BadgerCare Plus and/or Medicaid SSI CONTRACT

between

WISCONSIN DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAID SERVICES

and

<<HMO>>

Issued January 1, 2025

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Table of Contents

ADDENDUM

PREAMBLE

This contract is between the Wisconsin Department of Health Services (the Department) and the Health Maintenance Organization (HMO) participating in the State of Wisconsin BadgerCare Plus and/or Medicaid SSI programs. These programs are approved by the Secretary of the United States Department of Health and Human Services pursuant to the provisions of the Social Security Act. An HMO is an insurer offering comprehensive health care services delivered by providers. These providers may be both employees and partners of the HMO, or they may have entered into a referral or contractual agreement with the HMO for the purpose of providing contract-related services for enrolled members. HMOs should work with providers for the further specific purpose of promoting coordination and continuity of preventive health services and other medical care related to behavioral health, emergency care, and social determinants of health. In exchange for making contract-covered services available to enrolled members, the HMO will receive periodic fixed payments from the Department. The HMO shall retain at all times during the Contract a valid Certificate of Authority to write disability insurance issued by the State of Wisconsin Office of the Commissioner of Insurance. The HMO is not required to contract for both programs, and if they are not contracted for both, only the provisions applicable to their program apply. The HMO does herewith agree:

I. Definitions and Acronyms

A. Definitions

1. **Abuse:** For program integrity purposes abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to BadgerCare Plus and/or Medicaid SSI, in reimbursement for services that are not medically necessary, or services that fail to meet professionally recognized standards for health. Abuse also includes member practices that result in unnecessary costs to the BadgerCare Plus and/or Medicaid SSI program.

2. **Access:** Per 42 CFR § 438.320, as it pertains to external quality review, "access" means the timely use of services to achieve optimal outcomes, as evidenced by the HMO successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined in 42 CFR § 438.68 and 42 CFR § 438.206.

3. **Actuarially Sound Capitation Rates:** Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the HMO for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with CMS requirements.

4. **Actuary:** An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board.

5. **Administrative Service Organization (ASO):** An organization that provides outsourced solutions to meet the administrative and HR needs of the client, with the client retaining all employment-related risks and liabilities.

6. **Adverse Benefit Determination:** Includes any of the following:

    a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

    b. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.

    c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" under 42 CFR § 447.45(b) is not an adverse benefit determination.

    d. The failure to provide services in a timely manner.

e. The failure of the HMO to act within the standard resolution timeframes for grievances and appeals as detailed in Article IX of this contract.

f. For a resident of a rural area with only one HMO, the denial of a member's request to exercise their right to obtain services outside the network as detailed in Article VII.D.4. of this contract.

g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

h. Adverse benefit determination does not include any of the following: when the HMO, provider, or subcontractor, triages a member to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary."

7. **Affirmative Action Plan:** A written document that details an affirmative action program.

8. **Agent:** An entity that solicits and/or conducts marketing or research on behalf of an HMO and/or takes or transmits any applications for insurance coverage.

9. **Appeal:** For member appeals, a review by the HMO of an adverse benefit determination. For provider appeals, an application or proceeding for review when a provider does not agree with the claim reconsideration decision. For example: A claim is denied by the HMO for untimely claim filing. The Provider must appeal the denial action to the HMO; an internal review by the HMO is required.

10. **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.

11. **Authorized Representative:** An individual appointed by the member, including a power of attorney or estate representative, who may act on the member's behalf under certain circumstances with documented consent of the member. The role of the authorized representative primarily includes filing a grievance or appeal, and approving the member's care plan.

12. **BadgerCare Plus:** BadgerCare Plus is Wisconsin's health care program for low income individuals that merged BadgerCare, the family portion of the current Wisconsin Medicaid population, with Healthy Start to form a single program that expands coverage to Wisconsin residents. Effective April 1, 2014, the following populations are eligible for BadgerCare Plus:

    a. Parents and caretakers with incomes at or below 100 percent of the Federal Poverty Level (FPL).

    b. Pregnant members with incomes at or below 300 percent of FPL.

c. Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL.

d. Childless adults with incomes at or below 100 percent of the FPL.

e. Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL.

13. **Budget Neutral:** Per 42 CFR §438.5(a), a standard for any risk sharing mechanism that recognizes both higher and lower expected costs among contracted HMOs under a managed care program and does not create a net aggregate gain or loss across all payments under that managed care program.

14. **Business Associate:** A person (or company), meeting requirements in 45 C.F.R. § 160.103, that provides a service to a covered program that requires their use of individually identifiable health information.

15. **Business Continuity Plan:** means a plan that provides for a quick and smooth restoration of the health plan's administrative services after a disruptive event. The business continuity plan includes business impact analysis, plan development, testing, awareness, training, and maintenance and processes to ensure minimal member and provider disruption. This is a day-to-day plan.

16. **Capitation Payment:** A payment the State agency makes periodically to a contractor on behalf of each member enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State Plan. The State agency makes the payment regardless of whether the particular member receives services during the period covered by the payment.

17. **Care Coordination:** The purposeful organization by care management staff to seamlessly deliver comprehensive services in response to a member's needs and work toward achieving desired health outcomes.

18. **Care Management Model:** A health care delivery process to arrange, deliver, monitor and evaluate the member's care, including all medical and social services, with the goal of helping members achieve their self-identified goals.

19. **Care Management Service Referral:** Connecting a member to a service(s) for the purpose of responding to a request or addressing a member need. Referrals are made on behalf of the member from one professional to another professional. If a member requests, service information is provided to the member.

20. **Care Management Staff:** Staff that assists in patient-centered, evidence-based, coordinated care and services designed to effectively manage health conditions and help members meet their self-identified goals.

21. **Care Plan:** Written documentation of decisions made in advance of care provided, based on a comprehensive assessment of a person's needs, preferences and abilities, defining how services will be provided. This includes establishing objectives (desired outcomes) with the client and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing cycle of activity as long as care is being provided.

22. **Case Management:** A collaborative process of assessing, planning, facilitating, coordinating, evaluating, and advocating for options and services to meet an individual's comprehensive health needs through communication and available resources to promote quality and cost-effective outcomes.

23. **CESA (Cooperative Educational Service Agencies):** The unit serving as a connection between the state and school districts within its borders. There are 12 CESAs in Wisconsin. Cooperative Educational Service Agencies coordinate and provide educational programs and services as requested by the school district.

24. **Childless Adults (CLAs):** A person who is 19 to 64 years old, regardless of marital status, is not receiving Medicare and does not have any dependent children younger than 19 years who reside with them at least 40 percent of the time. As of April 1, 2014, childless adults are eligible for Standard Plan benefits.

25. **Claim:** Bill for services, a line item of service, or all services for one member.

26. **Clean Claim:** A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

27. **Cold Call Marketing:** Any unsolicited personal contact by the HMO with a potential member for the purpose of marketing.

28. **Communication Materials:** Communication materials designed to provide members or potential members with clear, concise and factual information about the HMO's program, the HMO's network, and resources about the BadgerCare Plus and/or Medicaid SSI program.

29. **Community Based Health Organizations:** Non-profit agencies providing community based health services. These organizations provide important health care services such as HealthCheck screenings, nutritional support, and family planning, targeting such services to high-risk populations.

30. **Complex rehabilitation technology:** Means items identified in Wis. Stat. § 49.45(9r)(a)2.

31. **Comprehensive Assessment (for Medicaid SSI members only):** A detailed evaluation where an appropriately qualified health care professional identifies a member's health

care, cultural and socioeconomic needs. The assessment may entail conducting a review of the member's past medical history, analyzing member records, using diagnostic tools and patient interviews to form the basis for the development of a multidisciplinary plan of care for the member. The evaluation must include an encounter of care with the member, either in-person or through telephonic contact. For the purposes of an assessment, qualified health care professionals may include non-physician providers such as an advanced practice nurse, physician assistant, registered nurse or social worker, or other staff as approved in the certification application.

32. **Comprehensive Care Plan (for Medicaid SSI members only):** Written documentation of a plan of action developed by the HMO and the member that identifies strengths, needs, goals, and necessary interventions to be addressed within a specific timeframe. The Care Plan is a living document that reflects an ongoing cycle of activity as long as care is being provided.

33. **Confidential Information:** All tangible and intangible information and materials accessed or disclosed in connection with this Contract, in any form or medium (and without regard to whether the information is owned by the State or by a third party), that satisfy at least one of the following criteria:

    a. Personally Identifiable Information;

    b. Individually Identifiable Health Information;

    c. Non-public information related to the State's employees, customers, technology (including databases, data processing, and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; or

    d. Information designated as confidential in writing by the State.

34. **Contract:** The agreement executed between the HMO and the Department to accomplish the duties and functions, in accordance with the rules and arrangements specified in this document.

35. **Contract Services:** Services that the HMO is required to provide under this Contract.

36. **Contractor:** An HMO awarded a contract resulting from the HMO certification process to provide capitated managed care in accordance with this Contract.

37. **Coordination of Benefits (COB):** Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.

38. **Copayment:** A fixed amount the HMO or provider is allowed to charge a member for part of the cost of medically necessary covered services. Allowable copayment amounts are listed in the ForwardHealth online handbook.

39. **Wisconsin Quality Reporting (WIQR):** Required reporting including audited Healthcare Effectiveness Data and Information Set (HEDIS) measures, as outlined in the annual HMO Quality Guide. DHS reports these measures to CMS as part of their oversight of the Medicaid Adults and Child Core Sets measure performance.

40. **Corrective Action or Corrective Action Plan:** A written plan drafted by the Department that requires the HMO to address

    a. A contractual performance deficiency,

    b. Non-compliance with a state or federal law,

    c. any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Agreement,

    d. that the loss or inability to account for any Confidential Information by the HMO.

41. **Culturally Competent:** A set of congruent behaviors, attitudes, practices and policies that are formed within an agency, and among professionals that enable the system, agency, and professionals to work respectfully, effectively and responsibly in diverse situations. Essential elements of cultural competence include understanding diversity issues at work, understanding the dynamic of difference, institutionalizing cultural knowledge, and adapting to and encouraging organizational diversity.

42. **Days:** Unless stated otherwise, “days” means calendar days. Calendar days include weekends and holidays.

43. **Deficiency or Contractual Performance Deficiency:** A failure to comply with any applicable law, regulation, contract term, policy, or deadline established by the Department. Each failure to comply is a separate deficiency.

44. **Department:** The Wisconsin Department of Health Services.

45. **Direct Mail Marketing:** Any materials sent to potential members by an HMO or its agents through U.S. mail or any other mail service.

46. **Disaster:** any natural event or communicable disease outbreak in which a national or Wisconsin state of emergency is declared.

47. **Disposable Medical Supplies:** Health care items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

48. **Dual Eligible Special Needs Plan (D-SNP):** An HMO that 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.

49. **Durable Medical Equipment or Appliances:** Items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in absence of disability, illness, or injury, can withstand repeated used and can be reusable or removable.

50. **Educational Materials:** These are materials designed to provide members with information and resources regarding their health.

51. **Electronic Visit Verification (EVV):** An electronic system that uses technologies to verify that authorized services were provided. EVV visit data must be collected for care provided under service codes listed on the Department's EVV website (https://dhs.wisconsin.gov/evv/programadmin.htm). Workers are required to send information at the beginning and end of each visit to the EVV system including:

    a. Who receives the service
    b. Who provides the service
    c. What service is provided
    d. Where service is provided
    e. Date of service
    f. Time in and out

52. **Emergency Medical Condition:**

    a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
        i. Placing the health of the individual (or, with respect to a pregnant member, the health of the member or their unborn child) in serious jeopardy;
        ii. Serious impairment of bodily functions; or
        iii. Serious dysfunction of any bodily organ or part.
    b. With respect to a pregnant member who is in active labor:
        i. Where there is inadequate time to effect a safe transfer to another hospital before delivery; or
        ii. Where transfer may pose a threat to the health or safety of the member or the unborn child.
    c. A psychiatric emergency involving a significant risk or serious harm to oneself or others.

d. A substance abuse emergency exists if there is significant risk of serious harm to a member or others, or there is likelihood of return to substance abuse without immediate treatment.

e. Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever or trauma. In all emergency situations, the HMO must document in the member's dental records the nature of the emergency.

53. **Emergency Medical Transportation:** Transportation by ambulance, specialized medical vehicle (SMV) or county-approved or tribe-approved common carrier as defined under Wis. Admin Code §DHS 107.23(1)(d) when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient's condition. Wis. Admin Code §DHS 107.23.

54. **Emergency Recovery Plan:** A plan developed by the health plan that outlines details for the restoration of the health plan's management information system in the event of an emergency or disaster. This is part of the business continuity plan.

55. **Emergency Room Care:** Any health care service given in an emergency room and provided to evaluate and/or treat any medical condition that a prudent layperson believes requires immediate unscheduled medical care.

56. **Emergency Services:** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act, and needed to evaluate or stabilize an emergency medical condition.

57. **Encounter:**

a. A service or item provided to a patient through the health care system. Examples include but are not limited to:

i. Office visits

ii. Surgical procedures

iii. Radiology (including professional and/or technical components)

iv. Durable medical equipment

v. Emergency transportation to a hospital

vi. Institutional stays (inpatient hospital, rehabilitation stays)

vii. HealthCheck screens

b. A service or item not directly provided by the HMO, but for which the HMO is financially responsible. An example would include an emergency service provided by an out-of-network provider or facility.

c. A service or item not directly provided by the HMO, and for which no claim is submitted but for which the HMO may supplement its encounter

data set. Such services might include HealthCheck screens for which no claims have been received and if no claim is received, the HMO must have conducted a medical chart review. Examples of services or items the HMO may include are:

i. HealthCheck Services

ii. Lead Screening and Testing

iii. Immunizations

d. Services or items as used above include those services and items not covered by BadgerCare Plus and Medicaid SSI, but which the HMO chooses to provide as part of its managed care product. Examples include educational services, certain over-the-counter drugs, and delivered meals.

58. **Encounter Record:** An electronically formatted list of encounter data elements per encounter as specified in the current Encounter User Guide. An encounter record may be prepared from paper claims such as the CMS 1500, UB-04, or electronic transactions such as ASC XX12N 837.

59. **Enrollee (see also definition of "Member"):** A BadgerCare Plus and/or Medicaid SSI member who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the HMO Enrollment Rosters that the Department transmits to the HMO according to an established notification schedule. These terms are used interchangeably.

60. **Enrollment Specialist:** An entity contracted by the Department to perform HMO choice counseling and HMO enrollment activities. Choice counseling refers to activities such as answering questions and providing unbiased information on available managed care organization delivery system options, and advising on what factors to consider when choosing among HMOs and in selecting a primary care provider. Enrollment activities refers to distributing, collecting, and processing enrollment materials and taking enrollments by phone, by mail, or in person.

61. **Excluded Services:** Services that Medicaid does not pay for.

62. **Expedited Grievance or Appeal:** An emergency or urgent situation in which a member or their authorized representative requests a review of a situation where further delay could be a health risk to the member, as verified by a medical professional.

63. **Experimental Surgery and Procedures:** Experimental services that meet the definition of Wis. Adm. Code § DHS 107.035(1) and (2) as determined by the Department.

64. **External Quality Review (EQR):** Per 42 CFR §438.320, the analysis and evaluation by an External Quality Review Organization of aggregated information on quality, timeliness, and access to the health care services that an HMO or their contractors furnish to Medicaid beneficiaries.

65. **External Quality Review Organization (EQRO):** Per 42 CFR § 438.320, an organization that meets the competence and independence requirements set forth in 42 CFR § 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR § 438.358, or both.

66. **Federally Qualified Health Center:** Defined in Section 4161 of the Omnibus Budget Reconciliation Act of 1990. The purpose of FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. FQHCs are providers such as community health centers, outpatient health programs funded by the Public or Indian Health Service, and programs serving migrants and the homeless.

67. **Fee-for-Service**: A method of payment in which a provider is paid a fee for each service rendered for a BadgerCare Plus or Medicaid member.

68. **Fiscal Agent (as cited in 42 CFR § 455.101):** A contractor that processes or pays vendor claims on behalf of the Medicaid agency.

69. **ForwardHealth Handbook:** This Portal also provides users with access to health care information available via the Online Handbook. The Online Handbook is an interactive tool containing current health care policy and procedural information for ForwardHealth programs.

70. **ForwardHealth interChange:** The ForwardHealth Portal serves as the interface to ForwardHealth interChange, the Medicaid Management Information System for the state of Wisconsin. Through this Portal, providers, managed care organizations, partners, and trading partners can electronically and securely submit, manage, and maintain health records for members under their care.

71. **Fraud:** An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to themself, itself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

72. **Functionally Equivalent:** means a service provided via telehealth where the transmission of information is of sufficient quality as to be the same level of service as an in person visit. Transmission of voices, images, data, or video must be clear and understandable.

73. **Grievance:** An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the HMO to make an authorization decision. The member or authorized representative may file a grievance either orally or in writing.

74. **Grievance and Appeal System:** The processes the HMO implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

75. **Habilitation Services and Devices:** Health care service and devices that help a person keep, learn, or improve skills and functioning for daily living

76. **Health Care Professional:** A person who is trained and licensed to give health care. Examples include: A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, licensed midwives, or certified respiratory therapy technician.

77. **Health Care Services:** All Medicaid services provided by an HMO under contract with the Department in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

78. **HealthCheck:** HealthCheck is Wisconsin's name for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children under age 21. The EPSDT benefit is defined in federal law at §1905(r) of the Social Security Act and provides comprehensive and preventive health care services for all children under 21 years old. Federal and state regulations establish certain requirements for comprehensive HealthCheck screenings.

79. **HealthCheck "Other Services":** HealthCheck "Other Services" is Wisconsin's term for the federal mandate (under EPSDT) that requires that states cover "other necessary health care, diagnostic services, treatment, and other measures" which a child (under age 21) may require to treat, correct or reduce illnesses and conditions regardless of whether the necessary service is covered in a state's Medicaid plan. The needed service must be allowable under federal Medicaid law (§1905(a) of the Social Security Act), and coverage is determined on a case-by-case basis.

80. **Health Information:** Any "health information" provided and/or made available by the Department to a Trading Partner, and has the same meaning as the term "health information" as defined by 45 CFR § 160.103.

81. **Health Insurance:** A contract with an individual that requires a health insurer to pay some or all of an individual's health care costs.

82. **Health Related Social Needs (HRSN):** Individually identified needs related to a social risk factor. Examples include homelessness or domestic abuse.

83. **HHS Transaction Standard Regulation:** 45 CFR, Parts 160 and 162.

84. **High Birth Weight:** Defined as a birth weight greater than 4,500 grams.

85. **Highest Needs Members:** Members with complex needs, multiple comorbidities, and/or a history of frequent emergency department visits or inpatient admissions during the previous 12 months as identified by the HMO's needs-stratification process.

86. **HIPAA:** The Health Insurance Portability and Accountability Act of 1996, federal legislation that is designed to improve the portability and continuity of health insurance.

87. **HMO:** The Health Maintenance Organization or its parent corporation with a Certificate of Authority to do business in Wisconsin as an HMO, that is obligated under this Contract. A separate Certificate of Authority and HMO Certification Application must be submitted for each contract the HMO intends to enter into with the Wisconsin Medicaid program.

88. **HMO Administrative Services:** The health plan's performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of the delivery of and payment for Covered Services, including: network adequacy, service utilization, clinical or quality management, service authorization, claims processing, management information systems operation, and reporting. This term also includes the infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract, outside of the Covered Services.

89. **Homeless:** An individual who lacks a fixed and regular nighttime residence or an individual whose primary nighttime residence is:

    a. A supervised shelter designed to provide temporary accommodations;

    b. A halfway house or similar institution that provides temporary residence for individuals; or

    c. A place not designed for, or ordinarily used as a regular sleeping accommodation for human beings (e.g., a hallway, bus station, or a lobby).

90. **Home Health Care:** Home health skilled nursing and therapy services, including medication management, are provided to a recipient who, due to his/her medical condition, is unable to leave home to obtain necessary medical care and treatment and therefore, must receive this care at home.

91. **Hospice Services:** Services necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided to the family and other individuals caring for the terminally ill recipient. Wis. Admin Code DHS 107.31(2)

92. **Hospitalization:** An inpatient stay at a certified hospital as defined in Wis. Admin Code DHS 101.03(76).

93. **Hospital Outpatient Care:** The provision of services by an outpatient department located within an inpatient hospital licensed facility which does not include or lead to an inpatient admission to the facility.

94. **Income Maintenance Agencies:** Agencies include tribes, consortia or counties that determine BadgerCare Plus and Medicaid SSI enrollment and ongoing case management. Members can apply for benefits online, by phone, by mail or in person with their local agency.

95. **Indian:** Pursuant to 42 CFR § 438.14(a), any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR §136.12. The individual:

    a. Is a member of a Federally recognized Indian tribe;

    b. Resides in an urban center and meets one or more of the four criteria:

        i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

        ii. Is an Eskimo or Aleut or other Alaska Native;

        iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

        iv. Is determined to be an Indian under regulations issued by the Secretary;

    c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

    d. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

96. **Indian Health Care Provider (IHCP):** Pursuant to 42 CFR § 438.14(a), a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

97. **Individually Identifiable Health Information (IIHI):** Pursuant to 45 CFR § 160.103, information that is a subset of health information, including demographic information collected from an individual, and:

    a. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

b. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

   i. That identifies the individual; or

   ii. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

In addition to any information that meets the above definition, individually identifiable health information also includes the following categories of information:

a. Individuals' names and addresses

b. Medical services provided to individuals

c. Individuals' social and economic conditions or circumstances

d. Agency evaluation of personal information

e. medical data, include diagnosis and past history of disease or disability

f. Any information received for verifying income eligibility and amount of medical assistance payments (see § 435.940 through § 435.965 of this subchapter). Income information received from SSA or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data, including section 6103 of the Internal Revenue Code, as applicable.

g. Any information received in connection with the identification of legally liable third party resources under 42 CFR § 433.138

h. Individuals' social security numbers

Individually identifiable health information may be determined not identifiable when the requirements of 45 CFR § 164.514 are met.

98. **Information Gathering and Assessment (for Medicaid SSI members only):** A detailed evaluation where the care management staff collects all relevant information about the member's health care, and cultural and socioeconomic needs to conduct needs-stratification and to develop the Comprehensive Care Plan.

99. **Limited English Proficiency (LEP):** Potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

100. **Low Birth Weight:** Defined as a birth weight of less than 2,500 grams.

101. **Mandatory:** For the purpose of this contract, mandatory refers to a service area where the Department may, under Title 42 of the CFR and the State Plan Amendment, require members to enroll in a HMO.

102. **Marketing:** Any communication, sponsorship of community events, or the production and dissemination of marketing materials by the HMO, its employees, affiliated providers, subcontractors, or agents to a potential member for the purpose of persuading such persons to enroll with the HMO or to disenroll from another HMO. Marketing does not include communication to a potential member from the issuer of a qualified health plan as defined in 45 CFR 155.200, about the qualified health plan.

103. **Marketing Materials:** Materials that are produced in any medium, by or on behalf of an HMO that can be reasonably interpreted as intended to market the HMO to potential enrollees of the HMO.

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

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

106. **Medicaid:** The BadgerCare Plus and Medicaid SSI Program operated by the Wisconsin Department of Health Services under Title XIX of the Federal Social Security Act, Wis. Stats., Ch. 49, and related state and federal rules and regulations.

