include tools used, procedures followed, and samples of related data reports.*
☐	☐	☐	8. Reporting of fraud, waste, and abuse to the Department. *Clearly denote where in the process these reports are made and by what mechanism. Identify the activities that occur pre- and post-reporting to OIG. Identify the plan's internal criteria for when to make an external report.*
☐	☐	☐	9. Recovery of overpayments. *Include the process by which overpayments are recovered and documented both when the plan identifies the overpayment and when the Department (BBM or OIG) identifies the overpayment.*
☐	☐	☐	10. Suspension of payments. *Include a clear description of how the plan complies with payment suspensions that stem from an OIG credible allegation of fraud. If the plan's contract with network providers has provisions for payment suspensions independent of a suspension notification from the OIG, include the criteria by which a provider is suspended and the criteria by which a suspension is lifted.*
☐	☐	☐	11. Evaluation of Special Investigations Unit and compliance program. *Include required benchmarks, plans for correcting deficiencies, and any existing self-imposed plans of correction.*
☐	☐	☐	12. Provisions for a method of verifying, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis. *Include a sample explanation of benefits (EOB) or other method by which this information is collected.*
☐	☐	☐	13. Reporting of providers terminated for cause *Include the documentation of the reporting process and the responsible party*
☐	☐	☐	14. Assist as necessary with OIG's audits of the plan's network providers. *Include processes, roles, and responsibilities relative to coordinating the scope and sample to avoid duplication, providing claims-level data, and returning overpayments associated with network provider audits to OIG*

☐	☐	☐	15. Subcontract must support network provider audits. *Include the excerpt of the subcontract related to participation in network provider audits and potential for the plan's recovery of overpayments.*
☐	☐	☐	b1. Program integrity training for internal personnel including the compliance officer, senior management, and employees.
☐	☐	☐	b2. Program integrity training for network providers.

8 Behavioral Health Services

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

In 2020, the American Academy of Pediatrics also recommended a "universal system of developmental surveillance and screening for the early identification of conditions that affect children's early and long-term development and achievement, including:

- Developmental surveillance is supported at every health supervision visit; standardized screening should be administered at the 9-, 18-, and 30-month visits.
- Special attention to surveillance is recommended at the 4- to 5-year well-child visit, prior to entry into elementary education, with screening completed if there are any concerns.
- Developmental surveillance includes bidirectional communication with early childhood professionals in child care, preschools, Head Start, and other programs, including home visitation and parenting, particularly around developmental screening."

Please describe the HMO's existing strategies for facilitating the use of these age-appropriate, validated tools.

☐ HMO requires the use of behavioral health screening tools to identify behavioral health needs within primary care settings. Specify tools required within the HMO's network for each of the following:
Mental Health: Click here to enter text.
Substance Use: Click here to enter text.
Developmental Screening: Click here to enter text.

☐ HMO provides education, training, and technical resources regarding the use of the above-stated screening tools.
Please elaborate: Click here to enter text.

☐ HMO covers the costs of administering or purchasing the age-appropriate validated behavioral health screening tools.

☐ Other strategies
Please specify any additional strategies that support the use of age-appropriate validated behavioral health screening tools: Click here to enter text.

If you do not require the use of specific standardized screening tools in your network and instead provide flexibility to your providers on which tools they use, please describe your requirements or oversight about tool selection.

Please describe your HMO's strategy to reach AAP's recommendations for ongoing developmental surveillance and standardized screening system at the recommended periodicity within your provider network: Click here to enter text.

DHS USE ONLY			Behavioral Health and Developmental Screening & Surveillance Services
Met	**Not Met**	**NA**	**Certification Application Review Criteria**
☐	☐	☐	1. The HMO provided responses to meet the above requirements.

9 Provider Network Participation Denial Reasons

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

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

10 Signature

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

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

Date: Click or tap to enter a date.

Signature of HMO's Authorized Agent: _____

Printed Name of HMO's Authorized Agent: _____