107. **Medicaid SSI (Supplemental Security Income):** Wisconsin's Medicaid plans for the elderly, blind or disabled provide health care for members who are:

    a. Age 65 or older, blind or disabled,

    b. With family income at or below the monthly program limit, and

    c. Who are United States citizens or legal immigrants.

    Plan eligibility depends on member income, assets, and the type of care needed. Individuals who receive SSI payments automatically qualify for Medicaid and are eligible for additional social services through their income maintenance agency.

108. **Medical Status Code:** The two-digit (alphanumeric) code in the Department's computer system that defines the type of BadgerCare Plus and/or Medicaid SSI eligibility a member has. The code identifies the basis of eligibility, whether cash assistance is being provided, and other aspects of BadgerCare Plus and/or Medicaid SSI. The medical status code is listed on the HMO enrollment reports.

109. **Medically Necessary:** A medical service, device or item that meets the definition of Wis. Adm. Code §DHS 101.03(96m).

110. **Member (see also definition of "Enrollee"):** A BadgerCare Plus and/or Medicaid SSI member who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the HMO Enrollment Rosters that the Department transmits to the HMO according to an established notification schedule. These terms are used interchangeably.

111. **Member-Centric Care:** Member-centric care is care that explicitly considers the member's perspective and point of view. For example, a member-centric care plan will include treatment goals and expected outcomes identified by the member, often expressed in the member's own words. A member-centric needs assessment includes the needs expressed by the member whether or not those needs fit neatly into medical or health nomenclatures. Member-centric care actively engages the patient throughout the care process.

112. **Member Communication:** Materials designed to provide an HMO's members with clear and concise information about the HMO's program, the HMO's network, and the BadgerCare Plus and/or Medicaid SSI program.

113. **National Culturally and Linguistically Appropriate Services (CLAS) Standards**[1]: The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

114. **Needs-stratification:** The assignment of individual members to specific levels of care management, based on individual member's overall medical and social needs that could affect the health care outcomes for that member. Needs-stratification helps align an individual member's overall medical and social needs with the most appropriate level of care management for that member.

115. **Newborn:** A member less than 100 days old.

116. **Non-Participating Provider:** Facility or provider that the HMO does not have a contract with to provide services to a member of the plan.

117. **Out-of-network provider:** Also called a "Non-Participating Provider" is a Facility or provider that the HMO does not have a contract with to provide services to a member of the plan.

118. **Outcomes:** Per 42 CFR §438.320, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

[1] https://www.thinkculturalhealth.hhs.gov/clas

119. **Outpatient Drug:** Outpatient Drug: any drug the meets that definition of covered outpatient drug as defined is Social Security Act s. 1927(k).

120. **Outreach Materials:** Materials used by the HMO to help bring awareness of services to members.

121. **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.

122. **Participating Provider:** Facility or provider the HMO has a contract with to provide covered services to a member of the plan.

123. **Pay-for-Performance (P4P):** DHS initiative to measurably improve quality of care provided to Medicaid members in focused areas. Includes HMO capitation withhold that can be earned back by HMOs based on their performance relative to quality targets for measures applicable to them.

124. **Performance Improvement Projects (PIPs):** Annual projects that HMOs are required to undertake as part of Quality Assessment and Performance Improvement (QAPI).

125. **Personally Identifiable Information:** An individual's last name and the individual's first name or first initial, in combination with and linked to any of the following elements, if the element is not publicly available information and is not encrypted, redacted, or altered in any manner that renders the element unreadable:

    a. The individual's Social Security number;

    b. The individual's driver's license number or state identification number;

    c. The individual's date of birth;

    d. The number of the individual's financial account, including a credit or debit card account number, or any security code, access code, or password that would permit access to the individual's financial account;

    e. The individual's DNA profile; or

    f. The individual's unique biometric data, including fingerprint, voice print, retina or iris image, or any other unique physical characteristic.

126. **Pharmacy Services Lock-in Program:** A program implemented by the Department to coordinate the provision of health care services for HMO members who abuse or misuse pharmacy benefits by seeking duplicate or medically unnecessary services, for restricted medications. Members enrolled in the program will have one pharmacy provider and one primary prescriber for restricted medications.

127. **Physician Services:** Any medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative services provided in a physician's office, in a hospital, in a nursing home, in a recipient's residence or elsewhere, and performed by or under the direct, on-premises supervision of a physician within the scope of the practice of medicine and surgery as defined in Wis. Stats. 448.01 (9).

128. **Plan:** A plan is an individual or group plan that provides, or pays the cost of, medical care.

129. **Post Stabilization Services:** Medically necessary non-emergency services furnished to a member after the member is stabilized following an emergency medical condition.

130. **Potential member:** A BadgerCare Plus or SSI member who is subject to mandatory managed care enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a member of a specific HMO.

131. **Potentially Preventable Readmissions (PPR) initiative:** DHS initiative requiring HMOs to collaborate with their providers to reduce preventable hospital readmissions within 30 days of discharge from inpatient care.

132. **Potentially Preventable Readmission (PPR):** When an HMO member is discharged from inpatient care, and is readmitted within 30 days of discharge, the readmission could be classified as a Potentially Preventable Readmission (PPR), based on 3M's PPR software logic and exclusions. PPR rates will be calculated for each HMO using only the HMO data and not Fee-for-Service data, by aggregating results for all members of an HMO who received inpatient care. Additional information re: the calculation of PPRs is provided in the "Annual Quality Guide" (the Guide).

133. **Premium:** The amount a member may pay each month for Medicaid coverage.

134. **Prescription Drug Coverage:** Drugs and drug products covered by Medicaid include legend and non-legend drugs and supplies listed in the Wisconsin Medicaid drug index which are prescribed by a physician, by a dentist licensed, by a podiatrist, by an optometrist, by an advanced practice nurse prescriber, or when a physician delegates the prescribing of drugs to a nurse practitioner or to a physician's assistant.

135. **Priced Amount:** The fee-for-service equivalent rate assigned to an encounter.

136. **Pricing Percentage:** Refers to percent priced for a defined time period such as a calendar or fiscal year. This measure is calculated by the HMO and is reported to the Department as a component of the Estimated Data Completeness measure.

137. **Primary Care Physician:** licensed physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions with specialties in general practice, family practice, internal medicine,

obstetrics, gynecology, and pediatrics. A Primary Care Physician may be a Primary Care Provider.

138. **Primary Care Provider (PCP):** Primary Care Physician or other licensed provider who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions. Including, but not limited to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), tribal health centers, and physicians, nurse practitioners, nurse midwives, physician assistants and physician clinics with specialties in general practice, family practice, internal medicine, obstetrics, gynecology, and pediatrics. Pursuant to 42 CFR §438.208(b)(1), the primary care provider is a person formally designated as primarily responsible for coordinating the services accessed by the member.

139. **Program Integrity:** As defined by CMS, it is the commitment to combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid enrollees. This includes, but is not limited to, the responsibility to review Medicaid provider activities, audit claims, identify and recover overpayments, and provider and public education.

140. **Prospective Risk Adjustment:** Per 42 CFR §438.5(a), a methodology to account for anticipated variation in risk levels with the contracted HMO that is derived from historical experience of the contracted HMO and applied to rates for the rating period for which the certification is submitted.

141. **Protected Health Information (PHI):** Health information, including demographic, that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual, that identifies the individual or provides a reasonable basis to believe that it can be used to identify an individual. PHI is a subset of IIHI.

142. **Provider:** A person who has been enrolled by the Department to provide health care services to members and to be reimbursed by BadgerCare Plus and/or Medicaid SSI for those services.

143. **Provider Agreement:** a written agreement between a provider as defined in this Article and the HMO or a subcontractor to provide services to the HMO's members.

144. **Provider Network:** A list of physicians, hospitals, urgent care centers, and other health care providers that an HMO has contracted with to provide medical care to its members. These providers are “network providers,” “in-network providers” or “participating providers.” A provider that has not contracted with the plan is called an “out-of-network provider” or “non-participating provider.”

145. **Public Institution:** An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined by federal regulations, including but not limited to prisons and jails.

146. **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.

147. **Quality:** Per 42 CFR §438.320, as it pertains to external quality review, the degree to which a HMO increases the likelihood of desired outcomes of its enrollees through:

    a. Its structural and operational characteristics.

    b. The provision of services that are consistent with current professional, evidenced-based-knowledge.

    c. Interventions for performance improvement.

148. **Rate Cell:** A set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

149. **Rate Region:** A grouping of counties with similar rate-setting attributes such as geography, member cost, and provider networks.

150. **Rating Period:** A period of 12 months selected by the Department for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR §438.7(a).

151. **Readily Accessible:** Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

152. **Reconsideration of a Claim:** A request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors.

153. **Recovery:** Refers to an approach to care which has its goals as a decrease in dysfunctional symptoms and an increase in maintaining the person's highest level of wealth, wellness stability, self-determination and self-sufficiency. Care that is consistent with recovery emphasizes the member's strengths, recognizes their ability to cope under difficult circumstances, and actively engages as partners in the provision of health care.

154. **Rehabilitation Services and Devices:** Services and devices designed for recovery or improvement of function and to restore to previous level of function if possible.

155. **Remediation**: The process by which the HMO must identify the root cause of a deficiency, develop, implement, and report on a Department approved plan for improvement.

156. **Resubmission of a Claim**: A claim or a portion of a claim that was denied is resubmitted through the claims process with changed or added information.

157. **Retrospective Risk Adjustment:** Per 42 CFR §438.5(a), a methodology to account for variation in risk levels with the contracted HMO that is derived from experience concurrent with the rating period of the contracted HMO subject to the adjustment and calculated at the expiration of the rating period.

158. **Risk Adjustment (Previously known as Chronic Illness & Disability Payment System (CDPS)):** Per 42 CFR §438.5(a), a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of HMOs contracted with the State.

159. **Sanction:** Any of the following, which is issued by the Department to the HMO:

    a. civil monetary penalties,

    b. appointment of temporary management of the HMO,

    c. suspension of further enrollment,

    d. allow enrollees the right to terminate enrollment without cause, or

    e. withholding all or part of the capitation payment issued by the Department to the HMO.

160. **Screening:** The use of data-gathering techniques, tests, or tools to identify or quantify the health and/or cultural needs of a member. Screening methods may include telephonic contact, mailings, interactive web tools, or encounters in person with screeners or health care providers. For Medicaid SSI members, the screening must be an in-person or telephonic interview where an HMO identifies the member's medical, dental, behavioral health and social needs.

161. **Secretary:** The Secretary of HHS and any other officer or employee of the Department of HHS to whom the authority involved has been delegated.

162. **Service Area:** An area of the State where the HMO has agreed to provide BadgerCare Plus and/or Medicaid SSI services to members. The Department monitors enrollment levels of the HMO by the HMO's service area(s). The HMO indicates whether they will provide dental or chiropractic services by service area. A service area may be a county, a number of counties, or the entire State.

163. **Service Authorization:** Approval of a member's request for the provision of a service.

164. **Significant Change:** Any change within a HMO's ability to fulfill the major components of the contract requirements, including but not limited to a change in provider network, service area, organizational structure or staff, or benefit package.

165. **Skilled Nursing Services:** Medically necessary skilled nursing services ordered by and to be administered under the direction of a physician that may only be provided by an advanced practice nurse, a registered nurse (RN), or a licensed practical nurse (LPN) working under the supervision of an RN.

166. **Social Determinants of Health:** Social, economic, environmental, and material factors surrounding people's lives, traumatic life events, access to stable housing, education, health care, nutritional food, employment and workforce development.

167. **Social Risk Factors:** Individual-level adverse determinants of health. Examples include social isolation or housing instability.

168. **Specialist:** A physician whose practice is limited to a particular branch of medicine or surgery, especially one who is professionally certified by a board of physicians.

169. **SSI Care Management**: initiative aims to provide person-centric care through needs stratification, integration of social determinants, person-centric care plans, interdisciplinary care teams, and on-going assessments and alignment of the SSI members' needs with their care.

170. **Standard Plan:** Effective April 1, 2014, all members eligible for BadgerCare Plus will be enrolled in the BadgerCare Plus Standard Plan. Standard Plan is the benefit package for BadgerCare Plus and Medicaid SSI defined in the ForwardHealth online handbooks and through State Plan Authority.

171. **State:** The State of Wisconsin.

172. **State Fair Hearing:** The process used by the Wisconsin Division of Hearing and Appeals to adjudicate member appeals of HMO adverse benefit determinations.

173. **Subcontract:** Any written agreement between the HMO and another party to fulfill the requirements of this Contract. However, such terms do not include insurance purchased by the HMO to limit its loss with respect to an individual member, provided the HMO assumes some portion of the underwriting risk for providing health care services to that member.

174. **Subcontractor**: means an individual or entity that has a contract with the HMO that relates directly or indirectly to the performance of the HMO's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the provider agreement with the HMO.

175. **Telehealth:** means the use of telecommunications technology by a certified provider to deliver services allowable under s. DHS 107.02 (5) and Wis. Stat. § 49.45 (61) and 49.46 (2) (b) 21. to 23., including assessment, diagnosis, consultation, treatment, or transfer of medically relevant data in a functionally equivalent manner as that of an in-person contact. Telehealth may include real-time interactive audio-only communication.

Telehealth does not include communication between a certified provider and a recipient that consists solely of an electronic mail message, text, or facsimile transmission.

176. **Third Party Liability (TPL):** The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the "payer of last resort," the identification of other payer obligations is a major requirement in the adjudication of claims (see Addendum IV.A. for additional definitions pertaining to TPL).

177. **Trade Secret:** Per Wis. Stat. §134.90(1), trade secrets are information, including a formula, pattern, compilation, program, device, method, technique or process to which all of the following apply:

a. s.134.90(1)(c)1. The information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use.

b. s.134.90(1)(c)2. The information is the subject of efforts to maintain its secrecy that are reasonable under the circumstances.

178. **Trading Partner:** Refers to a provider or HMO that transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162, or a business associate authorized to submit health information on the Trading Partner's behalf.

179. **Transaction:** The exchange of information between two parties to carry out financial or administrative activities related to health care as defined by 45 CFR §160.103.

180. **Transitional Care:** Processes to ensure continuity of care that include, but are not limited to, medication reconciliation, ensuring members have a comprehensive understanding of their treatment plan, and assisting members with scheduling follow-up appointments with their primary care provider or specialists as needed after a member is discharged from an emergency department, hospital, nursing home, or rehabilitation facility. Per 42 CFR § 438.208(b)(2), processes to coordinate services the HMO furnishes to the member between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.

181. **Trauma-informed Care:** An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

182. **Urgent care/service needs:** Services provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services are often but not always those that if not fulfilled could result in an emergency room visit or inpatient admission.

183. **Usual sources of care:** Doctor, clinic, health center, or other place that an individual reports visiting when sick. Persons who report the emergency department as the place of their usual source of care are defined as having no usual source of care.

184. **Validation:** Per 42 CFR §438.320, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

185. **Voluntary:** Refers to any service area where the Department cannot require members to enroll in an HMO.

186. **Waste:** Practices that, directly or indirectly, result in unnecessary costs to Medicaid funded programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the inappropriate utilization of services misuse of resources.

187. **Wisconsin Interdisciplinary Care Team (WICT):** A group of health care professionals, including HMO partners, and other ancillary staff representing diverse disciplines who work together to share expertise, knowledge, and skills to help members meet their self-identified goals. An effective WICT requires interdependent collaboration, open communication, and shared decision-making working toward a common goal.

188. **Wisconsin Statewide Health Information Network (WISHIN):** Wisconsin's health information network that shares electronic health information securely between participating physicians, clinics, hospitals, pharmacies, clinical laboratories, and HMOs across the state.

Per 42 CFR § 438.10, HMOs must use the definitions for managed care terminology found above when communicating with members to ensure consistency in the information provided to members. Terms that are not defined above shall have their primary meaning identified in Wis. Adm. Code chs. DHS 101-108.

B. Acronyms:

Acronym	Meaning
AA	Affirmative Action
AAAHC	Accreditation Association for Ambulatory Health Care
ACA	Affordable Care Act
ACOG	American Congress of Obstetricians and Gynecologists
ADRC	Aging and Disability Resource Center
ASAM	American Society of Addiction Medicine
ASO	Administrative Service Organization
BC or BC+	BadgerCare or BagderCarePlus
BQO	Bureau of Quality and Oversight
BRS	Bureau of Rate Setting

CAH	Critical Access Hospital
CAP	Corrective Action Plan
CBRF	Community Based Residential Facility
CCS	Comprehensive Community Services
CDPS	Chronic Illness & Disability Payment System
CEHRT	Certified Electronic Health Record Technology
CEO	Chief Executive Officer
CESA	Cooperative Educational Service Agencies
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CLA	Childless Adult
CLAS	Culturally and Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CPT	Current Procedural Terminology
CRC	Civil Rights Compliance
CRS	Community Recovery Services
CSA	Child Support Agency
CSP	Community Support Program
CY	Calendar Year
DATA	Drug Addiction Treatment Act
DBA	Dental Benefits Administrator
DMCPS	Division of Milwaukee Child Protective Services
DCTS	Division of Care and Treatment Services
DMS	Division of Medicaid Services
DOT	Directly Observed Therapy
DQA	Division of Quality Assurance
DRG	Diagnosis Related Groupings
DSPS	Department of Safety and Professional Services
DSS	Department of Social Services
DVT	Deep Vein Thrombosis
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERISA	Employee Retirement Income Security Act
EVV	Electronic Visit Verification

FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Federal Department of Health and Human Services
HIPAA	The Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
ICD	International Classification of Diseases
IDSS	Institute for Data, Systems, and Society
IFSP	Individualized Family Service Plan
IHCP	Indian Health Care Provider
IIHI	Individually Identifiable Health Information
IMD	Institutes for Mental Disease
IRS	Internal Revenue Service
LEP	Limited English Proficiency
LTC	Long Term Care
MA	Medical Assistance/Medicaid
MAPP	Medicaid Purchase Plan
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limits
NTS	Narcotic Treatment Services
OBMH	Obstetric Medical Home
OCI	Office of the Commissioner of Insurance
OIG	Office of the Inspector General
ONC	Office of National Coordinator
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider
PE	Pulmonary Embolism

PHI	Protected Health Information
PIP	Performance Improvement Project
PNCC	Prenatal Care Coordination
PPR	Potentially Preventable Readmissions
P4P	Pay for Performance
QAPI	Quality Assessment and Performance Improvement
QPIR	Quarterly Program Integrity Report
RHC	Rural Health Center
SBS	School Based Services
SCHIP	State Children's Health Insurance Program
SFTP	Secure File Transfer Protocol
SIU	Special Investigations Unit
SMV	Specialized Medical Vehicles
SSA	Social Security Administration
SSI	Supplemental Security Income
TCM	Targeted Case Management
TMSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability
UM	Utilization Management
URAC	Utilization Review Accreditation Commission
VFC	Vaccines for Children
WCAG	Web Content Accessibility Guidelines
WIC	Women, Infant, and Children
WIQR	Wisconsin Quality Reporting
WICT	Wisconsin Interdisciplinary Care Team
WIR	Wisconsin Immunization Registry
WISHIN	Wisconsin Statewide Health Information Network

II. Enrollment and Disenrollment

A. Enrollment

1. Enrollment Authority

   a. BadgerCare

   The current State Plan Amendment and 1115(a) waiver require mandatory enrollment into an HMO for those service areas in which there are two or more HMOs. Enrollment is voluntary for individuals who identify as American Indian or Alaskan Native.

   b. Medicaid SSI

   The current State Plan Amendment requires mandatory enrollment into an HMO for those service areas in which there are two or more HMOs.

   Enrollment for an HMO is voluntary for Medicaid members who are enrolled in Medicare and members who are enrolled in Medicaid Purchase Plan (MAPP).

2. Enrollment Determination

   The Department will identify BadgerCare Plus, Medicaid SSI and SSI-Related Medicaid members who are eligible for enrollment in the HMO as the result of eligibility under the medical eligibility status codes listed in the chart at the following link:

   https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Enrollment_Information/word/MedStats.docx.spage

   Medical Status Codes Eligible for BadgerCare Plus and Medicaid SSI HMO Enrollment.

3. Enrollment Section

   a. Members may generally choose an HMO upon eligibility.

   b. If the member does not choose an HMO and is required to enroll in an HMO, the Department will enroll the member in an HMO. The HMO will be selected based on a round robin selection, except for the following:

      i. Newborn Enrollment: If the mother is enrolled in a BadgerCare Plus HMO at the time of birth, and the child is reported to the certifying agency within 100 days of birth, the newborn will be enrolled in the same HMO as the mother back to the infant's date of birth.

      If the newborn is not reported to the certifying agency within 100 days, then the newborn will be enrolled in the same HMO as the mother the next available enrollment month. If the mother is not enrolled in a BadgerCare Plus HMO on the date of birth, the

newborn will be auto assigned to an HMO unless otherwise exempt.

ii. Infants weighing less than 1200 grams will be exempt from enrollment for one year if the data submitted to the fiscal agent by the HMO or the provider supports the infant's low birth weight. If an infant weighs less than 1200 grams, the HMO or provider should check the box on the BadgerCare Plus Newborn Report.

iii. Automatic Reenrollment: A member may be automatically reenrolled into the HMO if they were disenrolled solely because they lost BadgerCare Plus and/or Medicaid SSI eligibility for a period of two months or less.

iv. Prior HMO: The Department will assign a member to his/her prior HMO if the member was enrolled in an HMO within the past 12 months and does not make a selection of HMO.

4. Enrollment Rosters

The Department will promptly notify the HMO of all BadgerCare Plus and/or Medicaid SSI members enrolled in the HMO under this Contract. Notification will be effected through the HMO Enrollment Rosters. These rosters shall be available through electronic file transfer capability and will include medical status codes.

For each month of coverage through the term of the Contract, the Department will transmit "HMO Enrollment Rosters" to the HMO. These rosters will provide the HMO with ongoing information about its BadgerCare Plus and/or Medicaid SSI enrollees and disenrollees and will be used as the basis for the monthly capitation claim payments to the HMO. The HMO Enrollment Rosters will be generated in the following sequence:

a. BadgerCare Plus and Medicaid SSI

i. The Initial HMO Enrollment Roster will list all of the HMO's members and disenrollees for the enrollment month that are known on the date of roster generation. The Initial HMO Enrollment Roster will be available to the HMO on or about the twenty-first of each month. A capitation claim shall be generated for each member listed as an ADD or CONTINUE on this roster. Members who appear as PENDING on the Initial Roster and are reinstated into the HMO by the last business day of the month will appear as a CONTINUE on the Final Roster and a capitation claim will be generated at that time.

ii. The final HMO Enrollment Roster will list all of the HMO's members for the enrollment month, who were not included in the Initial HMO Enrollment Roster. The Final HMO Enrollment Roster will be available to the HMO by the first day of the

capitation month. A capitation claim will be generated for every member listed as an ADD or CONTINUE on this roster. Members in PENDING status will not be included on the final roster.

b. The Department will provide the HMO with effective dates for medical status code changes, county changes and other address changes in each enrollment roster to the extent that the income maintenance agency reports these to the Department.

5. Enrollment Errors

The Department must investigate enrollment errors brought to its attention by the HMO. The Department must correct systems errors and human errors and ensure that the HMO is not financially responsible for members that the Department determines have been enrolled in error. Capitation payments made in error will be recouped.

6. Open Enrollment

The HMO shall accept members eligible for coverage under this Contract, in the order in which they are enrolled. The HMO will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability.

7. Member Lock-in Period

a. Badger Care Plus

A mandatory member may disenroll from an HMO without cause during the first 90 days of an initial HMO enrollment. After 90 days, the member will be locked into the HMO for 9 months and may only disenroll for cause.

b. Mandatory SSI and SSI-Related Medicaid

Mandatory Medicaid SSI and SSI-related Medicaid may disenroll from an HMO without cause during the first 90 days of and initial enrollment. After 90 days, the member will be locked into the HMO for 9 months and may only disenroll for cause.

c. Voluntary Medicaid SSI and SSI-Related Medicaid

Voluntary Medicaid SSI and SSI-related Medicaid members will be locked into the HMO for 9 months. The member may disenroll from an HMO or choose FFS without cause during the first 90 days of an initial enrollment.

B. Disenrollment

The HMO must direct all members with disenrollment requests to the Enrollment Specialist for assistance. If the HMO is informed or becomes aware that a member has been incarcerated but was not disenrolled, then the HMO must report the member's incarceration and lack of disenrollment to the Enrollment Broker by sending an email to specializedmanagedcare@maximus.com.

Disenrollment requests will be processed as soon as possible and will be effective the first day of the next month of the request, unless otherwise specified.

The HMO will not be liable for services, as of the effective date of the disenrollment.

There are two types of disenrollment: Voluntary and system-based.

1. Voluntary Disenrollment

    a. A member may voluntarily disenroll from an HMO for any reason when the member is not in the lock-in period. Voluntary disenrollment requests must come from the member, the member's family, or legal guardian. Voluntary disenrollment shall be effective no later than the first day of the second month following the month in which the member requests disenrollment.

    b. A member may only disenroll from an HMO when in their lock-in period for the following reasons:

        i. Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BadgerCare Plus and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period.

        ii. If an HMO does not, because of moral or religious objections, cover the service the member seeks. The HMO must notify the Department, at the time of certification, of any services that they would not provide due to moral or religious objections.

        iii. If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

        iv. The SSI HMO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days.

        v. 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 the member's care needs.

2. System Based Disenrollments

System based disenrollments happen automatically in the system as a result of changes to the member's eligibility. If an HMO believes a member should have had a system-based disenrollment but has not, the HMO may request disenrollment through the Department's HMO Enrollment Specialists.

a. Loss of BadgerCare Plus and/or Medicaid SSI Eligibility

The member shall be disenrolled when a member loses BadgerCare Plus or Medicaid SSI eligibility. The date of disenrollment shall be the date of BadgerCare Plus or Medicaid SSI eligibility termination. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

b. Out-of-Service Area Disenrollment

The member shall be disenrolled when a member moves to a location that is outside of the HMO's service area but within the state of Wisconsin. The date of the disenrollment shall be the end of the month in which the move occurred.

c. Medicare Beneficiaries (BadgerCare Plus Only)

The member shall be disenrolled from the BadgerCare Plus HMO when the member is enrolled in Medicare. The Department will automatically disenroll the member when it receives notice of the Medicare eligibility. The disenrollment date will be determined as follows:

i. The end of the prior month in which the Department received notice of the Medicare eligibility when the Medicare eligibility begin date is in the same month the Department receives notice or is prior to the date the Department is notified of Medicare eligibility.

ii. The end of the month in which the Department received notice of Medicare eligibility when the Department received notice of Medicare eligibility for a prospective month.

d. Inmates of a Public Institution

The HMO is not liable for providing care to members who are inmates in a public institution as defined in 42 CFR § 435.1010.The HMO should provide documentation to the Department's HMO Enrollment Specialist that shows the member's placement. The disenrollment will be effective the first of the month of the date of incarceration.

e. Waiver Programs

The member is or will be participating in CLTS, FamilyCare, IRIS, PACE, or Partnership, or other home and community waiver programs. Disenrollment shall be effective the first month in which the member entered the other program. Disenrollments are not backdated more than

four months from the date the request is received. Any capitation payments made for months subsequent to disenrollment will be recouped.

f. Death

The member will be disenrolled from the HMO at date of death.

g. Out of State Moves

The member can be disenrolled from the HMO as of the date of the move. The HMO must provide a certified letter signed by the member confirming the date of the move. If the HMO does not provide this information, disenrollment will be effective at the end of the month of the move.

h. Change in Member Circumstance

i. Changes in circumstance include:

a) Change in the enrollee's residence when the enrollee is no longer in the HMO's service area.

b) The death of an enrollee.

ii. When the HMO has identified and verified a member's death, the HMO must provide prompt, written notification and proof of the change, no later than ten (10) calendar days from date of discovery.

a) For BadgerCare Plus and SSI HMO members, other than members with SSI Medicaid, send form F-02642 to the CDPU or MDPU

b) For SSI Medicaid HMO with SSI eligibility, send form F-02642a to the Enrollment Specialist.

iii. When the HMO has identified a change in the enrollee's residence, the HMO must instruct the enrollee to report the change in residence to their income maintenance agency.

C. Exemptions

Exemption requests will be processed as soon as possible and will be effective the first day of the next month of the request, unless otherwise specified. The HMO must direct all members with exemption requests to the Enrollment Specialist for assistance.

Exemption requests will not be backdated, unless an exception is granted by the Department. The HMO will not be liable for services, as of the effective date of the exemption.

Below are listed the exemption criteria that the Department uses to grant exemptions. Even if a member meets the exemption criteria, the Department may, in its sole

discretion, deny an exemption. Members who are denied an exemption may request a State Fair Hearing to appeal the denial.

1. Just Cause

   Just cause is defined as a situation in which the HMO cannot provide the member with appropriate medically necessary contract services for reasons beyond its control. The HMO may not request just cause disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative disruptive behavior resulting from their special needs (except when their continued enrollment in the HMO seriously impairs the entity's ability to furnish services to either this particular member or other members) (42 CFR 438.56). This exemption does not have an end date. The exemption is requested by the HMO and approved by the Bureau of Quality Oversight (BQO). The HMO requesting a just cause exception must provide documentation justifying the request. This exception lasts for a minimum of 2 years. If a member would like to transition back after two years, they must submit documentation demonstrating that they have remedied the issue that the HMO cited as reasoning for their inability to provide care. A member's request to transition back to the HMO does not guarantee that they will be allowed to transition back.

2. Nursing Home

   For BadgerCare Plus and Medicaid SSI members in a nursing home Cares Income Maintenance (MIM) or the HMO may request this exemption. This exemption is approved by the Enrollment Specialist or Fiscal agent staff.

   The HMO is responsible for nursing home costs until the date of the disenrollment. Although the HMO may request the exemption after 30 or 90 days in the nursing home, the exemption is effective the first of the month following the request.

   a. Medicaid SSI

      The HMO may request an exemption after an SSI member has been in a nursing home 90 days and is expected to remain in the facility. In the event the member transfers from the nursing home to a hospital and back to the nursing home, the applicable 90 day period shall run continuously from the first admission to the nursing home and shall include any days in the hospital. The HMO must wait until after 90 days before requesting an exemption, which will occur the first of the next month.

   b. BadgerCare Plus

      The HMO may request disenrollment when a member is in the nursing home longer than 30 days and is expected to remain in the facility. The HMO must wait 30 days before requesting an exemption, which will be effective the first of the next month.

3. Commercial Insurance

Members who have commercial insurance (HMO or otherwise) may be eligible for an exemption from a BadgerCare Plus or Medicaid SSI HMO if the commercial insurance does not participate in BadgerCare Plus or Medicaid SSI. In addition, members who have commercial insurance that limits them to a restricted provider network (e.g., PPOs, PHOs, etc.) may be eligible for an exemption from enrollment in a BadgerCare Plus or Medicaid SSI HMO. The member requests this exemption and it is approved by the Enrollment Specialist or fiscal agent. This exemption lasts for one year.

The HMO may request assistance from the Department's contracted Enrollment Specialist in situations where the member has commercial insurance that limits the members to providers outside of the BadgerCare Plus and/or Medicaid SSI HMO network.

When the Department's member eligibility file indicates commercial HMO coverage limiting a member to providers outside the BadgerCare Plus and/or Medicaid SSI HMO network and the member seeks services from the BadgerCare Plus and/or Medicaid SSI HMO network providers, the BadgerCare Plus and/or Medicaid SSI network providers may refuse to provide services to that member and refer them to their commercial network, except in the case of an emergency.

4. Stem Cell or Bone Marrow Transplant

Members who have had a stem cell or bone marrow transplant shall have a permanent exemption from HMO enrollment.

a. The exemption will begin on the first day of the month in which the surgery is performed.

b. For autologous bone marrow transplants, the person will be permanently exempt beginning on the date the bone marrow was extracted.

c. Members who have had one or more of the transplant surgeries referenced above prior to enrollment in an HMO will be permanently exempted. The effective date will be either the first of the month not more than six months prior to the date of the request, or the first of the month of the HMO enrollment, whichever is later.

d. Exemption requests may be made by the HMO or member and are approved by the State nurse consultant. Requests must include medical documentation:

i. records of the transplant,

ii. the date of the transplant,

iii. the procedure, and

iv. transplant facility.

5. Admission to a Birth-to-3 program (BadgerCare Plus Only)

This exemption applies when a child is under the age of 3 and is admitted to a Birth-to-3 program. The exemption request must be made by the case head of the member. Birth-to-3 exemption requests are approved by the Enrollment Specialist. Exemptions are backdated no more than two months from the date the request is received. The exemption lasts until the end of the month of the child's third birthday.

6. Native American

   Members who are Native American or American Indian and members of a federally recognized tribe are eligible for an exemption. The case head must request his exemption and it is approved by the Enrollment Specialist or fiscal agent. This exemption does not have an end date. The exemption applies to all members on the case, even if not all case members are tribal members.

7. Continuity of Care

   Continuity of Care exemptions may be granted when a person is newly enrolled or about to be enrolled in an HMO and is receiving care from a provider that is not part of the HMO network. The exemption must be requested by the member and may be approved by the Enrollment Broker, fiscal agent or the State Nurse Consultant. Continuity of Care exemptions are generally short term, granted for 6 months or less.

8. Voluntary (SSI Medicaid Plans – Dual Eligible Members with Medicaid and Medicare or MAPP members)

   This exemption applies when a member is not required to enroll in an SSI Medicaid HMO due to the member having Medicare or MAPP eligibility. This exemption is approved by the Enrollment Specialist or fiscal agent. This exemption does not have an end date. It will end if and when a member elects to transition into an HMO.

9. Long Term Complex Care (BadgerCare Plus and SSI Medicaid Plans)

   This exemption applies when a member has a long term/permanent medical condition which requires care in multiple HMO networks or providers who do not take HMOs. This exemption is requested by the member and approved by the state nurse consultant. This exemption is granted for a maximum of one year. At that time, the member must reapply for the exemption to continue.

10. Distance

    This exemption applies when the nearest HMO affiliated medical facility is more than twenty miles away from the member. This exemption may also be used when a member has moved from one HMO service area to another and needs to access care while getting their address changed. This exemption must be requested by the member and is approved by the Enrollment Specialist or fiscal agent. This exemption can last up to 12 months.

11. Low Birth Weight

This exemption applies when a newborn's weight at birth is 1200 grams or below. It is requested by the HMO and approved by fiscal agent when documentation (delivery room notes or a newborn report) is submitted by the HMO or hospital/provider showing that a newborn's weight is 1200 grams or below. This exemption lasts until the end of the month of the child's first birthday.

12. High Risk Pregnancy

This exemption applies when a member has a medical condition which poses a direct risk to the health of the member and/or the unborn child. This exemption is approved by the state nurse consultant. The length of this exemption is two full months past the expected date of delivery.

III. Care Management

A. Care Management Requirements

1. Care Management Policies and Procedures

   a. The HMO must develop care management policies and procedure to operationalize care management. The Department must approve the policies and procedures prior to the HMO implementing or changing the policies and procedures.

      The policies and procedures, at a minimum, must include the following:

      i. Mechanism to share with DHS the results of any identification and assessment of the members' needs to prevent duplication of services.

      ii. Per 42 CFR § 438.208(b)(2), procedures to coordinate the services the HMO provides to members:

         a) Between settings of care, including appropriate discharge planning for hospital or institutional stays. Upon notification of a change in setting of care, the HMO is responsible for coordination with the hospital or institution staff.

         b) With services provided by another HMO.

         c) With services a member receives through Medicaid Fee-for-Service.

         d) With services a member receives through community and social support providers.

         e) With Medicare provided services as applicable

      iii. Procedures to utilize member-specific information provided by DHS to prevent duplication of activities and as input into any needs stratification or care plan development activities. This must include results of any screens completed by the member, Department provided member demographics reports, Department provided member care coordination reports, HMO or Department provided claims/encounter history data, FFS and HMO prior authorization data provided by the Department, high-risk pregnancy indicators, and upcoming non-emergency medical transportation trips.

   b. The HMO must connect members to needed services identified by the member assessment process, request from the member, or other method. The HMO is responsible to identify the appropriate referrals, coordinate

the referral, and follow up with the member to ensure the effectiveness of the coordination. The HMO is also responsible to track referrals to identify areas of high need.

c. HMOs must also follow information sharing as written under Article VII. G.7.

2. Screening Requirements

Pursuant to 42 CFR § 438.208(b)(3), the HMO must make a best effort, which includes no less than three attempts, to conduct an initial screening of each member's needs, within 90 days of HMO enrollment for all new BadgerCare Plus members, and within 60 days of enrollment for new Medicaid SSI members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. New members include those that were previously enrolled in the HMO but re-enroll in the HMO at least six months after their last disenrollment.

See Article III.B. and C for BadgerCare Plus and SSI specific screening requirements.

3. Primary Care Provider Assignment

The HMO must assist members in identifying a primary care provider.

4. Care Management Staff Training Plan

The HMO must submit to the Department for review and approval a Care Management Staff Training Plan upon Department's request. The training plan must demonstrate how the HMO ensures staff are appropriately trained and supported to provide care management services to members.

5. Members with Special Health Care Needs

a. Definition

Members with Special Health Care Needs are defined by the Department as all SSI managed care members and any member who is in one or more of the following categories:

i. Children with serious emotional disorder;

ii. Children who have multiple significant chronic health problems that affect multiple organ systems and result in functional limitations;

iii. members who are pregnant or who are 0 to 12 months postpartum;

iv. members who have been incarcerated in the past 12 months;

v. members with a mental illness and another chronic condition (i.e. cardiovascular disease, diabetes, asthma; or

vi. members who are homeless.

b. Assessment

Per 42 CFR § 438.208(c)(2), the HMO must implement mechanisms to comprehensively assess each member with special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment shall be conducted by appropriately qualified staff.

c. Care Plans

Per 42 CFR § 438.208(c)(3), the HMO must produce a care plan, also known as a treatment or service plan, for members with special health care needs that are determined through the screen to need a course of treatment or regular care monitoring. The care plan must be:

i. Developed by appropriately qualified staff, and in consultation with any providers caring for the member;

ii. Developed by a person trained in person-centered planning using a person-centered process and plan as defined in § 441.301(c)(1);

iii. Approved by the HMO in a timely manner, if this approval is required by the HMO;

iv. In accordance with any applicable State quality assurance and utilization review standards; and

v. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member per § 441.301(c)(3) of this chapter.

d. Access to Specialists

The HMO must have policies and procedures to allow members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the member's condition and identified needs.

e. Utilization Review

The HMO must regularly conduct utilization review of its data, including claims, prior authorizations, hospital admissions, and emergency department utilizations, to identify members who could benefit from care management/care coordination and to ensure members are appropriately stratified.

B. Care Management Requirements for BadgerCare Plus Members

1. The HMO must conduct the member’s initial screen by telephonic contact, mailings, interactive web tools (live chat, online screen), or in person. The HMO

must train customer care staff to identify screen results that must be reported to the care management team.

2. Pursuant to 42 CFR § 438.208(b)(3), the HMO must make a best effort, which includes no less than 3 attempts to contact the member. to conduct an initial screen of each member's needs, within 90 days of HMO enrollment for all new members.

3. At a minimum, the member's initial screen must include questions that enable the HMO to identify all the following elements:

   a. The member's chronic physical, mental, and behavioral health illnesses

   b. The member's perception of their strengths and their general well-being, including chronic conditions and access to prescription medications

   c. Informal supports the member may have, such as family, social, or community-based supports

   d. Immediate or long-term concerns the member has about their overall well-being

   e. Whether the member needs assistance to conduct activities of daily living or instrumental activities of daily living

   f. Urgent medical and or behavioral needs

   g. Sources of care, such as the member's primary care provider, clinic, specialist(s) and dental provider

   h. Frequency in use of emergency and inpatient services

   i. Number of prescription mediations

   j. Behavioral and medical risk factors

   k. Weight and blood pressure indicators

   l. Risk factors that may indicate a need for care management

   m. Social determinates of health categories

   n. Special health or cognitive needs

4. Screen Completion Data

   a. The HMO must monitor and collect data on success in reaching members to provide a screen. The HMO must monitor member screens completed timely, members who refused, and members who were unable to contact.

   b. If the HMO has an inadequate screen completion success rate, as determined by the Department to be less than 35% annual success rate for initial screening of BadgerCare Plus members, then the HMO must remediate the score. This remediation includes but is not limited to a root

cause analysis and developing a Department approved plan to improve member screen completion rates.

c. If the HMO has an annual screen completion success rate of less than 35% for more than one measurement year, then the HMO may be subject to action provided under Article XIV.D.

5. Care Coordination and Referrals

The HMO must:

a. Coordinate assistance and/or referrals that address any needs identified in the screen.

b. Follow up with the member to ensure the identified needs are met after the assistance and/or referral

c. Document the follow up and result of the assistance and/or referral in the member record.

C. Care Management Model for the Medicaid SSI Population

HMOs must develop a comprehensive, integrated care model which incorporates social, behavioral health, and medical needs for members

SSI Medicaid members who are enrolled in and receive Medicare benefits from a Medicare Advantage Organization are exempt from the Care Management requirement.

1. The HMO care model(s) must have the following characteristics:

a. Effective Member Outreach and Engagement

HMOs must develop effective outreach strategies to connect with and engage SSI members using a member-centric, culturally competent, collaborative approach to care. The HMO must encourage member self-determination and self-care.

b. A Coordinated, Team-based, Patient-centered Approach to Care

The care management model must include shared decision-making between the care management team and members; scheduling flexibility; and team-based, care coordination services.

c. Social Determinants Approach to Care

The HMO must establish partnerships and maintain effective working relationships with social service and community-based agencies to ensure the social determinants of health (e.g., housing instability, low health literacy, chronic stress, traumatic life events, and other social factors) are identified and addressed.

d. Use of Information Technology Integral to Care Management Model

The HMO must use information technology to improve communication within and across health care settings and to reduce fragmentation in the delivery of services to the member.

The HMO must encourage use of the Office of the National Coordinator's (ONC) Interoperability Standards Advisory best available standards to share information electronically across the continuum of care.

e. Evidence Based Approach to Care

The HMO must monitor health care outcomes regularly and promote the use of evidence-based care.

2. Care Management Infrastructure

The HMO must have a sufficient number of adequately trained care management staff to meet individual member needs. The HMO must also have a Wisconsin Interdisciplinary Care Team (WICT) capable of intensive intervention, maintains a caseload of members identified by the HMO ,and serves as a consultative resource for other care management staff.

At a minimum, the care management infrastructure must include the following:

a. Care Management Staff Qualifications

The HMO must employ licensed healthcare professionals and other qualified care management staff with the following skills and knowledge needed to coordinate care for members:

i. Motivational interviewing skills

ii. Patient engagement strategies

iii. Knowledge of the target population

iv. Knowledge and experience with trauma informed care and the stages of change approach

v. An understanding of the impact of social determinants (e.g., poverty, lack of food or social supports) on health.

b. Wisconsin Interdisciplinary Care Team (WICT)

The care management infrastructure must include a Wisconsin Interdisciplinary Care Team (WICT) that provides member-centered care management services for members with the highest needs. The WICT must engage the member and their caregivers/family supports.

i. WICT Structure

The WICT must have a Core Team that includes a minimum of two licensed health care professionals with adequate expertise across medical, mental and behavioral health, and social determinants of health. The WICT Core Team must have access to

dedicated resources such as pharmacists, physicians, psychiatrists, dieticians, rehabilitation therapists, and substance abuse specialists.

The WICT Core Team must also coordinate with the member's PCP, medical specialists, behavioral health specialists, dental providers, and other community resources as driven by the member's care plan.

ii. WICT Functions

The WICT must work collaboratively with members, providers, and caregivers to accomplish shared goals across medical, mental and behavioral health, and other settings to achieve coordinated, high-quality care.

At a minimum, the WICT Core Team must meet weekly, preferably in-person, to discuss their entire shared case load.

At a minimum, a team member of the WICT Core Team must meet once a month in-person with the member to discuss the member's care. The in-person meeting with the WICT member may be completed by a community-based case manager if the case manager has a close, collaborative relationship with the WICT Core Team that is demonstrated in the member's care plan and includes reciprocal communication between the WICT Core Team and the community-based case manager.

The WICT is intended to be a short-term, intensive intervention. The Department will conduct a chart review for any member enrolled in the WICT for more than 12 months.

c. Caseloads

The HMO must allow care management staff and the WICT adequate time to effectively coordinate the delivery of integrated care. The HMO must have strategies in place to monitor care management team workloads and to assure that each team member is assigned a manageable caseload based on their roles and responsibilities within the team. HMOs must develop and maintain written caseload standards in consideration of the following:

i. The complexity of the cases.

ii. The need for licensed health care professionals and other care management staff to coordinate with other providers and community resources.

iii. The need for in-person contacts with the member, providers, and others instrumental to meeting the needs of the member.

iv. Management duties, including providing direction to care management team members and ensuring adequate documentation of care management activities.

3. Care Management Process

a. Initial Screen

i. Purpose

The HMO must identify medical, dental, mental and behavioral health or social needs of members. The initial screen must be used by the HMO's care management team to:

a) Inform the need for additional assessments as needed,

b) Refer members with the highest needs to the WICT.

ii. Timeframe

a) The screen must be completed by the HMO within 60 days of the member's HMO enrollment for newly enrolled members and members who re-enrolled with the HMO and had a period of disenrollment of six or more months.

b) The screen must be completed no later than the end of the twelfth month from the date of the most recent screen. For example, if the HMO completes a screen on May 2 of year one, then the HMO must complete another screen by May 31 of year two.

c) Current Members – The screening must be completed by the HMO no later than the end of the twelfth month from the date of the most recent screen. For example, if the HMO completes a screen on May 2 of year one, then the HMO must complete another screen by May 31 of year two.

iii. Modes of Contact

The initial screen must be conducted in-person, by interactive video technology, over the phone, or if the member prefers, the screen can be conducted via mail, electronic questionnaire, or email. The results of the screen must be discussed in-person, via interactive video, or over the phone with the member. Results and discussion must be documented in the member's chart.

iv. Required Components

At a minimum, the screening must include questions that enable the HMO to identify the following:

a) The member's chronic physical, mental and behavioral health illness(es) (e.g. respiratory disease, cardiac disease, stroke, diabetes/pre-diabetes, renal disease, back pain and musculoskeletal disorders, cancer, overweight/obesity, all mental health and substance abuse disorders).

b) The member's perception of their strengths, their general well-being (including chronic conditions and access to prescription medications).

c) If the member has a usual source of care.

d) Any indirect supports the member may have (family and social supports).

e) Any relationships the member may have with community resources.

f) Any immediate and/or long-term concerns a member may have about their overall well-being (e.g. social determinants of health).

g) If the member needs assistance to conduct activities of daily living (including but not limited to bathing, dressing and eating) as well as instrumental activities of daily living (including but not limited to medication management, money management and transportation).

b. Screen Completion Data

i. The HMO must monitor and collect data on success in reaching Medicaid SSI members to provide a screen. The HMO must monitor member screens completed timely, members who refused, and members who they were unable to contact.

ii. If the HMO has an inadequate screen completion success rate, as determined by the Department to be less than a 50% annual success rate for initial screening of Medicaid SSI members, then the HMO must remediate the rate. This remediation includes but is not limited to a root cause analysis and developing a Department approved plan to improve member screen completion rates.

iii. If the HMO has screen completion success rates of less than 50% for more than one measurement year, then the HMO may be subject to action as provided under Article XIV.D.

c. Information Gathering and Assessment

The care management team must collect, maintain, and update all relevant information to conduct needs-stratification and to develop the Comprehensive Care Plan including:

i. Reviewing the results of the member's screening and conducting other assessments for specific conditions as needed.

ii. Collecting and analyzing a comprehensive set of available data regarding the member's medical and behavioral health history including data provided by the Department.

iii. Collecting additional information about the member's social determinants of health.

d. Needs-Stratification

Needs stratification aims to align the member's overall medical and social needs with the most appropriate level of care management for that member, including WICT for highest needs members. The HMO must use individual member-level needs stratification as an input for developing individual care, and for using those plans to provide care management for the members. The HMO's care management team will be responsible for conducting and validating the needs stratification results. The HMO must have established processes, systems, tools, models, and administrative and clinical staff to conduct the following tasks related to needs stratification:

i. Proactively stratify individual members upon enrollment, using clinical, social, administrative and other relevant data collected.

ii. Use the stratification information for each member to assign individual members to the most appropriate care management strata, including the WICT for the highest-needs members. Prior to assigning a member to the WICT, HMOs must confirm that the member is able to participate in the intensive short-term intervention and the HMO is able to meet the WICT functional requirements for that member.

iii. Use stratification information as an input to develop individualized comprehensive care plans.

iv. Use the care plans to provide the most appropriate care management for individual members based on their needs.

v. Periodically reassess whether the members are assigned to the most appropriate strata, based on changes in their overall medical and social needs.

vi. Continuously monitor and enhance HMO's stratification methods for improving the health outcomes for members.

vii. If a HMO's needs stratification process results in over 5% of its monthly SSI caseload being identified as high needs and enrolled in a WICT, the HMO must notify DHS within 15 calendar days of the next calendar month. The Department will discuss with the HMO any approved continued high-WICT enrollment or any

changes the HMO makes to the needs stratification process and/or care management model.

e. Comprehensive Care Plan

i. Purpose

The purpose of the Comprehensive Care Plan is to ensure that appropriate care is delivered to the member by following an evidence-based, member-centric treatment plan that addresses their unique needs. The Comprehensive Care Plan must be developed by the care management team or the WICT and the member, incorporating the elements identified in the Screening, Information Gathering, and the Needs-stratification processes. Per 42 CFR 438.208(c)(3)(iv), the Comprehensive Care Plan must be in accordance with Utilization Management requirements outlined in Article X.H. of this contract.

ii. Timeframe

a) The Comprehensive Care Plan must be completed within 30 days of completion of the Screening or 90 days after enrollment in the HMO, whichever comes first for new and re-enrolled members.

b) All currently enrolled members must have a Comprehensive Care Plan completed by the HMO within 30 days of completion of the annual screen.

iii. Modes of Contact

The care management team or the WICT must develop the Comprehensive Care Plan in coordination with the member in-person, via interactive video, or over the phone.

iv. Care Plan Characteristics

The Comprehensive Care Plan must have the following characteristics:

a) Be member-centric, incorporating the member's short and long-term health and well-being goals.

b) Incorporate health literacy and cultural competency attributes based on the individual member needs.

c) Reflect understanding between the member and the care management team or WICT.

d) Identify all formal and informal supports, by name or position, that are instrumental to the member's care plan goals (e.g. family, friends, caregivers, providers,

community agencies). Include their role in executing the care plan, and if/how they will receive care plan updates.

e) Identify the member's current medical and non-medical needs including:

1) Chronic conditions and acute illnesses;

2) Mental and behavioral health conditions and history of abuse, violence, or traumatic life events;

3) Dental care needs;

4) Medications taken by the member;

5) 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 medication management, money management, and transportation);

6) Social determinants of health;

7) Other factors that will impact the member's ability to achieve goals.

f) Identify and address any gaps in care ensuring that the member has a primary care provider, and behavioral health specialist, dentist, or other health specialists as needed.

f. Care Plan Development

i. As part of the Comprehensive Care Plan development, the care management team or the WICT, in coordination with the member, must create an evidence-based plan of care that includes:

a) Specific goals appropriate for the member's needs,

b) The member's readiness to self-manage their care and their willingness to adopt healthy behaviors,

c) A description of the interventions that will be implemented to address the member's needs and their sequence.

ii. The care management team or the WICT must:

a) Obtain the member's agreement prior to its implementation.

b) Upon completion, share the Comprehensive Care Plan with:

1) the member;

2) the member's primary care provider, with member approval; and

3) others identified in the care plan and discussed with member.

c) Document the Comprehensive Care Plan, preferably according to the specifications for Care Plans in the ONC Interoperability Standards Advisory.

g. Reviews and Updates to the Comprehensive Care Plan

The care management team or the WICT must monitor available sources (e.g. data received from the Department, claims data, discharge information) for changes in the member's condition. The team must contact the member and update the Comprehensive Care Plan to ensure the member is receiving the appropriate services and care.

At a minimum, all SSI Managed Care members must be contacted once every 12 months (by either the care management team or the WICT) to review the Comprehensive Care Plan, or more frequently based on the member's needs.

The Comprehensive Care Plan must be updated as necessary to reflect changes in the member's condition and new information collected during the review.

i. Review of the Comprehensive Care Plan

As part of the review of the Comprehensive Care Plan, the care management team or the WICT must:

a) Have documentation of care and services provided to the member.

b) Determine if the member received care and services according to the Comprehensive Care Plan and the member's preferences.

c) Determine if the interventions that were conducted helped the member achieve the goals identified in the Comprehensive Care Plan.

d) Reassess the member's health and psychosocial status to identify necessary care plan updates.

e) Assess the member's satisfaction with the care received.

f) Conduct additional screening, information gathering, and/or needs stratification as appropriate.

ii. Updating the Comprehensive Care Plan

The Comprehensive Care Plan must be updated, in any of the following scenarios:

a) Whenever there are significant changes to the member's medical and behavioral health conditions. For example, when a member is diagnosed with a new chronic condition or experiences severe complications from an existing condition that results in a hospitalization.

b) The member is not responsive to the treatment plan outlined in the Care Plan.

c) The member frequently transitions between care settings, e.g. members that have an Emergency Room visit or are admitted to the hospital and then are discharged to home, or members that are discharged from a hospital to a Skilled Nursing Home facility.

d) At the member's request or whenever the care management team or the WICT identifies a problem or a gap in the member's care. This would include social determinants such as becoming homeless or experiencing food instability.

The member must approve all updates made to the Comprehensive Care Plan and member consent must be captured in the updated Comprehensive Care Plan.

h. Appropriate Transitional Care

The HMO is responsible for having appropriate transitional care processes and procedures in place to assist members after a discharge from emergency departments, hospitals and nursing homes or rehabilitation facilities. This includes coordinating with providers to share a summary care record, as specified in the ONC Interoperability Standards Advisory. As part of appropriate transitional care processes, the care management team or the WICT must assist with and ensure the member understands their discharge plan and medication regimen.

At a minimum, the following transitional care management activities (billed using G9012) must occur after every discharge from an inpatient hospitalization:

i. The care management team or WICT must have follow-up contact with the member and his/her family supports within five business days of discharge from an inpatient hospital facility.

a) The follow-up contact must be done in-person, via interactive video, or over the phone.

b) The follow-up must include reviewing the discharge information with the member, medication list review and reconciliation, including a comparison of medications prescribed vs taken by member, an evaluation of the member's ability to set up, administer, and monitor their own medication and helping the member understand:

1) Their treatment plan.

2) Their medications and medication schedule.

3) How to best manage their conditions.

ii. The care management team or the WICT must assess if the member should have a follow-up visit and assist with scheduling appointments, as necessary, with their primary care provider and/or appropriate specialists.

iii. The care management team or the WICT must have adequate documentation in the Comprehensive Care Plan of the meeting with the member, their feedback, and any follow-up appointments the member had with their provider.

4. Care Management Billing Rules

The Department has a care management benefit for the SSI managed care population. The benefit is defined above in Article III.C. The Department will reimburse HMOs for the care management services outside of the regular capitation payment. The Department will continue to cover other care management activities as an administrative component of the capitation rate or as an integral and inseparable component of another Medicaid covered benefit, as appropriate.

The Department has identified specific procedure codes to represent the Medicaid SSI care management benefit. HMOs will be required to use these procedure codes to identify SSI care management activities provided by the WICT and / or SSI care management staff. HMOs will be required to submit member-specific claims via encounter records for the SSI care management benefit. The HMO must maintain documentation for each member that supports the claimed services in their care management system.

The HMO must submit member-specific claims via encounters no later than 365 days after the date of service of the claim. If an HMO encounter is denied within the Department's Medicaid Management Information System (MMIS), the HMO has 90 days to resolve the encounter to priced status within the system.

5. Non-Duplication of Care Management Services

The Department developed the care management services defined in Article III.C., as a separate and distinct benefit for the Medicaid SSI managed care population. As a distinct benefit, the care management requirements defined in

Article III.C., must be reported as such using encounter records. HMOs must not report these care management activities using the financial template typically used to report the HMO's administrative activities.

HMOs must have a process to ensure that care management activities provided to the SSI managed care population are identified and accurately reported as either a benefit or as an administrative activity. A specific care management activity must never be deemed both a benefit and an administrative activity. For example, a general reminder call to SSI members about the availability of seasonal influenza vaccines cannot be reported both as an encounter and as an administrative activity. The HMO is responsible for ensuring that these activities are clearly defined and categorized. Services outside the allowed Medicaid-covered services and the billing codes, as documented in the SSI Care Management Billing Guide, are defined as an administrative service.

All care coordination activities reported as an encounter must be provided in accordance with the identified member's care plan. Care management activities that are not provided to an identified member and not provided in accordance with the requirements of Article III.C., are not covered as a separate benefit and must not be submitted as an encounter. HMOs must continue to report other care management costs under "administration" in the financial template.

The Department will provide detailed billing instructions, including procedure codes, reimbursement levels, and other claim submission requirements, in the SSI Care Management Billing Guide. HMOs must use the billing guide in addition to the HMO Contract to ensure that care management activities that are intrinsic to the SSI Care Management benefit are properly documented, billed and reported.

6. Evaluation of Care Management Requirements (Medicaid SSI)

   The Department and the EQRO will develop a methodology to review the HMO's member records to determine compliance with the performance targets and other requirements of the Care Management Model. The Department's EQRO will perform a chart review annually to determine if the HMO has met the performance targets and other Care Management requirements. In addition, the Department will analyze the encounter data with G codes submitted by the HMOs to evaluate how well the care management services delivered by the HMOs meet the program objectives. The Department reserves the right to request additional data and reports from HMOs as needed to monitor compliance with the Care Management requirements.

   The HMO Quality Guide for the appropriate contract year provides additional information about the targets, measures and other operational aspects related to the evaluation of care management requirements for Medicaid SSI.

7. Submission of Care Management Information to WISHIN (Medicaid SSI)

   The HMO must submit care management information for SSI members to the Wisconsin Statewide Health Information Network (WISHIN), The HMO shall

adhere to the technical specifications, formatting, and submission standards required by DHS and WISHIN when submitting care management information to WISHIN.

IV. Services

A. Provisions of Contract Services

1. The HMO must promptly provide or arrange for the provisions of all services required under Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23), Wis. Adm. Code Ch. DHS 107 and the Online ForwardHealth Handbook.
2. The HMO Contract Administrator, or their designee, is responsible for subscribing to ForwardHealth Updates and Alerts, and disseminating them to HMO staff for analysis and implementation.
3. The HMO must provide services in an amount, duration and scope that is no less than the amount, duration, and scope for the same services furnished to the member under fee for service Medicaid as defined in published policy within the Wisconsin Health Care Program Online ForwardHealth Handbook, as set forth in 42 CFR § 438.210(a)(2), 42 CFR § 440.230, and 42 CFR part 441, subpart B.
4. Pursuant to 42 CFR §438.210(a)(3), the HMO:
    a. Must ensure that the services furnished to the member are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
    b. May not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member. In addition, the HMO must comply with the care coordination.

B. Medical Necessity

1. The actual provision of any service is subject to the professional judgment of the HMO providers as to the medical necessity of the service, except that the HMO must provide assessment, evaluation, and treatment services ordered by a court.
2. Per 42 CFR §438.210(a)(4), the HMO can make decisions to provide or deny medical services on the basis of medical necessity and appropriateness as defined in the State Plan and 101.03(96m) or place appropriate limits on a service for the purpose of utilization control provided that:
    a. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i);
    b. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports; and
    c. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

3. The HMO must specify what constitutes "medically necessary" in a manner that is no more restrictive than that used in the Medicaid program as indicated in DHS 101.03(96m), the State Plan, Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23) and Wis. Adm. Code DHS 107, Wisconsin Health Care Programs Online Handbook and HMO Contract Interpretation Bulletins, and the ForwardHealth Provider Updates; and

4. The HMO is responsible for covering services related to:

   a. The prevention, diagnosis and treatment of a member's disease, condition, and/or disorder that result in health impairments and/or disability.

   b. The ability for a member to achieve age-appropriate growth and development.

   c. The ability for a member to attain, maintain or regain functional capacity.

5. HMOs must consider reimbursement for any service allowable under Section 1905(a) of the Social Security Act under EPSDT (referred to in Wisconsin as HealthCheck "Other Services") coverage criteria for all members under age 21 prior to denying coverage to any service.

   For a service to be reimbursed through HealthCheck "Other Services", the requirements outlined in the ForwardHealth Online Handbook Topics 22 and 41 must be met.

6. Disputes between the HMO and members about medical necessity can be appealed through the process described in Article IX. The Department will consider whether BadgerCare Plus and/or Medicaid SSI would have covered the service on an FFS basis (except for certain experimental procedures).

C. In Lieu of Services

1. An HMO may cover services for a member that are in addition to those services covered under the state plan per 42 CFR §438.3(e). In lieu of services can be covered by HMOs on a voluntary basis as follows:

   a. 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;

   b. The member is not required by the HMO to use the alternative service or setting;

   c. The approved in lieu of services are identified in the HMO contract and will be provided at the option of the HMO;

   d. The HMO cannot deny access to a service or setting covered under the State plan on the basis that the member has been offered an ILOS as an optional substitute for a service or setting covered under the State plan, is currently receiving an ILOS as a substitute for a service or setting covered under the State plan, or has utilized an ILOS in the past;

e. Members must have the option to appeal an adverse benefit determination or file a grievance regarding an ILOS consistent with Article IX; and

f. The utilization and cost of in lieu of services is taken into account in developing the component of the capitation rates that represent the covered state plan services.

2. An HMO may cover the following services:

a. Inpatient services in an IMD for a person 22-64 years of age for no more than 15 days during the period of monthly capitation payment in lieu of traditional psychiatric intervention services. The HMO may not cover Residential Substance Use Disorder treatment provided in an IMD as an in lieu of service.

The network provider must document medical necessity of inpatient services in an IMD in the member's medical record.

b. Medically Tailored Meals

i. Definition

Medically tailored meals are fresh or frozen prepared meals that are medically tailored to the nutritional needs of the member by a Registered Dietitian. Medically tailored meals are designed to improve health outcomes, lower cost of care, and increase satisfaction. Meals may help members manage a medical condition, meet their nutrition goals, and avoid hospitalizations or emergency department visits.

Meals are provided under the supervision of a Registered Dietitian, employed by, or contracted with the medically tailored meal provider, and must follow evidence-based nutritional practice guidelines to address medical conditions, symptoms, allergies, medication management, or side effects to ensure the best possible nutrition-related health outcomes. Additionally, meal options must meet member~~,~~ allergy restrictions, preferences for specific food items, and cultural or religious preferences.

Medically tailored meals include up to two prepared meals per day for up to 12 weeks, or longer if medically necessary, and initial evaluation and follow-up assessments by a Registered Dietitian. Medically tailored meals may be reauthorized every 12 weeks for up to one year (365 days) following the initial authorization or authorization after another eligibility event, such as discharge from a hospital.

a) The HMO must submit the following for encounter:

1) HCPCS codes S5170 or S9977 for meals and 97802-97804 for initial and follow-up assessments

with a Registered Dietitian, and S9470 for audio-only telehealth with a Registered Dietitian (initial or follow-up visit).

2) At least one modifier indicating the target population(s) the member belongs to. Members may belong to more than one population.

A) U1 for high risk pregnant or postpartum members

B) U2 for diabetes after a hospital discharge

C) U3 for cardiovascular disease after a hospital discharge

ii. Clinically Oriented Target Population(s) and Eligibility

If offering the medically tailored meals in lieu of service, the HMO must offer the service to all of the following clinically oriented target populations.

a) High-risk pregnant or postpartum members as determined by the ordering provider or HMO staff provider, including, but not limited to, members in OB Medical Homes (See Art. IV.I).

b) Members with diabetes who have been discharged from a hospital in the past 90 days.

c) Members with cardiovascular disease who have been discharged from a hospital in the past 90 days.

The HMO must define consistent criteria for the authorization of services determined to be medically appropriate and cost-effective for members. The licensed HMO staff provider or referring network provider's determination that medically tailored meals are medically appropriate for the specific member must be documented in the member record.

iii. The in lieu of service will substitute emergency department visits and hospital inpatient stays.

D. Medicaid Services for which the HMO is Not Responsible

The HMO is not responsible to provide the following Medicaid services to its members:

1. Non-emergency Medical Transportation (NEMT) as listed in Article IV.E.4.
2. Dental, except HMOs serving Milwaukee, Waukesha, Racine, Kenosha, Ozaukee and Washington counties must provide dental services.

3. Prenatal Care Coordination (PNCC), except the HMO must sign a Memorandum of Understanding (MOU) with the PNCC.
4. Targeted Case Management (TCM), except the HMO must work with the TCM case manager as indicated in Addendum II and the HMO is responsible to reimburse and arrange for the provision of Child Care Coordination services.
5. School-Based Services (SBS)
    a. The HMO must use its best efforts to sign a Memorandum of Understanding (MOU). SBS are those services identified in a student's Individualized Education Plan (IEP) and provided by a school district or CESA.
    b. The HMO must not consider physical, occupational, and speech and language therapy services supplied in school settings automatically duplicative when it is considering the medical necessity of a requested community based therapy.
6. Certain Tuberculosis-related services, including directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring.
7. Crisis Intervention Benefit.
8. Community Support Program (CSP) services.
9. Comprehensive Community Services (CCS).
10. Community Recovery Services (CRS).
11. Chiropractic services, unless the HMO elects to provide chiropractic services.
12. Lead investigations, as defined in s. 254.11(8s), of persons having lead poisoning or lead exposure, as defined in s. 254.11(9).
13. Medication therapy management.
14. Prescription, over-the-counter drugs, and diabetic and other drug related supplies (as defined by the Department dispensed by a provider licensed to dispense by the Wisconsin Department of Safety and Professional Services (DSPS)).
15. Provider administered drugs, as discussed in the following handbook topics: Provider-Administered Drugs (Topic #5697), of the Covered and Non-covered Services chapter of the ForwardHealth Online Handbook.
16. Behavioral Treatment Services (Autism Services) as defined in ForwardHealth Online Handbook
17. Residential Substance Use Disorder Treatment
18. Hub and Spoke Integrated Recovery Support Services Health Home for SUD Pilot Program

E. Additional Information Regarding Services

1. Physician and Other Health Services

   Services required under Wis. Stats. s. 49.46(2), and Wis. Adm. Code DHS Ch. 107, include (without limitation due to enumeration) private duty nursing services, nurse-midwife services and independent nurse practitioner services; physician assistant services and physician services, including primary care services, are not only services performed by physicians, but services under the direct, on-premises supervision of a physician performed by other providers such as nurses of various levels of certification.

2. Pre-existing Medical Conditions

   The HMO must assume responsibility for all covered pre-existing medical conditions for each member as of the effective date of coverage under the Contract. The aforementioned responsibility does not apply in the case of persons hospitalized at the time of initial enrollment.

3. Emergency Ambulance Services

   The HMO may require submission of a trip ticket with ambulance claims before paying the claim. Claims submitted without a trip ticket need only be paid at the service charge rate. The HMO must:

   a. Pay a service fee for an ambulance response to a call in order to determine whether an emergency exists, regardless of the HMO's determination to pay for the call.

   b. Pay for emergency ambulance services based on established BadgerCare Plus and/or Medicaid SSI criteria for claims payment of these services.

   c. Either pay or deny payment of a clean claim from an ambulance service within 45 days of receipt of the clean claim.

   d. Respond to appeals from ambulance providers within the time frame described. Failure will constitute the HMO's agreement to pay the appealed claim to the extent FFS Medicaid would pay.

4. Transportation

   Most non-emergency Medical Transportation (NEMT) is coordinated by the Department's NEMT manager. The NEMT manager arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include public transportation such as a city bus, non-emergency ground ambulance, rides in specialized medical vehicles (SMV), or rides in other types of vehicles depending on a member's medical transportation needs, as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus and Medicaid SSI covered services. Non-emergency medical transportation also includes coverage of meals and lodging in accordance with the ForwardHealth policy.

   The HMO must direct members to the NEMT manager for non-emergency medical transportation.

The HMO must promptly provide or arrange for the provision of transportation services, including all air transport, not reimbursed by the NEMT manager as listed in the ForwardHealth Online Handbook Topic #11898..

5. Transplants

   a. The HMO must cover cornea, kidney, liver, heart, lung, heart-lung, pancreas, and pancreas-kidney transplants. These services are no longer considered experimental.

   b. The HMO is not required to cover stem cell or bone marrow transplants.

      The State Plan requires HMOs to follow written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or providers to be consistent with the accessibility of high quality care to members.

6. Dental Services

   a. Dental services covered by HMOs who are not contracted to provide comprehensive dental services for BadgerCare Plus and Medicaid SSI Plans:

      i. Emergency Dental Care

         The HMOs must cover emergency dental care. The only exceptions are the charges for professional services billed using CDT codes and the charges for professional services rendered by a dentist and billed using CPT codes.

      ii. Dental Surgeries Performed in Hospital

         The HMO must pay all ancillary charges relating to dental surgeries when a hospital or freestanding ambulatory care setting is medically indicated. Ancillary charges include, but are not limited to physician, anesthesia, and facility charges. The only exceptions are the charge for professional services billed using CDT codes and the charges for professional services rendered by a dentist and billed using CPT codes. If the HMO is unable to arrange for the dental surgery to be performed within their own provider network then the HMO must authorize the service(s) to be performed out of plan.

      iii. Prescription Drugs Prescribed by a Dental Provider

         Fee-for Service is liable for the cost of all medically necessary prescription drugs when ordered by an enrolled BadgerCare Plus and/or Medicaid SSI dental provider.

      iv. Coordination with Fee-for-Service

As defined in Article III.A. the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Service.

b. Dental services covered by the HMO contracted to provide dental care for BadgerCare Plus and Medicaid SSI:

i. All BadgerCare Plus and/or Medicaid SSI covered dental services are required under § DHS 107.07 and Wisconsin Health Care Programs Online Handbooks and Updates.

ii. HMOs providing dental coverage in service areas of Racine, Marathon, Brown, and Polk Counties will be required to participate in a dental pilot program authorized in the 2015-17 biennial budget.

iii. Diagnostic, preventive, and medically necessary follow-up care to treat a dental disease, illness, injury or disability of members while they are enrolled in the HMO.

iv. Completion of orthodontic or prosthodontic treatment begun while a member was enrolled in the HMO if the member became ineligible for BadgerCare Plus and/or Medicaid SSI or disenrolled from the HMO, no matter how long the treatment takes. The HMO will not be required to complete orthodontic or prosthodontic treatment on a member who began treatment as a FFS member and who subsequently was enrolled in the HMO.

v. The HMO or HMO affiliated dental provider must advise the member within 30 days of effective enrollment of the name of the dental provider and the address of the dental provider's site. The HMO or HMO affiliated dental provider must also inform the member in writing how to contact his/her dentist (or dental office), what dental services are covered, when the coverage is effective, and how to appeal denied services.

vi. The HMO or HMO affiliated dental provider who designates all or some BadgerCare Plus and/or Medicaid SSI HMO members to specific participating dentists must give members at least 30 days after designation to choose another dentist. Thereafter, the HMO and/or affiliated provider must permit members to change dentists at least twice in any calendar year and more often than that for just cause.

vii. HMO-affiliated dentists must provide a routine dental appointment to an assigned member within 90 days after the request. Member requests for emergency treatment must be addressed within 24 hours after the request is received.

[Refer to the chart following this page of the Contract for the specific details of completion of orthodontic or prosthodontic treatment in these situations.]

c. Right to Audit

The Department may conduct validity and completeness audits of dental claims. Upon request, the HMO must submit paid claims to the Department along with any other records the Department deems necessary for the completion of the audit. Payment of incomplete or inaccurate claims will subject the HMO to action as provided under Article XIV.D.

d. Requirements to Dental Service Providers

If an HMO subcontracts with a dental benefits administrator, the participating dentist has the right to appeal to both the HMO and Department, according to the Department's provider appeal requirements. This right to appeal is in addition to that of the provider's right to appeal.

HMOs must pay at a minimum the Medicaid fee-for-service rates for dental services. Providers rendering services must be paid at a minimum the Medicaid fee-for-service rates.

HMOs must ensure their contracted Dental Benefits Administrator is compliant with the appeal rights and service coverage decisions required in this contract.

e. Dental Benefits Administrator Surveys

HMOs using a Dental Benefits Administrator (DBA) must survey in-network dental providers twice per year. Results of this survey, and any subsequent remediation the HMO plans for their contracted DBA will be shared with DHS. The survey must include but is not limited to:

i. specific questions to measure successful DBA communication,

ii. ability for providers to appeal,

iii. general provider satisfaction, and

iv. access and availability to covered services.

7. Child Care Coordination (CCC)

Beginning in 2025, the HMO must reimburse and arrange for the provision of Child Care Coordination (CCC) services. CCC is a Targeted Case Management benefit designed to provide enhanced care coordination for eligible children. Providers are community-based and have local relationships to culturally appropriate resources and services to address members' needs. Services include assessment, care plan development, and ongoing care coordination and management. CCC services are only offered in Milwaukee County and the City of Racine.

Responsibility for Payment of Orthodontic and Prosthodontic Treatment
When There is an Eligibility Status Change During the Course of Treatment

	Who pays for completion of orthodontic and prosthodontic treatment* when there is an enrollment status change		
	First HMO	Second HMO	FFS
Person converts from one status to another: 1. FFS to the HMO covering dental.		N/A	X
2. HMO covering dental to the HMO not covering dental.	X		
3. HMO covering dental to the HMO not covering dental.			X
4. HMO with dental coverage to FFS because person exempted from HMO enrollment.		N/A	X
5. HMO with dental coverage to FFS because person's medical status changes to an ineligible HMO code.	X	N/A	
6. HMO with dental to ineligible for BadgerCare Plus and/or Medicaid SSI	X	N/A	

8. Emergency and Post-Stabilization Services

a. 24-Hour Coverage

The HMO must provide all emergency contract services and post-stabilization services as defined in this Contract 24 hours a day, seven days a week, either by the HMO's own facilities or through arrangements approved by the Department with other providers.

The HMO must:

i. Have one toll-free telephone number that members or individuals acting on behalf of a member can call at any time to obtain assistance in determining if emergency services are needed, to obtain authorization for urgent care and to obtain authorization for transportation. This telephone number must provide access to individuals with authority to authorize treatment as appropriate.

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Orthodontia treatment is available only to members under age 21 to address concerns identified during a wellness visit such as an interperiodic or HealthCheck screen.

Responses to these calls must be provided within 30 minutes. If the HMO fails to respond timely, the HMO will be liable for the cost of subsequent care related to that illness or injury incident whether the treatment is rendered by in or out-of-plan providers and whether the condition is emergency, urgent or routine.

Authorization here refers to the requirements defined in the Standard Member Handbook Language, regarding the conditions under which a member must receive permission from the HMO prior to receiving services from a non-HMO affiliated provider in order for the HMO to reimburse the provider.

ii. Be able to communicate with the caller in the language spoken by the caller or the HMO will be liable for the cost of subsequent care related to that illness or injury incident whether the treatment is in or out-of-plan and whether the condition is emergent, urgent, or routine. These calls must be logged with the time, date and any pertinent information regarding the persons involved, resolution and follow-up instructions.

iii. Notify the Department and county human services department with which the HMO has a MOU or in which the HMO has enrollment of any changes to this toll-free telephone number for emergency calls within seven business days of the change.

iv. Per Article III.A. the HMO must coordinate the services it provides to members between settings of care.

b. Coverage of Payment of Emergency Services

The HMO must promptly provide or pay for needed contract services for emergency medical conditions and post-stabilization services, regardless of whether the provider that furnishes the service has a contract with the entity. The HMO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or HMO of the member's screening and treatment within ten (10) days of presentation for emergency services. The HMO in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the HMO as identified in 42 CFR § 438.114(b) and 42 CFR § 438.114(d) as responsible for coverage and payment. Nothing in this requirement mandates the HMO to reimburse for non-authorized post-stabilization services.

i. The HMO shall provide emergency services consistent with 42 CFR § 438.114. It is financially responsible for emergency services whether obtained within or outside the HMO's network. This includes paying for an appropriate medical screening

examination to determine whether or not an emergency medical condition exists.

ii. The HMO may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

iii. The HMO may not deny payment for emergency services for a member with an emergency medical condition (even if the absence of immediate medical attention would not have had the outcomes specified in Article I.A.52.a.i-iii. of the definition of Emergency Medical Condition) or for a member who had HMO approval to seek emergency services.

iv. The member may not be held liable for payment of screening and treatment needed to diagnose the specific condition or stabilize the patient.

v. The treating provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the HMO.

c. Coverage and Treatment of Post-Stabilization Care Services

i. The HMO is financially responsible for:

a) Emergency and post-stabilization services obtained within or outside the HMO's network that are pre-approved by the HMO. The HMO is financially responsible for post-stabilization care services consistent with the provision of 42 CFR § 438.114(C).

b) Post-stabilization services obtained within or outside the HMO's network that are not pre-approved by the HMO, but administered to maintain, improve or resolve the member's stabilized condition if:

1) The HMO does not respond to a request for pre-approval of further post-stabilization care services within one (1) hour;

2) The HMO cannot be contacted; or

3) The HMO and treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation In this situation, the HMO must give the treating physician the opportunity to consult with the HMO care team or medical director. The treating physician may continue with care of the member until the HMO care team or

medical director is reached or one of the following occurs:

A) A network physician assumes responsibility for the member's care at the treating hospital or through transfer;

B) The treating physician and HMO reach agreement; or

C) The member is discharged.

ii. The HMO's financial responsibility for post-stabilization care services it did not pre-approve ends when a network provider assumes responsibility for care, at the treating hospital or through transfer, when the treating physician and HMO reach agreement or when the member is discharged.

iii. The HMO must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if they had obtained the services through the HMO. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

d. Additional Provisions

i. Payments for qualifying emergencies (including services at hospitals or urgent care centers within the HMO service area) are to be based on the medical signs and symptoms of the condition upon initial presentation. The retrospective findings of a medical work-up may legitimately be the basis for determining how much additional care may be authorized, but not for payment for dealing with the initial emergency. Liability for emergency services continues until the patient is stabilized and can be safely discharged or transferred.

ii. When emergency services are provided by non-affiliated providers, the HMO is liable for payment only to the extent that BadgerCare Plus and/or Medicaid SSI pays, including Medicare deductibles, or would pay, FFS providers for services to BadgerCare Plus and/or Medicaid SSI populations. For more information on payment to non-affiliated providers, see Article XV.D.4. The HMO must not make any payments to providers with a financial institution outside the United States. In no case will the HMO be required to pay more than billed charges. This condition does not apply to:

a) Cases where priority payment arrangements were established and

b) Specific subcontract agreements.

e. Memoranda of Understanding (MOU) or Contract with Hospitals/Urgent Care Centers for the Provisions of Emergency Services

The may have a contract or a MOU with hospital or urgent care centers within the HMO's service area to ensure prompt and appropriate payment for emergency services. Unless a contract or MOU specifies otherwise, the HMO is liable to the extent that FFS would have been liable for a situation that meets the definition of emergency. The Department reserves the right to resolve disputes between the HMO, hospitals and urgent care centers regarding emergency situations based on the emergency definition. For situations where a contract or MOU is not possible, the HMO must identify for hospitals and urgent care centers procedures that ensure prompt and appropriate payment for emergency services. Refer to Article VIII, Provider Appeals.

9. Family Planning Services and Confidentiality of Family Planning

a. BadgerCare Plus and Medicaid SSI Plan Members:

i. The HMO must give members the opportunity to have a different primary physician for the provision of family planning services. This physician does not replace the primary care provider chosen by or assigned to the member.

ii. The member may choose to receive family planning services at any Medicaid-enrolled family planning clinic. Family planning services provided at non-network Medicaid-enrolled family planning clinics are paid FFS for HMO members including pharmacy items ordered by the family planning provider.

iii. All information and medical records relating to family planning shall be kept confidential including those of a minor.

10. Pharmacy Coverage

a. Pharmacy Coverage

HMOs must carve out all SSA §1927 covered outpatient drugs to fee-for-service (covered outpatient drugs include drugs dispensed in a pharmacy, administered in a doctor's office, or clinic; drugs reimbursed at bundled rate are not considered outpatient drugs).

Per Article III.A., the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Service.

b. Pharmacy Services Lock-In Program

DMS will manage a Pharmacy Services Lock-In Program to coordinate the provision of health care services for HMO members who abuse or

misuse pharmacy benefits by seeking duplicate or medically unnecessary services, for restricted medications.

Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wisconsin Administrative Code. Restricted medications are most controlled substances.

HMO members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one primary prescriber who will prescribe restricted medications.

HMO members will remain enrolled in the Pharmacy Services Lock-In Program for two years. At the end of the two-year enrollment period, DMS or the HMO will assess if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Policy on the Pharmacy Services Lock-In Program can be found in the BadgerCare Plus and Medicaid Pharmacy Provider Handbook.

i. The Division of Medicaid Services (DMS) or its designated representative must

   a) manage the Pharmacy Services Lock-In Program and communicate directly with the HMOs regarding their members.

   b) monitor prescription drug usage for members enrolled in the Pharmacy Services Lock-In Program.

   c) accept select review requests from the HMO for potential Pharmacy Services Lock-In Program members. Not all select reviews may result in intervention letters or lock-in for the member.

   d) accept referrals from the HMO for the Pharmacy Services Lock-In Program. DMS or its designated representative will proceed with Pharmacy Services lock-in for referred members.

   e) may request additional information from the HMO for referrals. The HMO must provide requested information to DMS or its designated representative.

   f) identify the lock-in pharmacy and the HMO must identify the lock-in primary prescriber for each member. In addition, the HMO must identify any alternate prescribers for restricted medications, as appropriate.

   g) send letters of notification to the lock-in member and HMO for the lock-in pharmacy.

h) provide an electronic monthly report to the HMO that identifies any members in the Pharmacy Services Lock-In Program for the specific HMO.

i) coordinate with the HMO for the Pharmacy Services Lock-In Program policies and procedures.

ii. HMO Responsibilities

a) HMOs may request select reviews based on prescription drug utilization for potential Pharmacy Services Lock-In Program members. Not all select review requests may result in intervention letters or lock-in for the member.

b) HMOs may provide Pharmacy Services Lock-In Program referrals to the DMS or its designated representative. The DMS or its designated representative will proceed with Pharmacy Services lock-in for all HMO-referred members.

c) The HMO should evaluate referred Pharmacy Services Lock-In Program members at the end of the two-year enrollment period, to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program and notify the DMS or its designated representative.

d) The HMO must be responsible for preparing all documentation and acting as the DMS representative for member appeals to the Division of Hearings and Appeals related to the Pharmacy Services Lock-In Program referrals.

e) The DMS may request additional information from the HMO for referrals. The HMO must provide requested information to the DMS or its designated representative.

f) HMOs lock-in primary prescribers may designate alternate prescribers for restricted medications, as appropriate.

g) HMOs must send letters of notification to the lock-in member and the DMS or its designated representative. HMOs must notify primary prescribing provider and alternate prescribers when assigned for a lock-in member.

h) HMOs must communicate with the DMS or its designated representative.

i) The DMS or its designated representative will identify the lock-in pharmacy and the HMO will identify the lock-in primary prescriber for each member. In addition, the HMO

will identify any alternate prescribers for restricted medications, as appropriate.

j) HMOs may refer members to the DMS or its designated representative for the Pharmacy Services Lock-In Program if any of the following are documented by the HMO:

1) Evidence of a member intentionally providing incorrect information such as ForwardHealth eligibility status or medical history to a provider to obtain restricted medications.

2) Evidence of a member being convicted within one year of a crime related to restricted medications. Crimes include: forgery, theft, distribution, etc.

3) Two or more occurrences of violating a pain management contract within six months from the same or different prescribers. A prescriber must agree to continue managing the member after the Lock-In Program has been initiated.

4) Any combination of four or more medical appointments/urgent care visits/emergency department visits within a 14 day time period at which the member is seeking a restricted medication as the primary reason for the visits.

5) A member required an ER visit or hospitalization due to suicide attempt, poisoning, or overdose from the use of restricted medication(s) in the last ninety days.

11. Electronic Visit Verification

The HMO must use Electronic Visit Verification (EVV) for designated service codes. HMOs must submit a daily authorizations file for all EVV required services as outlined on the Department's EVV website (https://dhs.wisconsin.gov/evv/programadmin.htm). The HMO must use a daily file that contains all verified EVV visits to ensure that claims processed for EVV services can be associated with EVV visit information. Encounters details without a valid EVV record may be excluded in future rate-setting development. The HMO must outline expectations for contracted providers regarding the use of an EVV system within subcontracts and/or provider manuals. The HMO must also

provide assistance and support to both the Department and the Department's contracted EVV vendor for training, outreach, and utilization of the data collection system, as requested. The HMO is required to submit accurate, complete, and timely data. Failure to comply with EVV may result in a corrective action plan and/or the application of remedies for violation, breach, or non-performance of the contract under Article XIV, D.

12. Nursing Home Services

Nursing facility services shall be covered if they meet the requirements of DHS 107.09(2) and 107.09(4)(e). Nursing facility care need not be rehabilitative in order to be covered. Custodial care and care intended to manage assistance with activities of daily living that is medically necessary shall also be covered. If a nursing facility stay results in the disenrollment of a member due to the length of the member's stay in the nursing facility, and Medicaid Fee For Service subsequently finds the nursing facility stay to be medically necessary, the HMO is responsible for payment of the stay up to the point the member's disenrollment is effective.

13. Telehealth Services

The HMO must develop policies and procedures that are consistent with ForwardHealth policies and Wisconsin Statute Wis. Stat. § 49.45(61). The HMO may not impose additional restrictions for telehealth services that are not similarly required for in person services and must offer members like services in physical locations in addition to telehealth services.

F. Mental Health and Substance Abuse Coverage Requirements/Coordination of Services with Community Agencies

The HMO must provide Medicaid covered services. The HMO may provide additional or alternative treatments if the other treatment modalities are more appropriate and result in better outcomes than Medicaid covered services.

1. Mental Health/Substance Abuse Treatment

   a. The HMO must have an adequate network to provide Medicaid-covered mental health and substance abuse treatment, including but not limited to services identified in Wis. Admin. Code s. DHS 107.13(1)-(4), and s.107.22(4).

      The HMO must guarantee all enrolled BadgerCare Plus and/or Medicaid SSI members access to all covered, medically necessary mental health and substance abuse treatment.

2. Mental Health Parity Compliance

The Mental Health Parity Rule, in 42 CFR § 438.910(b)(2), requires the HMO to provide mental health or substance abuse benefits to members in every classification in which medical benefits are provided.

When mental health or substance abuse treatment is deemed medically necessary, the HMO cannot impose any of the following:

a. Any aggregate lifetime or annual dollar limits on mental health or substance abuse benefits;

b. Any financial requirement or treatment limitation to mental health or substance abuse benefits;

c. Any limit on the number of hours of outpatient treatment that the HMO must provide or reimburse; and

d. Any monetary limit or limit on the number of days of inpatient hospital treatment.

The HMO must comply with 42 CFR 438.910(d) when establishing prior authorization requirements for parity in mental health and substance abuse benefits.

Generally, the HMO cannot impose non-quantitative treatment limits (NQTL) for mental health or substance abuse benefits in any classification. The HMO can impose NQTL only when the HMO has processes, strategies evidentiary standards, or other factors used in applying the NQTL to mental health or substance abuse benefits comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical benefits.

The HMO must submit to the Department a parity analysis as part of the HMO certification application process and upon request.

3. Mental Health/Substance Abuse Assessment Requirements

When a member requests or a provider refers a member for mental health or substance abuse treatment services, the HMO must complete an assessment of services. Also, the HMO must complete an assessment for any denials of service or selection of particular treatment modalities.

The HMO's assessment must

a. be conducted by qualified staff in a certified program who are experienced in mental health/substance abuse treatment;

b. include a review of the effectiveness of the treatment for the condition (including best practice, evidence based practice) and the medical necessity of treatment;

c. be based on the American Society of Addiction Medicine as mandated for substance abuse care providers in DHS 75, as well as the Wisconsin Uniform Placement Criteria; and

d. not consider the member's motivation to participate in treatment.

4. SUPPORT Act Compliance (BadgerCare Plus Only)

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, requires behavioral health services be available to Children's Health Insurance Program (CHIP) populations. These services include mental health treatment, substance use disorder treatment, and interventions for developmental delays.

Per section 5022(d) of the Act, the HMO must ensure that providers use age-appropriate, validated screening tools to identify behavioral health needs for individuals ages 0-18 in primary care settings. Validated screening tools for children can be found at https://www.uspreventiveservicestaskforce.org/BrowseRec/Index .

The HMO must ensure that provider screenings are conducted according to the most recently published AAP/Bright Futures periodicity schedule: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf .

On an annual basis, the HMO must report to the Department the specific tools and/or protocols used by their primary care providers when screening children for the following behavioral health areas:

a. General Development;

b. Autism spectrum disorder;

c. Tobacco, alcohol or drug use;

d. Depression;

e. Any additional areas/tools.

This report must be submitted to DHSDMSBBPAdmin@dhs.wisconsin.gov , Attn: Behavioral Health Policy Section in Excel format by July 1st of each calendar year.

5. Assurance of Expertise for Child Abuse, Child Neglect and Domestic Violence

The HMO must cover examination and treatment services with adequate provider expertise for:

a. Members who are victims of child abuse, incest, and/or neglect;

b. Members diagnosed with post-traumatic stress syndrome;

c. Members who are victims of domestic violence; and

d. Members who are perpetrators of child abuse, incest, neglect, and/or domestic violence.

The HMO must also cover court-ordered physical, psychological and mental or developmental examinations and medical and psychiatric treatment for victims and perpetrators of child abuse and neglect.

The HMO must ensure that HMO employees and in-network providers who are required by law to report suspected child abuse and neglect know and understand the laws, identification requirements, and reporting procedures.

6. Court-Related Children's Services (BadgerCare Plus Only)

   a. The HMO must cover assessments provided under the Children's Code, Wis. Stats. s. 48.295, and must reimburse for medically necessary treatment The medical necessity of court-ordered evaluation and treatment is assumed to be established.

   b. b. The HMO may provide treatment through its network.

   c. c. The HMO cannot withhold or limit services unless or until the court has agreed to the withholding or limit.

7. Court-Related Substance Abuse Services

   a. The HMO must cover medically necessary substance abuse treatment ordered in the member's Driver Safety Plan, pursuant to Wis. Stats., Ch. 343, and Wis. Adm. Code Ch. DHS 62. The HMO must assume that the medical necessity of services specified in this plan is established, and the HMO must provide those services.

   b. The HMO is not liable for coverage of substance abuse educational programs, and/or the initial assessment used to develop the Driver Safety Plan.

   c. The HMO must respond within five days from receipt of the referral or request when a provider sends a written referral or request for treatment authorization. The referral or authorization is retroactive to the date of the request. After the fifth day, the provider may assume that the service is authorized until the HMO responds in writing.

      The HMO may apply the mental health and substance abuse coverage limitations specified in the ForwardHealth Provider Updates.

8. Emergency Detention and Court-Ordered Services

   a. Emergency Detention

      The HMO must cover all court-ordered services during an emergency detention, including services provided by out-of-network providers.

      i. Care is assumed medically necessary, and the HMO must cover care provided prior to the Emergency Detention probable cause hearing.

   b. Court-Ordered Services

      The HMO must cover all court-related mental health/substance abuse treatment, including stipulated and involuntary commitment provided by out-of-network providers. The extent of the HMO's liability for

appropriate emergency treatment is the current FFS rate for such treatment.

i. The HMO may provide an alternative treatment plan for the county to submit at the probable cause hearing. The HMO must submit the name of an in-network facility willing to treat the member if the court rejects the alternative treatment plan and orders the member to receive an inpatient evaluation.

c. The HMO must cover court ordered evaluations and/or treatment when the member is defending themself against a mental illness or substance abuse commitment when one or more of the following circumstances exists:

i. services are provided in an in-network facility; or

ii. The HMO approves provision in a out-of-network facility; or

iii. The HMO was given the opportunity but failed to provide the county with the name of an in-network facility and, as a result, the member is sent for court-ordered evaluation to an out-of-network provider; or

iv. The HMO gives the county the name of an in-network facility and the facility refuses to accept the member.

9. Court-Ordered Institutionalized Individuals

a. Court-Ordered Institutionalized Children

The HMO must cover inpatient and institutional services provided to children enrolled under this Contract for the entire period for which capitation is paid, including when the child's medical status code changes, or if the child's relationship to the original BadgerCare Plus case changes.

b. Court-Ordered Institutionalized Adults

The HMO is not liable for any service to a person 22 to 64 years of age who is a resident of an institution for mental disease (IMD), except for services to an individual on convalescent leave from an IMD that are reimbursed by FFS. If a person 22 to 64 years of age requires hospitalization for mental health or substance abuse issues, the HMO must coordinate coverage with a hospital.

An HMO may provide inpatient services in an IMD for a person 22 to 64 years of age for no more than 15 days during the period of monthly capitation payment in lieu of traditional psychiatric intervention services.

10. Transportation Following Emergency Detention

The HMO must cover medical transportation to an in-network provider when the member is under emergency detention or commitment and when the HMO requires the member to be moved to a participating provider, provided the transfer can be made safely. The HMO is not responsible for the transfer of a member

when it is determined by a county agency or law enforcement that a secure transfer is required and conducted by local law enforcement officials.

11. Coordination of Services with Community Agencies

    a. The HMO must assign a representative to coordinate services with public health agencies or treatment programs within the HMO's service area including out-of-network providers.

    b. The HMO must work with the agency to coordinate a member's transition to or from covered mental health and substance abuse care within the HMO's network.

    c. Any member transitioning from crisis intervention services must be able to access an appropriate level of ongoing care within 30 days of the crisis.

    The HMO is not required to pay for ongoing services outside the HMO network, unless the HMO has authorized those services.

12. Memoranda of Understanding (MOU) with Community Agencies

    Per Article III.A. the HMO must coordinate services received through Medicaid Fee-for-Services or through community and social support providers. The HMO is encouraged to develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services to members.

    The HMO must negotiate either an MOU or a contract with the counties in its service area. The MOU(s) or written documentation of a good faith attempt must be available during the certification process and when requested by the Department.

    MOUs must be signed every two years as part of certification. If no changes have occurred, then both the county and the HMO must document that no changes have occurred. HMOs must conduct outreach to agencies that do not have a MOU with the HMO, at a minimum, every two years. The HMO must submit evidence that it attempted to obtain a MOU in good faith.

13. Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services

    a. Services

       This benefit will be limited to members who require behavioral health: short term residential (non-hospital residential treatment program) per diem (over midnight census).

       Providers must use code H0018 under the CBRF provider ID.

       Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization.

An HMO's licensed clinical staff or contracted network provider must use tests listed in item b. to guide their professional judgment and determine whether the ILOS is medically appropriate for the specific member.

This benefit will be reimbursed at $450 per diem.

Included in this per diem cost are services such as:

i. Comprehensive interdisciplinary biopsychosocial mental health assessment;

ii. Crisis assessment, intervention and stabilization;

iii. Psychiatrist and Advanced Practice Nurse Prescriber to include medication assessment, review, consultation and prescribing;

iv. Psychosocial group education;

v. Individual counseling;

vi. Peer support;

vii. Family consultation, as needed;

viii. Individualized community linkage to ongoing services and supports within the community.

Post-discharge services will be provided on an individual outpatient basis in cooperation and consent with the members' HMO. These outpatient mental health services will be included as part of the HMO capitation.

b. Provider Qualifications

i. The provider must be a licensed Community Based Residential Facility (CBRF).

ii. The provider must be experienced with at least 5 years as a community based provider of non-institutional sub-acute psychiatric services.

iii. The provider must be DQA certified as an Outpatient Mental Health clinic is required.

iv. The staffing plan must include the following positions:

a) Director

b) Clinic Coordinator

c) Community Recovery Specialist

d) Peer Recovery Specialist

e) Mental Health Professional

f) Registered Nurse

g) Advanced Practice Nurse Prescriber

h) Medical Director

i) Other professional and/or para-professional staff as required to meet the needs of the members.

14. Narcotic Treatment Services

The HMO must provide access to narcotic treatment services (NTS) or medication-assisted treatment (MAT) for opioid dependence vial eligible facilities and/or providers within a reasonable distance from the member's residence. The HMO must regularly monitor its NTS and MAT provider networks to ensure that members have access to these services.

Narcotic treatment services include

a. member assessment,

b. screening for drugs of abuse,

c. screening for certain infectious diseases,

d. prescription and administration of narcotic medication, and

e. substance abuse counseling.

The ForwardHealth Online Handbook section for 'Narcotic Treatment' outlines policy for services provided by narcotic treatment programs certified under Wis. Adm. Code § DHS 75.59. For members who require narcotic treatment, HMOs must ensure access to providers authorized to prescribe opioid dependency agents. Authorized providers include Wis. Adm. Code § DHS 75.59 facilities or physicians who have obtained a Drug Addiction Treatment Act (DATA) 2000 waiver allowing them to prescribe buprenorphine-based agents. The requirement to provide narcotic treatment services does not include coverage of opioid dependency agents themselves, which are covered by fee-for-service.

G. HealthCheck

1. HMO Responsibilities

a. Arrange and reimburse for comprehensive HealthCheck screening, referral, and treatment for children or adults under age 21 years.

i. Periodicity and Access to HealthCheck Services

a) For members less than 1 year old, the provider must provide a HealthCheck screening within 30 days of when a screen is due according to the American Academy of Pediatrics periodicity schedule or when requested by a parent, guardian, or member (if over age 18).

b) For members ages 1-21 years, the provider must provide a HealthCheck screening within 60 days of when a screen is due according to the American Academy of Pediatrics

periodicity schedule or when requested by a parent, guardian, or member (if over age 18).

ii. Recommended HealthCheck Screening Activities to be completed with member, parent, or guardian consent

a) A complete health and developmental history

b) A comprehensive unclothed physical examination

c) Age-appropriate vision testing

d) Age-appropriate hearing testing

e) Age-appropriate laboratory tests

f) An oral assessment plus referral to a dentist beginning at one year of age

g) Appropriate immunizations according to age and health history per the Center for Disease Control and Prevention guidelines

h) Blood lead level testing at ages 12 and 24 months or if the member is under age 6 with no record of prior test

iii. HealthCheck screening services may be provided by a qualified HMO network provider, Community Based Health Organization or Local Health Department, if enrolled with WI Medicaid as a HealthCheck screener.

iv. Providers must provide treatment referrals that result from the HealthCheck physical exam when findings indicate the need for further evaluation, diagnosis, and treatment. All appointments for further diagnosis or treatment as a result of the screening should be scheduled within 60 days of the date of the HealthCheck screening. All BadgerCare plus and Medicaid services on a HealthCheck referral should be provided within six months of the screening date.

b. Arrange and reimburse for other necessary health care services, as medically-necessary, even if those services are not otherwise covered or, exceed coverage limitations (i.e., HealthCheck "Other Services"). The HMO is responsible for all HealthCheck "Other Services." Refer to Topic #2391 In the ForwardHealth Online Handbook for examples of HealthCheck "Other Services."

H. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Members

The OB Medical Home (OB MH) is a care delivery model for high-risk pregnant members that is patient-centered, comprehensive, team-based, coordinated, accessible

and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha.

Member eligibility criteria, enrollment information, and other additional information about the OB MH Initiative are available in the ForwardHealth Portal:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Managed_Care_Medical_Homes/Home.htm.spage

1. OB MH Payment Criteria

   a. The Department will issue a payment of $2,000 to the HMO when an eligible and enrolled OB MH member has a positive birth outcome and no maternal mortality. Please visit the ForwardHealth Portal for information on eligibility, enrollment, birth outcomes, and maternal mortality.

   b. The Department's External Quality Review Organization (EQRO) conducts medical record reviews that are used for the following:

      i. To verify enrolled members meet the defined contract requirements;

      ii. To collect data to support potential future program refinements; and

      iii. To collect data to support program evaluation.

   c. The Department issues payments to the HMO, and the HMO subsequently issues the enhanced payment to the OB MH.

2. HMO Requirements

   a. Timely Document Submission

      The HMO must ensure that all required documentation from OB MHs is submitted to the Department's EQRO in a timely manner.

      i. The Department does not provide additional reimbursement to HMOs or OB MHs for submission of medical records for the EQR.

   b. HMO representative:

      i. The HMO must designate a staff person to oversee the execution of the OB MH Initiative.

      ii. The HMO designee must represent the HMO regarding OB MH inquiries and must be available during normal business hours.

      iii. The HMO representative must ensure that the OB MH is implemented in accordance with the contract.

   c. HMO Outreach and Member Engagement:

      The HMO must actively seek to identify and engage eligible members for participation in the OB MH Initiative. This engagement must include a

variety of strategies, e.g., working with existing organizations having similar goals, increasing public awareness about the OB MH Initiative and its services, screening new members for eligibility, reviewing the BORN report periodically and working with colleagues to develop and implement creative strategies such as health fairs or street teams.

d. The HMO must offer the OB MH Initiative only to single clinics or networks of clinics that are accountable for the total care of the members.

e. The HMO must submit information about its OB MH Initiative upon request of the Department.

f. The HMO must work with clinic sites to identify and/or develop and participate in at least one collaborative learning opportunity per year. Such opportunities must address identify needs of clinics serving as OB MH and the members the OB MHs serve.

I. Immunization Program

As a condition of certification as a BadgerCare Plus and/or Medicaid SSI provider, the HMO must share member immunization status with the local health departments and other non-profit HealthCheck providers upon their request without the necessity of member authorization. The Department also requires that the local health departments and other non-profit HealthCheck providers share the same information with the HMO upon request. This provision ensures proper coordination of immunization services and prevents duplication of services.

The HMO must have a signed user agreement with the Wisconsin Immunization Registry (WIR) or must be able to demonstrate that its major providers have signed WIR user agreements.

J. Abortions, Hysterectomies and Sterilizations

The HMO shall comply with the following state and federal compliance requirements for the services listed below:

1. Abortions must comply with the requirements of Wis. Stats., s. 20.927, Wis. Stats., s. 253.107 and with 42 CFR Part 441, Subpart E-Abortions.

2. Hysterectomies and sterilizations must comply with 42 CFR Part 441, Subpart F—Sterilizations.

Financial penalties in the amount of $10,000.00 may be imposed for non-compliance with the above compliance requirements.

The HMO must abide by Wis. Stats., s. 609.30.

K. Health Homes

1. Health Home Providers

Health home providers coordinate care across all settings, including medical, behavioral, dental, pharmaceutical, institutional and community care settings.

Covered health home activities include:

a. Comprehensive care management

b. Care coordination

c. Health promotion

d. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

e. Patient and family support, including authorized representatives

f. Referral to community and social support services

When arranging for direct care services for the member, the health home provider must follow the HMO's requirements regarding prior authorization for HMO-covered services, referrals to in-network providers, and claim submission.

2. HIV/AIDS Health Home

HMOs are required to establish contracts with HIV/AIDS health home providers and reimburse for HIV/AIDS health home allowable activities. Vivent Health is the only organization that currently meets s. 252.12(2)(a)8, Wis. Stats., for reimbursement as a ForwardHealth HIV/AIDS health home provider.

Member participation in the health home is voluntary. Members must have a diagnosis of HIV and at least one other chronic condition, or be at risk of developing another chronic condition to participate. The risk factors include diabetes, hypertension and high cholesterol, among others. The ForwardHealth online handbook includes detailed policies related to member eligibility for health home services. (ForwardHealth Online Handbook Topic #14237.)

The HMOs contract with the health home provider should:

a. Establish coverage policy for health home services.

b. Clearly delineate the respective roles of the HMO and health home to avoid duplication of care coordination activities.

c. Include engagement activities of the HMO to support member access of needed health care identified by the health home.

d. Identify level of data sharing necessary to ensure the goals of the health home services are accomplished as established by ForwardHealth Handbook Topic #14197.

3. SUD Health Home Pilot Program

Members diagnosed with or identified as being at risk of having Substance Use Disorder (SUD) or who have been identified as being at risk of developing

conditions frequently associated with SUD, may be referred with the member's consent for specialized Hub and Spoke services.

HMOs are encouraged to enter into MOUs with the Department contracted hub and spoke pilot sites in the HMO service area to coordinate services. Hub and spoke pilot sites are reimbursed by the Department for providing six core SUD Health Home services, as detailed in ForwardHealth Update 2022-37 https://www.forwardhealth.wi.gov/kw/pdf/2022-37.pdf .

When serving co-enrolled members, HMOs must work with the health home providers to develop Memorandums of Understanding (MOUs) that:

a. Clearly delineate the respective roles of the HMO and health home to avoid duplication of care coordination activities;

b. Identify engagement activities of the HMO to support member access of needed health care identified by the health home; and

c. Identify level of data sharing necessary to ensure the goals of the health home services are accomplished.

Department approved pilot sites and the geographic service areas where they provide the benefit are available on the Department website for the program: https://www.dhs.wisconsin.gov/aoda/hubandspoke-sud-hh.htm .

HMOs are encouraged to monitor this link for a current list of participating Hub Sites. Pilot Hub sites will determine eligibility and enroll members at the Hub Site for SUD Health Home services. Members must have a diagnosis of SUD and at least one other chronic condition or be at risk of developing another chronic condition to participate. The risk factors include but are not limited to: mood disorder, anxiety disorders, diabetes, heart disease, COPD, hypertension, asthma, HIV/AIDS, hepatitis A, B, and C, liver/kidney disease, PTSD, psychotic disorders, Traumatic Brain Injury and cognitive disorders, ADHD, and chronic pain.

L. HMO Moral or Religious Objection

The HMO is not required to provide counseling or referral service if the HMO objects to the service on moral or religious grounds. If the HMO elects not to provide, reimburse for, or provide coverage of, counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

1. To the Department and Enrollment Specialist so the Department can notify members of the HMO's non-coverage of service;
2. With the HMO's certification application for a BadgerCare Plus and/or Medicaid SSI contract;
3. Whenever the HMO adopts the policy during the term of the contract;
4. It must be consistent with the provisions of 42 CFR 438.10;

5. It must be provided to potential members before and during enrollment;

6. It must be provided to members within ninety (90) days after adopting the policy with respect to any particular service; and

7. In written and prominent manner, the HMO shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI but which are not available through the HMO because of an objection on moral or religious grounds. The HMO must inform members about how to access those services through the State.

M. Routine Services Associated with Qualifying Clinical Trials

1. The HMO must authorize and cover all routine patient costs associated with participation in qualifying clinical trials as described in ForwardHealth Topic # 23037.

   a. Authorization of routine services associated with qualifying clinical trials must:

      i. Be expedited and completed by the HMO within 72 hours, and;

      ii. Be determined without regard to geographic location or network affiliation of the healthcare provider or principal investigator of the qualifying clinical trial, including out-of-state providers or out-of-network providers.

   b. Service authorization must be based on an attestation of the appropriateness of the qualifying clinical trial by the health care provider and principal investigator using the Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial.

   c. Service authorization determinations must not require submission of the protocols of the qualifying clinical trial or any other documentation that may be proprietary or burdensome.

V. Provider Network and Access Requirements

The HMO must demonstrate covered services within the provider network are available and accessible to members per 42 CFR § 438.206, 438.68, and 438.14 and has the capacity to serve expected enrollment in its service area per 42 CFR § 438.207.

The HMO must establish provider network access, availability, and capacity expectations within provider's contracts, to include standards, protocols, methods of monitoring, reporting, and remediation.

A. Availability and Accessibility

The HMO must establish mechanisms to ensure compliance by network providers; regularly monitor to determine compliance; take corrective action if there is a failure to comply by a network provider; and make readily available to the department upon request records of such actions.

1. Provider Network

   The HMO must:

   a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.

   b. Provide female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

   c. Provide for a second opinion from a network provider or arranges for the member to obtain one outside the network, at no cost to the member.

   d. Provide necessary services, covered under the contract, to a particular enrollee, the HMO must adequately and timely cover these services out of network for the member, for as long as the HMO's provider network is unable to provide them.

   e. Coordinate with out-of-network providers for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network.

   f. Reimburse for emergency services provided out-of-network at a cost to the member no greater than if the services were provided in-network.

   g. Demonstrates network providers are credentialed as required by 42 CFR § 438.214.

2. Furnishing of Services and Timely Access

The HMO must:

a. Require network providers meet standards for timely access to care and services, considering the urgency of the need for services.

b. Ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid FFS. The HMO must ensure appointment and facility wait time standards do not discriminate against members.

c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

d. Provide medically necessary high risk prenatal care within two weeks of the member's request for an appointment, or within three weeks if the request is for a specific HMO provider, who is accepting new patients.

3. Access and Cultural Considerations

The HMO must:

a. Participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex or gender identity.

b. Have written protocols ensuring access to children's Healthcheck and adult members access to screening, diagnosis and referral services.

c. Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

B. Network Capacity

The HMO must demonstrate sufficient capacity to serve members in service areas and must make documentation readily available, demonstrating it complies with the following:

1. Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members for the service area.

2. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

3. The HMO notifies the Department and submits documentation regarding network providers when:

a. The HMO enters into the initial contract with the Department,

b. annually, or

c. a significant change in benefit programs, geographic service area, member enrollment, new member population, or composition of or payments to the provider network occur.

4. The HMO must, at a minimum, sustain a network that meets standards specified in HMO Provider Network Adequacy Standards Table-1. This does not preclude the HMO's requirements to demonstrate sufficient capacity among covered network services.

5. HMOs may request an exception to provider-specified network standards in HMO Provider Network Adequacy Standards Table 1 based, at a minimum, on the number of participating provider specialties in the specified service area.

6. DHS expects the HMO submit member communications and transition plan 120 days before the intended geographic service area reduction.

C. Indians, Indian Health Care Providers (IHCP), and Indian Managed Care Entities (ICME)

1. The HMO must demonstrate sufficient IHCPs participate in the network to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services as specified in 42 CFR § 457.1209 and 438.14. This section pertains to Indians, IHCP, and IMCE definitions defined in 438.14(a).

2. The HMO must pay IHCPs for covered services provided to Indian members who are eligible to receive services. The HMO shall pay all providers, including non-network providers, as follows:

   a. At a rate negotiated between the HMO and the IHCP, or

   b. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the HMO would make for the services to a network provider which is not an IHCP; and

   c. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR § 447.45 and 447.46.

3. The HMO must permit any Indian member who is enrolled in the HMO that is not an IMCE and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as their primary care provider, if that provider has capacity to provide the services.

4. The HMO must permit Indian members to obtain covered services from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.

5. Where timely access to covered services cannot be ensured due to few or no IHCPs, the HMO will be considered to have met the requirement in Article V.C.1. of this section if the HMO permits Indian members to access out-of-State IHCPs.

6. The HMO must permit an out-of-network IHCP to refer an Indian member to a network provider.

7. An IMCE may restrict enrollment to Indians in the same manner as Indian Health Programs, as defined in 25 U.S.C. 1603(12), may restrict the delivery of services to Indians, without being in violation of the requirements in § 438.3(d).

D. Provider Network Adequacy Certification

The Department will conduct an annual network adequacy analysis confirming the HMO's network adequately supports members' access, availability, and capacity standards specified in HMO Provider Network Adequacy Standards Table-1. The Department will also consider additional metrics or data sources to determine network adequacy, including member grievances and appeals, out-of-network reports, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys as specified in the HMO Quality Guide, and the Department's external quality review organization. The network adequacy analysis will result in either an approval, conditional, or exception status by service area.

1. Approval Status

   The Department grants Approval Status when the HMO service area is within HMO Provider Network Adequacy Standards.

2. Conditional Status

   The Department grants Conditional Status when the Department determines that the HMO's Provider Network Adequacy has deficiencies, but that the deficiencies are such that the HMO may continue providing services in a service area but must remediate the specific deficiencies. The HMO must provide the Department member impact assessments and goeaccess reports. The Department may pursue action against an HMO in affected services areas under Conditional Status as provided under Article XIV.D. Continued network inadequacies may lead to contract termination in the affected service area.

3. Exception Status

   The Department may grant Exception Status during the Annual Compliance Review and upon expansion requests where limited services providers preclude the HMO from meeting Network Adequacy Standards. The Department will use the following conditions to determine Exception Status or take alternative contract enforcement action:

   a. Reason for limited services providers is outside the control of either or both the Department and HMO.

   b. The HMO provides documentation and justification for adequate network despite deficiencies.

   c. The HMO monitors and provides periodic member access impact assessments.

E. Healthcare Provider Network Files

1. The HMO must submit complete and accurate Healthcare Provider Network and Healthcare Facility Network files by the last business day of the month, upon significant changes, or upon the Department's request through the State SFTP. A significant network change prompting a file submission would include, but not limited to, inadequate provider type capacity and services, modification to HMO benefits, service area, provider network, and member enrollment. Format
    a. The file must be submitted in the designated format specified in the ForwardHealth HMO Provider Network Universe and meet minimum threshold standards to be accepted.
    b. Each line item must includethe providers' taxonomy.
    c. The file must include only Medicaid-enrolled providers who are contracted with the HMO to provide contract services to BadgerCare Plus and Medicaid SSI members.
2. The Department may conduct audits of provider and facility data for completeness and accuracy during the contract period. Incomplete or inaccurate provider and/or facility data may subject the HMO to administrative sanctions outlined in Article XIV.D.

F. HMO Network Reviews

The HMO must provide assurances to the Department demonstrating the HMO's capacity to serve expected enrollment in its service area per 42 CFR § 438.207 and Department standards for access to care published on ForwardHealth. The Department's network review is based on the provider network files, and MMIS enrollee data to determine the metrics in Table 1 of HMO Provider Network Adequacy Standards.

G. Telehealth Services

HMOs must develop policies and procedures for internal monitoring and telehealth utilization. HMOs will submit these policies and any applicable monitoring information to the Department as requested. Monitoring information may consist of the number of visits per county.

Since distance, time, and ratio standards are dependent on fixed locations, telehealth utilization will be considered in the event a network adequacy standard is not met.

VI. Marketing and Member Materials

HMOs are required to implement and enforce the requirements regarding communication and marketing processes, including Title 42 Code of Federal Regulations§ 438.10 and 42 CFR § 438.104.

The Department encourages HMOs to perform outreach to newly enrolled members, to provide health education, and information to members and to participate in community events.

A. Materials for Members and Potential Members

1. HMO Communication Requirements

   a. The HMO may electronically provide member information required in 42 CFR § 438.10 only when all of the following are met:

      i. The format is readily accessible;

      ii. The information is placed in a location on the HMO, website that is prominent and readily accessible;

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

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

      v. The member is informed that the information is available in paper form without charge upon request and the HMO provides it upon request within five (5) business days.

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

   c. The HMO must include the following information on its website:

      i. service area; and

      ii. 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.

   d. The HMO may provide information about enrollment, including renewals, to BadgerCare Plus/SSI programs. The HMO must direct potential members to:

      i. Apply online at the ACCESS website: www.access.wisconsin.gov

      ii. Complete the online form at www.dhs.wisconsin.gov/forms/F1/F10182.pdf

iii. Call or go to their county IM agency or tribal agency to complete an application. For a map of the IM agencies by county, visit www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

iv. For Medicaid SSI information, https://www.dhs.wisconsin.gov/ddb/apply.htm

v. For Social Security Administration Resources, https://www.ssa.gov/disabilityssi/ and https://www.ssa.gov/ssi/text-apply-ussi.htm

e. The HMO must

i. Designate a staff person to be responsible for the administration of language access services and auxiliary aids and services.

ii. Obtain prior approval to use social media (e.g., Facebook, Twitter, etc.). The HMO must provide the name of the page, a link, and/or account information that the HMO intends to use. HMOs are responsible for ensuring that no laws are violated (e.g., the Health Insurance Portability and Accountability Act, or HIPAA).

2. Language and Format Requirements

a. The HMO must designate a staff person to be responsible for the administration of language access services and auxiliary aids and services.

b. The HMO must document all requests and results for any language access services provided to members and make the requests and results available to the Department upon request.

c. Oral Interpretations Services

i. The HMO must make oral interpretation in any language available to members and potential members free to charge.

ii. The HMO must maintain a current list of "On Call" interpreters who can provide interpreter services. Provision of interpreter services must comply with Title VI of the Civil Rights Act.

d. Written Translation Services

i. The HMO must make written translation available in each prevalent language identified in the following chart. The Department will translate the Standard Member Handbook language into the prevalent languages for each rate region.

Rate Region	HMO Prevalent Non-English Languages*			
1	Spanish	Hmong	Burmese	Mandarin Chinese
2	Spanish	Hmong	Somali	
3	Spanish	Hmong	Lao	
4	Spanish	Hmong	Arabic	Mandarin Chinese
5	Spanish	Mandarin Chinese	Vietnamese	Russian
6	Spanish	Hmong	Mandarin Chinese	Burmese

* Prevalent Language data calculated for CY 2024

e. Auxiliary Aids and Services

i. The HMO must make auxiliary aids, such as TTY/TDY and American Sign Language (ASL) available to members and potential members free of charge.

f. Written Materials

i. Written materials that are critical to obtaining services, including at minimum provider directories, member handbooks, appeal and grievance notices, and denial and termination notices must:

a) Be available in the prevalent non-English languages for the HMO's Rate Region,

b) Be made available in alternative formats and through the provision of auxiliary aids and services upon request of the member or potential member at no cost,

c) Include conspicuously visible taglines in the prevalent non-English languages in the State, explaining the availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and

d) Include the toll-free telephone number of the entity providing choice counseling services.

ii. All written materials must:

a) be in easily understood language and format,

b) use a font size no smaller than 12 point,

c) 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.

d) be at a sixth-grade reading level.

g. Taglines

Suggested conspicuously visible taglines translated in the prevalent non-English languages identified across all HMO Rate Regions are provided in a fillable Word Document and PDF and are available for download at:

i. https://www.dhs.wisconsin.gov/publications/p02057.docx

ii. https://www.dhs.wisconsin.gov/publications/p02057.pdf

h. Notification to Members

The HMO must notify members and potential members:

i. That oral interpretation is available for any language and written translation is available in prevalent non-English languages;

ii. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and

iii. How to access oral interpretation and auxiliary aids and services.

3. Standard Member Handbook

a. The HMO must use the state-developed Standard Member Handbook.

i. The HMO may draft member handbook language that is simpler than the standard language and must submit the language to the Department for approval.

ii. When the HMO drafts member handbook language simpler than the standard language, the HMO must independently arrange for the translation of any non-standard language.

iii. The HMO must submit any exceptions to the standard language to the Department for approval. The Department will only approve such exceptions for exceptional reasons.

iv. If the standard member handbook language changes during the course of the Contract period due to changes in federal or state laws, rules or regulations, the HMO must insert the new language into the member handbooks as of the effective date of any such change and notify members of the changes.

b. The HMO must submit its member handbook to the Department for review and approval no more than 60 days after the effective date of the Contract.

c. Timeframe to Distribute to Members

i. Within 10 days of final enrollment notification to the HMO, the HMO must distribute the member handbook to new members. See "handbook distribution" below for more information about distributing the handbook to members.

ii. The HMO 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.

a) The HMO must submit all changes to the Department prior to the changes going into effect.

d. Handbook Content

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:

i. Services covered by the HMO

ii. How and where to access any benefits provided by the state (pharmacy, non-Emergency Medical Transportation, dental (when relevant to the HMO Rate Region), chiropractic (when relevant to HMO), and cost sharing)

a) In the case of counseling or referral services the HMO does not cover due to moral or religious objections, the HMO must inform the member that the service is not covered by the HMO.

b) The HMO must inform all members how they can obtain information from the state about how to access the services.

iii. Procedures for obtaining benefits, including all the following information

a) The amount, duration and scope of benefits available in sufficient detail to ensure the member understands the benefits they are entitled to.

b) The extent to which, and how, the member may obtain benefits, including family planning services and supplies from an out-of-network provider, including an explanation that the HMO cannot require a member to obtain a referral before choosing a family planning provider.

c) The extent to which, and how, after-hours and emergency coverages are provided, including:

1) What constitutes an emergency medical condition and emergency services

2) The member has a right to use any hospital or other setting for emergency care

3) Prior authorization is not required for emergency services

4) Any prior authorization or referral requirements for specialists and for any benefit not provided by the member's primary care provider

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

6) The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers, including an explanation that the HMO cannot require a member to obtain a referral before choosing a family planning provider.

d) Any restrictions on the member's freedom of choice of network provider

e) Any copays that are required by the state.

f) Members rights and responsibilities

g) How to select and change primary care providers.

h) The Department developed or approved grievance, appeals, and fair hearings procedures and timeframes, including the following information:

1) Right to file grievances and appeals

2) Requirements and timeframes for filing a grievance or appeal

3) Availability of assistance in the filing process

4) Right to request a state fair hearing after the HMO has made an adverse determination on the member's appeal

5) When requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, and that the enrollee may,

consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

i) How to exercise an advanced directive

j) How to access auxiliary aids and services, including additional information in alternative formats and languages.

k) The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.

l) How to report suspected fraud or abuse.

m) How to access the provider directory

n) Information about the HMO, including all of the following

1) The HMO's mailing address(es)

2) The HMO's physical location(s)

3) The HMO's hour of operation

o) HealthCheck

p) Languages spoken by the provider

q) SSI comprehensive assessments for only Medicaid SSI members

r) Medicaid terminology definitions

e. Handbook Distribution

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

i. Mailing a printed copy to the member's mailing address,

ii. Emailing to the member a copy of the member handbook after obtaining the member's agreement to receive the information by email,

iii. Posting the member handbook to the HMO's website and either mailing or e-mailing the member notice after obtaining the member's agreement to receive the information by e-mail that the handbook is available on the Internet and what the Internet address for the member handbook is, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost, or

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

v. The HMO must post its current member handbook on its website following the requirements of 42 CFR § 438.10(g) and (h).

f. Member Notification about Member Handbook

i. Annually, the HMO must notify all members that the member handbook is available on the HMO's website and that the member may request that the HMO mail the member a hard copy using one or more of the following methods:

a) Mailing a printed notice to the member's mailing address,

b) Emailing to the member a notice after obtaining the member's agreement to receive the information by email,

c) Posting notice to the HMO's website and either mailing a notice or emailing to the member a notice after obtaining the member's agreement to receive the information by email that the handbook is available on the Internet and what the Internet address for the member handbook is, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost, or

d) Providing the member a notice by any other method that can reasonably be expected to result in the member receiving the handbook.

4. Provider Directory

a. Provider Directory Distribution

i. The HMO must make available on its website a provider directory for members, network providers, and the Department to access;

ii. The HMO must make the provide directory available in paper form upon request and in searchable electronic form at no cost to the member;

iii. The HMO must update pits paper provider directory at least

a) monthly, if the HMO does not have a mobile-enabled electronic directory, or

b) quarterly, if the HMO has a mobile-enabled, electronic provider directory.

iv. HMO's must have a machine-readable file and format available on the HMO's website.

b. Member Notification about Provider Directory

i. Annually, the HMO must notify all members that the provider directory is available on the HMO's website and that the member may request that the HMO mail the member a hard copy using one or more of the following methods:

a) Mailing a printed notice to the member's mailing address,

b) Emailing to the member a notice after obtaining the member's agreement to receive the information by email,

c) Posting notice to the HMO's website and either mailing a notice or emailing to the member a notice after obtaining the member's agreement to receive the information by email that the handbook is available on the Internet and what the Internet address for the member handbook is, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost, or

d) Providing the member a notice by any other method that can reasonably be expected to result in the member receiving the handbook.

c. Provider Directory Contents

i. HMOs are required to list the following information about network providers:

a) Provider's name;

b) Provider's Street address(es);

c) Provider's phone number(s);

d) Provider's gender;

e) Provider's race and ethnicity (if available and provider does not opt out of publication);

f) Provider's website (if available);

g) Provider's Specialty;

h) Whether the provider is accepting new patients;

i) Provider's cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office;

j) Provider completed cultural competence training;

k) Whether the provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment;

l) Provider's hospital affiliation;

m) Provider's medical group affiliation;

n) Provider's board certification.

o) Whether the provider offers covered services via telehealth.

ii. The HMO must include the following information on provider type in the directory:

a) Physicians, including specialists

b) Hospitals

c) Pharmacies

d) Behavioral health providers

e) Long term services and supports providers, as appropriate

5. HMOs must notify members of transition of care requirements as defined in 42 CFR § 438.62 and Article VII.G.8 of the contract.

B. Marketing Materials

HMOs must comply with 42 CFR § 438.104 including the requirements in Article VI. B.

Marketing materials are defined in Article I.

1. Federal Requirements

HMOs must:

a. Not distribute any marketing materials without first obtaining Department approval;

b. Distribute the materials to its entire service area;

c. Comply with the information requirements of 42 CFR § 438.10 to ensure that, before enrolling, the beneficiary receives, from the HMO or the State, the accurate oral and written information the member needs to make an informed decision on whether to enroll;

d. Not seek to influence enrollment in conjunction with the sale or offering of any private insurance;

e. Not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

f. Specify the methods by which the HMO assures the Department that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the Department. Statements that

will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that:

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

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

2. State Requirements:

a. Allowed Marketing Practices

i. HMOs 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.

ii. Eligible HMO marketing activities include member and non-member written communications, websites, and other marketing media. Quality in HMO marketing activities is limited to health, service delivery, or member experience topics only.

iii. HMOs may only reference their own quality results, rankings, metrics, etc. in their marketing materials.

iv. HMOs 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.

v. The HMO must submit quality data and/or supporting quality documentation with the marketing materials to validate the HMO quality claims. It is the responsibility of the HMO 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.

vi. HMOs 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 HMO quality claims.

vii. HMOs 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.

viii. For television and radio advertisements, HMOs must provide the Department 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 HMO can identify the block of advertising time.

b. Prohibited Marketing Activities

i. HMOs are prohibited from marketing to recipients of BadgerCare Plus or Medicaid SSI members who are not the HMO's members.

ii. HMOs are prohibited from

a) Offer of material or financial gain to potential members as an inducement to enroll. This includes telling potential members about money they could receive from incentive and reward programs.

b) Materials which contain the assertion that the client must enroll in the HMO in order to obtain benefits or avoid losing benefits.

c) Practices that discriminate against an individual or class of individuals on the basis of any classification protected under federal or state law.

d) Activities that could mislead, confuse, or defraud members or potential members or otherwise misrepresent the HMO, its marketing representatives, the Department, or CMS.

e) Materials that contain false information.

f) Practices that are reasonably expected to have the effect of denying or discouraging enrollment.

g) 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.

h) Use paid advertising, including mass media, that does not primarily focus on providing public health messages or improving health literacy.

i) Participate in any activity that interferes with a potential member's ability to seek out enrollment or plan information on their own terms; this includes marketing through unsolicited contacts.

j) Solicit to potential members to enroll with a specific HMO. Potential members must seek out plan information.

k) Portray competing HMO in a negative manner or encourage members to disenroll from competing HMOs.

c. Policies Related to Medicaid Managed Care Program Providers

i. HMOs are required to inform all providers in their network of the policies contained within this Section.

ii. Providers may educate and inform their patients about the HMO with which they contract.

iii. Providers may inform their patients of the benefits, services, and specialty care services offered through the HMO in which they participate.

iv. Providers may give a member contact information for a particular HMO, but only at the member's request.

v. Providers may to assist potentially eligible individuals with enrollment in the Medicaid managed care program by helping them:

a) Apply online at the Access website: www.access.wisconsin.gov;

b) Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf; or

c) 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

vi. Providers may 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.

vii. Providers may refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at 1-800-291-2002.

viii. HMOs may conduct orientations, health fairs, or community baby showers for their members in a private setting at a provider's office.

ix. 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. Incentives for the purposes of marketing and member materials are any form of financial compensation,

including material items, travel or transportation reimbursement, child care services, etc., offered to members or potential members.

d. Other Medicaid and Medicare Programs

i. HMOs may provide general information on Family Care, PACE, Family Care Partnership, or IRIS to Medicaid managed care members. HMOs must refer individuals to the ADRC for options and enrollment counseling.

ii. HMOs are prohibited from marketing other lines of Wisconsin Medicaid programs to current Medicaid members to entice enrollment with the HMO.

e. Qualified Health Plans and Medicaid HMOs

i. HMOs may inform their current 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.

ii. HMOs may participate in community-wide outreach and marketing activities surrounding Marketplace participation.

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

iv. 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

C. Department Review and Approval of Communication and Marketing Materials

1. Approval Process

a. HMOs must submit all communication originating from the HMO or their providers relating to BadgerCare Plus and Medicaid SSI to the Department for approval prior to publication or display.

b. HMOs that identify as a QHP and a BadgerCare Plus and/or Medicaid SSI HMO must receive Department approval prior to distribution of materials.

c. HMOs must submit a completed Member Communication/Outreach Material Checklist with each review request submitted to the Department.

d. HMOs must submit a completed Events Spreadsheet for requests specific to event participation.

e. HMOs must correct any problems and errors the Department identifies.

f. The HMO agrees to comply with Wis. Admin. Code and practices consistent with the Balance Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [42 U.S.C. 1396v(d)(2)].

g. 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, or Medicaid SSI programs.

h. HMOs must provide the Department with final copies after materials are approved.

i. The Department has the discretion to request previously approved documents for re-review at any time.

j. HMOs must submit event schedules monthly or upon substantial updates. The schedule must be submitted five (5) days prior to an updated event if materials were previously approved by the Department, otherwise submit ten (10) days prior to the event with materials for Department approval. The Event Schedule, at a minimum, must include:

i. the Event;

ii. Purpose;

iii. Location, Address, City, and Zip;

iv. Materials Distributed;

v. Promotional Activities;

vi. Raffles, Incentives, or Rewards, and

vii. Description/Values;

viii. Sponsor(s);

ix. Event Date(s), and

x. Date Reviewed by the Department.

The information may be submitted in either Word, PDF, or Excel format.

2. Review and Approval Timeframe

a. The Department will review and either approve, approve with modifications, or disapprove all communication materials and marketing materials within 10 business days. Member Handbooks will be reviewed within 30 days. If the HMO does not receive a response from the Department within the prescribed time frame, the HMO must contact their HMO Managed Care Analyst. A response will be prepared within two business days of this contact.

b. Materials requiring additional time for Department review

c. The Department may require additional time to review materials that need Secretary's Office or Communications Team review. The Managed Care Analyst will notify the HMO within three (3) business days of the expected time needed to review the materials.

d. Expedited Review

i. The HMO must clearly mark time-sensitive member communication and outreach materials. The Department will approve, approve with modifications, or disapprove within three business days. The Department reserves the right to determine whether the materials are indeed time-sensitive. If the HMO does not receive a response from the Department within three business days, the HMO must contact the HMO Contract and Quality Compliance Section Manager. A response will be prepared within one business day of this contact.

ii. Materials that can be reviewed by the Managed Care Team and that may be eligible for expedited review include:

a) Notifications to members:

1) Letters notifying members of minor changes in the HMO provider network. (Exception: Privacy violations or significant changes in the HMO provider network, such as major contract terminations, are not eligible for expedited review).

b) Care coordination, wellness program, or disease management information, including materials to educate members on the management of certain conditions.

c) Incentives to members

1) For expedited review, incentives must be less than $25, and the material has clear instructions for members or providers to follow in order to qualify for the incentives. Incentives for the purposes of marketing and member materials are any form of financial compensation, including material items, travel or transportation reimbursement, child care services, etc., offered to members or potential members.

2) HMOs must prohibit the use of rewards or incentives to be used toward the purchase of items such as alcohol, tobacco products, and firearms.

3) The HMO may provide information about its rewards and incentives programs to potential members on its website only.

4) HMOs must provide the option to unsubscribe from health rewards/wellness incentive programs at any point during enrollment.

5) The Department will review incentives over $25 using the typical 10 day review timeline.

d) Notifications about HMO policies and procedures for member grievances

3. Failure to Complete the Approval Process

a. If the Department determines that the HMO has failed to complete the approval process, including engaging in member communication or outreach activities, or distributing materials to members without Department approval, then the Department may require the HMO to immediately retract the materials and may take actions provided under Article XIV.D.

4. Materials that do not require Department approval

a. Educational materials prepared by the HMO or by their contracted providers and sent to the HMO'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, or Medicaid SSI.

b. Educational materials prepared by outside entities (i.e. American Cancer Society etc.) do not require the Department's approval.

5. Additional Requirements for Member Communication and Marketing Materials

a. HMO Websites

i. All new and updated information relating to the Medicaid managed care programs that an HMO intends to post on its website must be approved by the Department prior to posting and must be consistent with the Department standards and state law.

ii. HMOs must notify the Department when their website is in place and when approved updates are made.

b. Surveys

i. HMOs may survey current members only. HMOs are prohibited from contacting former and potential members for a survey,

including a survey to determine why the former member disenrolled from the HMO.

ii. All survey methods must be approved by the Department prior to use

iii. All surveys must be translated into the prevalent languages by rate region.

iv. HMOs must provide the data obtained through these surveys to the Department upon request.

v. All efforts to solicit feedback from members and all gift offers must be approved by the Department and must be part of the HMO's Quality Assessment/Performance Improvement (QAPI) plan.

vi. The value of incentives used to encourage survey participation may not exceed $25 per person. Incentives for the purposes of marketing and member communication are any form of financial compensation, including material items, travel or transportation reimbursement, child care services, etc., offered to members or potential members.

c. Raffles and Nominal Gifts

i. All raffle items, must be submitted to the Department for approval no later than 10 business days prior to the event and must include:

a) including a description,

b) declared amount, and

c) number to be disbursed.

ii. HMOs may provide promotional raffles valued at $100 or less at community health events.

iii. HMOs may offer raffles or gifts valued at $100 or less for specific members-only initiatives, including participation in disease management programs. Only a few members may receive gifts of high value, subject to Department approval.

iv. HMOs may provide nominal gifts for member participation in focus groups. The amount of the gifts must be reasonable give the amount of participation and must be approved by the Department.

d. HMOs may use their logos and names on materials.

e. HMOs may provide health messaging and other materials to improve health literacy.

f. Provide plan information to educate members and potential members.

g. The HMO must notify DHS of its participation in a community or health event using the Events Spreadsheet.

h. Participation in community events may be publicized via social media, HMO Program websites, direct communication with current membership, and/or via press releases.

i. HMOs may use social media to provide general health messaging.

E. Reproduction/Distribution of Materials

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

F. HMO Identification (ID) Cards

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

G. Preferred Method of Communication

1. The HMO must have a policy describing the HMO's process for assessing the preferred method of communication of each hearing-impaired member. The HMO 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 HMO must include its policy on providing materials in Braille, larger fonts, or other alternatives.

H. Supplemental Contact Information and Email

1. Use of Phone Numbers

a. HMOs are allowed to use additional telephone numbers included on the Supplemental Demographic Information Report for members enrolled in the HMO. All requirements regarding telephone communications included within this guide apply for all telephone numbers provided by the member.

b. If provided, HMOs 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 HMO is unable to speak with the member but is able to leave a message, the HMO 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.

c. The Supplemental Demographic Report is intended to provide additional information that is not currently on the Initial and Final Enrollment Rosters and support HMOs in getting in contact with members. The Supplemental Demographic Report will be provided to HMOs 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.

2. Email Communication

a. Personal Health Information (PHI) must not be included in email communication from the HMO 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 HMO must inform the member that the HMO will never request personally identifiable information via email. Rather, HMOs will request members to log-in to a secure portal to update or provide personally identifiable information.

b. 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.

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

3. Email Content

a. Within the email, the HMO 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 HMO in the future. The HMO cannot sell or transfer email addresses to a third party outside the terms of a subcontract or provider agreement, including in the form of a mailing list.

4. Subscribing to Emails

a. The HMO can ask for the member's email address for purposes of subscribing to the HMO's electronic communications for the HMO's records. The HMO must explicitly indicate the type of information that will be communicated electronically and how to unsubscribe to emails

from the HMO before requesting a member's email address. The HMO cannot require a member to sign up for email subscription in order to get information about the HMO.

5. Text Message Notifications

   a. HMOs must follow the standard DHS approval process for written communications to members prior to circulation of materials, including text messages. DHS approval indicates only that the content of the message is acceptable to DHS. HMOs will need to work with their own legal counsel to confirm they have consent to text members and ensure that all materials are HIPAA and Telephone Consumer Protection Act (TCPA), if applicable, compliant.

6. Unsubscribing from Emails Messages

   a. The HMO must inform the member on how and where to unsubscribe from receiving email communications from the HMO.

   b. Email address will continue to be shared with the HMO until the member updates their information in ACCESS. In order to prevent the member's email address from being shared with the HMO, 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 HMOs.

7. Automated Chat

   Use of an automated chat feature within an HMO website does not need Department approval.

I. Contact with Former Members Who Have Lost Medicaid Eligibility within 90 days for Limited Purpose of Providing Enrollment and Renewal Information

1. HMOs may contact former members who have recently lost eligibility due to lack of renewal or late verification, for the limited purpose of providing former members with information about re-establishing Medicaid eligibility.

2. HMOs may only contact former plan members if the former plan members are within their 90-day period to complete a renewal. The Department will provide HMOs with lists of former members who have lost eligibility and the timeframe in which the member must complete the renewal process.

3. HMOs must follow the standard the Department approval process for communications to members prior to circulation of materials to former members.

4. Under this section, HMOs may provide information about enrollment, including renewals, in BadgerCare Plus and Medicaid programs. HMOs may direct former members to do the following as applicable:

a. Apply online at the ACCESS website: www.access.wisconsin.gov

b. Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf;

c. Call ForwardHealth Member Services at 1-800-362-3002;

d. Call or go to their county IM agency or tribal agency to complete an application: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

5. For Medicaid SSI information please direct members or potential members to:

a. The Department Link - https://www.dhs.wisconsin.gov/ddb/apply.htm

b. Social Security Administration Resources – How to apply for Medicaid SSI:

https://www.ssa.gov/disabilityssi/

https://www.ssa.gov/ssi/text-apply-ussi.htm

6. HMOs are prohibited from completing the renewal process on behalf of a former member.

a. HMOs may provide a member with assistance in completing the renewal process.

b. With the former member's permission, HMOs may contact an IM agency on a former member's behalf in order to obtain contact information or arrange for an initial appointment between IM staff and the former member.

VII. Member Rights and Responsibilities

A. Policies

The HMO must have written policies guaranteeing each member's rights, and share those written policies with staff and affiliated providers to be considered when providing services to members. The HMO must comply with any applicable Federal and State laws, including those identified in 42 CFR 438.100, that pertain to member rights. The HMO must have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. As cited in 42 CFR 438.100, enrollees of HMOs have the following rights:

1. Receive information in accordance with 42 CFR § 438.10.
2. Be treated with respect and with due consideration for their dignity and privacy.
3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
4. Participate in decisions regarding their health care, including the right to refuse treatment.
5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
6. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and § 164.526.
7. Be furnished health care services in accordance with 42 CFR § 438.206 through § 438.210.
8. Be free to exercise their rights, and that the exercise of those rights does not adversely affect the way the HMO and its network providers treat the enrollee.

B. Advocate Requirements

The HMO must employ a BadgerCare Plus and/or Medicaid SSI HMO Advocate(s) during the entire contract term. The HMO Advocate(s) must work with both members and providers to facilitate the provision of benefits to members. The advocate is responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. The advocate position must be in an organizational location within the HMO that provides the authority needed to carry out these tasks. The HMO advocate may delegate the below tasks to appropriate plan staff as the HMO advocate determines appropriate. The detailed requirements of the HMO Advocate are listed below:

1. Functions of the BadgerCare Plus and/or Medicaid SSI HMO Advocate(s)

a. Investigate and resolve access and cultural sensitivity issues identified by HMO staff, State staff, providers, advocate organizations, and members.

b. Monitor grievances and appeals, along with the grievance and appeal personnel, for the purposes of identification of trends or specific problem areas of access and care delivery. The monitoring function includes ongoing participation in the HMO grievance and appeal committee.

c. Attempt to resolve grievances and appeals without formal hearings or reviews whenever possible. Resolution of issues and concerns should happen through internal review, negotiation, or mediation, when possible.

d. Recommend policy and procedural changes to HMO management including those needed to ensure and/or improve member access to and quality of care. The recommended changes can be for both internal administrative policies and subcontracted providers.

e. Act as the primary contact for member advocacy groups. Work with member advocacy groups on an ongoing basis to identify and correct member access barriers.

f. Act as the primary contact for local community based organizations (local governmental units, non-profit agencies, etc.). Work with local community based organizations on an ongoing basis to acquire knowledge and insight regarding the special health care needs of members.

g. Participate in working with DMS Managed Care staff assigned to the HMO on issues of access to medical care, quality of medical care, and working with the enrollment specialist, ombudsmen, and the Department's approved external advocate on issues of access to medical care, quality of medical care, and enrollment and disenrollment.

h. Analyze on an ongoing basis internal HMO system functions that affect member access to medical care and quality of medical care.

i. Attend, organize and provide ongoing training and educational materials for the HMO staff and providers to enhance their understanding of the values and practices of all cultures with which the HMO interacts.

j. Provide ongoing input to HMO management on how changes in the HMO provider network will affect member access to medical care and member quality and continuity of care. Initiate and participate in the development and coordination of plans to minimize any potential problems that could be caused by provider network changes.

k. Review and approve the HMO's informing materials to be distributed to members to assess clarity and accuracy.

l. Assist members and their authorized representatives for the purpose of obtaining their medical records.

m. The lead advocate position is responsible for overall evaluation of the HMO's internal advocacy plan and is required to monitor any contracts the HMO may enter into for external advocacy with culturally diverse associations or agencies. The lead advocate is responsible for training the associations or agencies and ensuring their input into the HMO's advocacy plan.

n. Be willing to travel, as needed, to be accessible to meet the needs of members in different areas of the state.

Upon request from the Department, the HMO must provide evidence of compliance with the job duties mentioned above, such as proof of complaint investigations and participation in cultural competency training.

2. Staff Requirements and Authority of the BadgerCare Plus and/or Medicaid SSI HMO Advocate

a. At a minimum, the HMO must have one HMO Advocate for BadgerCare Plus and at least two for Medicaid SSI depending on HMO certification. The advocate(s) must be located in the organizational structure so that they have the authority to perform the functions and duties listed in Article VII.B.1.a-n. above.

b. Upon request from the Department, HMOs are required to state the staffing levels to perform the functions and duties listed in Article VII.B. 1. a-n. above in terms of number of full and part time staff and total full time equivalents (FTEs) assigned to these tasks. The Department assumes that an HMO acting as an Administrative Service Organization (ASO) for another HMO will have at least one advocate or FTE position for each ASO contract as well as maintain their own internal advocate(s). The HMO must consider and monitor current enrollment levels when evaluating the number of advocates necessary to meet the needs of members. The HMO may employ less than the required FTE advocate position(s), but must justify to the satisfaction of the Department why less than one FTE position(s) will suffice for the HMO's member population. The HMO must also regularly evaluate the advocate position(s), work plan(s), and job duties and allocate an additional FTE advocate position or positions to meet the duties listed in Article VII.B.1.a-n above if there is significant increase in the HMO's member population or in the HMO service area. The Department reserves the right to require the HMO to employ an FTE advocate position if the HMO does not demonstrate the adequacy of a part-time advocate position.

c. In order to meet the requirement for the advocate position statewide, the Department encourages the HMO to contract or have a formal memorandum of understanding for advocacy and/or translation services with associations or organizations that have culturally diverse populations within the HMO service area. However, the overall or lead responsibility

for the advocate position must be within each HMO. The HMO must monitor the effectiveness of the associations and agencies under contract and may alter the Contract(s) with written notification to the Department.

d. The Medicaid SSI advocate must be knowledgeable and have experience working with people with disabilities and shall have adequate time to advocate for the target Medicaid SSI populations.

C. Advance Directives

The HMO must maintain written policies and procedures related to advance directives. (Written information provided must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.) An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated. The HMO must:

1. Provide written information at the time of HMO enrollment to all adults receiving medical care through the HMO. Per 42 CFR § 438.3(j), if a member is incapacitated at the time of initial enrollment and is unable to receive information or articulate whether or not they have executed an advance directive, the HMO may give advance directive information to the member's family or authorized representative. The written information should be regarding:

   a. The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and

   b. The individual's right to file a grievance with the Department of Health Services, Division of Quality Assurance, regarding noncompliance with advance directive requirements. If requested, assist the member in filing a grievance with the Division of Quality Assurance regarding noncompliance with advance directive requirements; and

   c. The HMO's written policies respecting the implementation of such rights.

2. Per 42 CFR § 438.3(j), maintain written policies and procedures concerning advance directives which must, at a minimum, do the following:

   a. Clarify any differences between any HMO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives.

   b. Describe the range of medical conditions or procedures affected by the conscience objection.

   c. Document in the individual's medical record whether or not the individual has executed an advance directive.

d. Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

e. Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

f. Provide education for staff and the community on issues concerning advance directives.

g. Providing staff training about HMO specific policies and procedures related to advance directives.

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

D. Primary Care Provider Selection and Designation

Per 42 CFR § 438.208(b)(1), the HMO must ensure that every member has a primary care provider or a primary care clinic responsible for coordinating the services accessed by the member. The HMO must have a process in place to link each BadgerCare Plus and Medicaid SSI member with a primary care provider, a primary care clinic, or a specialist when appropriate based on the preferences and health care needs of the member. The process shall include a defined method to notify the member of their primary care provider and how to contact the provider. The HMO shall allow members an initial choice of primary care provider or primary care clinic prior to designation.

1. HMO primary care provider or primary care clinic selection and designation strategy

   a. The strategy the HMO uses to link members to a primary care provider or primary care clinic must take into account the preferences and health care needs of the member. In particular, for those members with chronic conditions including but not limited to those listed below, HMOs are to take additional steps to ensure these members are linked to a primary care provider or primary care clinic that can appropriately address their condition, as well as ensure the member receives coordinated care to help manage the condition. Depending on the condition, the primary care provider may be a specialist. The specific chronic conditions include, but are not limited to:

      i. Diabetes

      ii. Asthma

      iii. COPD

iv. Congestive heart failure

v. Behavioral health

vi. Prenatal and post-partum care

b. HMOs must ensure members are linked to a primary care provider or primary care clinic that provides culturally appropriate care. Specifically, the provider must be able to relate to the member and provide care with sensitivity, understanding, and respect for the member's culture.

c. As part of the primary care provider or primary care clinic selection and designation strategy, HMOs must include the following:

i. A process for linking all members to an appropriate primary care provider or primary care clinic (or specialist for members identified with chronic conditions), including a step in which members are given the opportunity to choose their PCP. HMOs shall ensure care is coordinated between the primary care provider, primary care clinic and/or specialists, which includes the development of a patient-centered and comprehensive treatment plan.

ii. Communication methods that notify members of their primary care provider, primary care clinic or specialist to ensure the member utilizes primary care and encourages members to keep their scheduled appointments.

iii. The HMO will evaluate the effectiveness of their primary care provider selection and designation strategy to ensure quality of care.

2. Changing and lock-in PCP Selection

The HMO must permit members to change primary providers at least twice in any year, and to change primary care providers more often than that for just cause. Just cause includes a lack of access to quality, culturally appropriate health care. The HMO must treat a request for change in primary care provider due to just cause as a grievance, and adhere to the notification and timeframe requirements in this Contract..

3. Data sharing with PCP

The HMO must have a process to share information on members to their primary care provider on a regular basis. The information must include, but is not limited to, utilization data and prescription drug data such as from the pharmacy extract provided by the Department.

4. Rural area resident with only one HMO

a. For a rural area resident with only one HMO, the HMO must notify the member of the member's ability to obtain services outside the network:

i. From any other provider (in terms of training, experience and specialization) not available within the network.

ii. From a provider not part of the network who is the main source of a service to the member – provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.

b. The member may also receive services outside of the network for the following reasons:

i. Because the only plan or provider available does not provide the service because of moral or religious objections.

ii. Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network.

iii. The State determines the other circumstances warrant out-of-network treatment

The member has the right to request an appeal if they are denied their rights as detailed under this Article VII.A.4. The HMO must comply with the notice and timing requirements in this Contract..

E. Member Appointment Compliance

The HMO must have a strategy in place to reduce the number of members who do not show up for scheduled appointments. This strategy must include outreach and education components for both members and providers. DHS may request additional information from HMOs on member appointment compliance during the contract period.

F. Choice of Network Provider

The HMO must offer each member covered under this Contract the opportunity to choose a primary care provider affiliated with the HMO, to the extent possible and appropriate. If the HMO designates a PCP to members, then the HMO must notify members of the designation. If the HMO has reason to lock in a member to one primary provider in cases of difficult case management, the HMO must submit a written request in advance of such lock-in to the HMO's managed care analyst. Culturally appropriate care in this section means care by a provider who can relate to the member and who can provide care with sensitivity, understanding, and respect for the member's culture.

G. Coordination and Continuation of Care

The HMO must have a system in place to ensure well-managed patient care, including at a minimum:

1. Management and integration of health care through primary provider/gatekeeper/other means.
2. Systems to ensure referrals for medically necessary, specialty, secondary and tertiary care.
3. Systems to ensure provision of care in emergency situations, including an education process to ensure that members know where and how to obtain medically necessary care in emergency situations.
4. Systems that clearly specify referral requirements to providers and subcontractors. The HMO must keep copies of referrals (approved and denied) in a central file or the patient's medical records.
5. Systems to ensure the provision of a clinical determination of the medical necessity and appropriateness of the member to continue with mental health and substance abuse providers who are not subcontracted with the HMO. The determination must be made within 10 business days of the member's request. If the HMO determines that the member does not need to continue with the non-contracted provider, it must ensure an orderly transition of care.
6. Per Article III.A., coordinate the services the HMO provides to the member:
    a. Between settings of care, including appropriate discharge planning for hospital or institutional stays.
    b. With services provided by another HMO.
    c. With services a member receives through Medicaid Fee-for-Service.
    d. With services a member receives through community and social support providers.
7. Share with other HMOs (which may include Medicare or commercial plans, or members transitioning to a new BadgerCare Plus or Medicaid HMO) serving the member the results of its identification and assessment of any member with special health care needs (see Article I for definition of special health care needs) so that those activities need not be duplicated as described in 42 CFR § 438.208(b)(4).
8. The HMO must ensure continuity of care for members receiving health care under FFS prior to their enrollment in the HMO, and for newly enrolled members switching HMO enrollment. The HMO must:
    a. Ensure members receive continued access to previous services when the absence of continued services would pose serious health or hospitalization risks per 42 CFR § 438.62 (b). Members who meet this criteria are not subject to the 90-day access limitations described in Article VII.F.8.b.1-3.

b. Provide continued access to services consistent with previous access levels.

i. Authorize coverage of state plan approved services with the member's current providers for the first 90 days of enrollment.

ii. Authorize approved prior authorizations at the utilization level previously authorized for 90 days. Exceptions to the 90 day requirement will be allowed in situations where the member agrees to change providers, the member agrees to a lower level of care, or if the HMO can document that continuing the care would result in abuse, safety or quality concerns. This does not extend authorizations beyond the time or visits previously approved.

iii. The 90 day continued access requirement only applies to services and authorizations covered under the state plan. In-lieu of services and authorizations are exempt.

c. The HMO must have a detailed automated system for collecting all information on member contacts by care coordinators, case managers and any other staff that has a direct impact on the member's access to services.

d. The HMO shall assist members who wish to receive care through another HMO or return to the FFS system by making appropriate referrals and by assisting in the transfer of medical records to new providers.

9. The HMO must notify members of transition of care requirements as defined in 42 CFR § 438.62 and Article VII.G.8. of the contract.

10. Pursuant to Wis. Stat. § 609.24:

The HMO shall, with respect to covered benefits, provide coverage to a member for the services of a provider, regardless of whether the provider is in-network at the time the services are provided, if the HMO represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the member during the most recent enrollment period.

a. Time limitations

i. For primary care physicians: Coverage shall be provided by the HMO until the end of the contract year for which it was represented that the provider was, or would be, a participating provider in the HMO network.

ii. For a participating provider who is not a primary care physician and whose position with the plan terminates: for the remainder of the course of treatment or for 90 days after the provider's participation with the plan terminates, whichever is shorter, except that the coverage is not required to extend beyond the end of the contract year for which it was represented that the provider was, or would be, a participating provider.

iii. If maternity care is the course of treatment and the member is a person who is in the 2nd or 3rd trimester of pregnancy when the provider's participation with the plan terminates, until the completion of postpartum care for the member and infant.

iv. The coverage required under this section need not be provided or may be discontinued if any of the following applies:

a) The provider no longer practices in the HMO's geographic service area.

b) The HMO terminates or terminated the provider's contract for misconduct on the part of the provider.

b. Medical Necessity

i. This section does not preclude the application of any provisions related to medical necessity that are generally applicable under the plan.

c. Notice to Members

The HMO shall notify all members of the provisions under this section whenever a participating provider's participation with the plan terminates, or shall, by contract, require a participating provider to notify all plan members of the provisions under this section if the participating provider's participation with the plan terminates.

H. Culturally and Linguistically Appropriate Services (CLAS) Standards

1. The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to implement culturally and linguistically appropriate services. The National CLAS Standards include:

a. Principal Standard

i. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

b. Governance, Leadership and Workforce

i. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

ii. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

iii. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

c. Communication and Language Assistance

i. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

ii. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

iii. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

iv. Provide easy-to-understand print and multimedia and signage in the languages commonly used by the populations in the service area.

d. Engagement, Continuous Improvement, and Accountability

i. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

ii. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

iii. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

iv. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

v. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

vi. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

vii. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

2. The HMO must incorporate the National CLAS standards into organizational practices and the delivery of services with a focus on care management services for members. The HMO must:
    a. Develop and submit policies and procedures at certification demonstrating how all National CLAS standards have been incorporated into organizational practices and delivery of services.
    b. Describe and submit CLAS-related self-assessments, trainings, implementation plan(s), and evaluation plan(s) the HMO has previously done or plans to complete in the upcoming calendar year at an organizational level including:
        i. a timeline with dates for initiation and completion of activities
        ii. assessment questions
        iii. aggregate level self-assessment and evaluative results
        iv. all documents referenced within the CLAS self-assessments, trainings, implementation plan(s), and evaluation plan(s).
    c. Submit an evaluation of CLAS standard based on data, including member experience, and members' feedback, including:
        i. effectiveness of incorporated elements;
        ii. areas not effective; and
        iii. description of how to revise the approach.
3. The HMO must incorporate in its policies, administration and service practice the following:
    a. Recognizing members' beliefs,
    b. Screening members for social risk factors and/or health related social needs,
    c. Partnering with community based organizations to address members' unmet health related social needs
    d. Addressing cultural and linguistic differences in a responsive manner, and
    e. Fostering in its staff and providers behaviors that effectively address interpersonal communication styles that respect members' cultural backgrounds.
    f. Permitting members to change provider's based on the provider's ability to provide culturally and linguistically appropriate services.
    g. Requiring culturally and linguistically appropriate grievance and appeal protocols.

4. The HMO must encourage and foster CLAS Standards among providers and increase diversity in the HMO's network to respond appropriately to member's linguistic and cultural needs. The HMO must permit members to choose providers from the HMO's network based on linguistic and/or cultural needs. The HMO must permit members to change primary care providers based on the provider's ability to provide services in a culturally and linguistically responsive manner.

I. Health Education and Disease Prevention

The HMO must inform all members of ways they can maintain their own health and properly use health care services.

The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:

1. An individual responsible for the coordination and delivery of services.
2. Information on how to obtain these services (locations, hours, telephone numbers, etc.).
3. Health-related education materials in the form of printed, audiovisual and/or personal communication.

   Health-related educational materials produced by the HMO must be at a sixth grade reading comprehension level and reflect sensitivity to the diverse cultures served. Also, if the HMO uses material produced by other entities, the HMO must review these materials for grade level comprehension and sensitivity to the diverse cultures served. Finally, the HMO must make all reasonable efforts to locate and use culturally appropriate health-related material.
4. Information on recommended checkups and screenings, and prevention and management of disease states that affect the general population. This includes specific information for persons who have or who are at risk of developing such health problems as hypertension, diabetes, STD, asthma, breast and cervical cancer, osteoporosis and postpartum depression.
5. Health education and disease prevention programs, including injury control, family planning, teen pregnancy, sexually transmitted disease prevention, prenatal care, nutrition, childhood immunization, substance abuse prevention, child abuse prevention, parenting skills, stress control, postpartum depression, exercise, smoking cessation, weight gain and healthy birth, postpartum weight loss, and breast feeding promotion and support. (Note: Any education and prevention programs for family planning and substance abuse would supplement the required family planning and substance abuse health care services covered by BadgerCare Plus and/or Medicaid SSI.)
6. The HMO should offer a discrete substance abuse screening and prevention program for members at risk of substance abuse disorder. Wisconsin Medicaid and BadgerCare Plus covers a screening, brief intervention, and referral to

treatment benefit (SBIRT) for all members (see ForwardHealth online handbook, Topic #8297) and a similar benefit for pregnant members (see Topic #4442).

7. Promotion of the health education and disease prevention programs, including use of languages understood by the population served, and use of facilities accessible to the population served.

8. Information on and promotion of other available prevention services offered outside of the HMO, including child nutrition programs, parenting classes, programs offered by local health departments and other programs.

9. Systematic referrals of potentially eligible women, infants, and children to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and relevant medical information to the WIC program. More information about the WIC program as well as list of the local WIC agencies can be found on the WIC website (https://www.dhs.wi.gov/wic/).

VIII. Provider Appeals

A. Provider Appeals to the Department

1. Process to appeal to the Department
    a. Providers may choose to pursue resolution directly with the Department through the provider appeal process after exhausting the HMO appeal process.
    b. The provider has 60 calendar days from the HMO's final appeal decision to submit all required information pertaining to the case(s) in question.
    c. The Department will seek rebuttal from the HMO when it has determined that the provider's appeal necessitates further review.
    d. The Department may send an official Request for Additional Information notice to the HMO. A response to the request for additional information must be received by the Department within 14 calendar days (extensions may be available upon request), via the Provider Appeals Portal. If the HMO fails to submit the requested information by the date required by the Department, the Department may overturn the original denial and compel the HMO to pay the claim. The Department will uphold the original denial if the provider fails to provide the requested information as outlined in the BadgerCare Plus Handbook.
2. Appeal Decision Issued by the Department
    a. The Department has 45 days from the date of receipt of all pertinent information to inform the provider and the HMO of the final decision.
    b. If the Department's decision is in favor of the provider, the HMO will pay provider(s) within 45 days of receipt of the Department's final determination.
    c. A reconsideration of a final decision will only be made if an error has been made or there was a misrepresentation of facts.
    d. The Department will review the appeal documents and make a Final Decision based on the contract (both the DHS-HMO contract and the HMO-provider contract, if submitted, will be used to make the decision).
    e. The Department will not review decisions based on contractual requirements between the provider and HMO, including appeals related to:
        i. Clinical level of care (e.g. observation vs. inpatient) provided to the member, or the results of contractually agreed upon HMO reviews of claims or medical records.

B. HMO Responsibility

1. The HMO must have adequate staff available to train and support providers on resources available in order to prevent claim processing issues and denials. Refer to Article XI.C.7.
    a. The HMO must provide information to network providers of any HMO-facilitated training opportunities which may reduce denied claims and provider appeals.
    b. Ensure that providers know, understand and comply with all business standards regarding completion and submission of accurate, correct and timely claims. This includes correct coding and maintenance of medical record.
    c. Grant providers access to all online technology and communication offered by the HMO (i.e. not limited to claim and appeal submission, policy resources, HMO website). Electronic notification from the HMO constitutes receipt of information or claim action; it is not necessary to wait for paper notification of claim action.
    d. Encourage providers to access and use the ForwardHealth Portal, including online Handbooks and Provider Updates.
2. The HMO must perform ongoing monitoring of provider appeal numbers and perform provider outreach and education/training on trends to prevent future denials/partial payments, thus reducing future provider appeals to the HMO and to the Department.
3. The HMO must inform providers and subcontractors, in writing at the time they enter into a contract, of the toll-free number for members to file appeals as well as the provider's and subcontractor's right to appeal a denied/reduced payment or payment recoupment.
4. HMOs must provide a clear process for claim dispute escalation which must include the below elements in their contract or MOU with providers, in their provider manual, on the HMO website, or through written notification for non-contracted providers.
    a. Language distinguishing "resubmission of a claim" or, "reconsideration of a claim" and "appeal of a claim" as defined in Article I with a clear indication of level of action being taken. A "resubmission of a claim" or "reconsideration of a claim" is not a formal appeal.
    b. the HMO must complete the reconsideration process within 60 days.
    c. The HMO must provide an explanation of the process the provider should follow to appeal the HMO's decision to the HMO once all claim reconsideration action has been exhausted. This must include a statement regarding the provider's rights to appeal to the HMO, including the timeline and the name of the person and/or function at the HMO to whom the provider appeal should be submitted.

d. The HMO must provide a statement advising the provider of their right to appeal to the Department if the provider is not satisfied with the HMO's decision on the appeal or the HMO fails to respond to the appeal within 45 calendar days from the date of the receipt of the appeal.

5. The HMO must adhere to the following timelines:

   a. The HMO must accept written appeals, including appeals submitted via HMO automated programing from providers submitted, at minimum, within 60 calendar days of the HMO's initial payment and/or nonpayment notice, or notice of recoupment. In exceptional cases, the Department may override the HMO's time limit for submission of claims and appeals. The Department will not exercise its authority in this regard unreasonably.

   b. The HMO must respond in writing within 45 calendar days from the receipt of the appeal letter. If the HMO fails to respond within 45 calendar days, or if the provider is not satisfied with the HMO's response, the provider may seek a final determination from the Department.

6. HMO Provider Appeal notification requirements

   a. The HMO must acknowledge the receipt of each formal written appeal received from providers within 10 calendar days.

   b. The HMO must provide notification to the provider of the outcome of the formal appeal.

   c. All notifications must include the member's name, Medicaid Member ID number, date of service, date of payment and/or nonpayment. Each page of the payment remittance document must include the date the denial action was taken and specific explanation of the payment amount or a specific reason for nonpayment.

   d. If the appeal is overturned, a EOP from the reprocessed claim is acceptable if it indicates the claim was reprocessed.

   e. If the appeal is upheld, in cases of denial of payment, written (or HIPAA 835 transaction) notification must occur on the date the payment was denied.

7. The HMO must submit to the Department, on a quarterly basis, a provider appeal log containing information as stated in the Provider Appeal Quarterly report data dictionary. The provider appeal log must include any provider claim appeals processed by any subcontractor. The provider appeal log must be submitted to the Department the last business day of April, July, October and January for the prior quarter.

C. Provider Responsibility

The HMO must educate providers of their responsibilities:

1. Receive access to and use the ForwardHealth Portal, including online handbooks and Provider Updates in order to understand and correctly bill a covered service.
2. Access online technology and communication/trainings offered by the HMO (i.e. not limited to claim and appeal submission, policy resources, HMO website). Electronic notification from the HMO constitutes receipt of information or claim action; it is not necessary to wait for paper notification of claim action.
3. Understand and comply with all business standards regarding completion and submission of accurate, correct and timely claims. This includes correct coding, maintenance of medical record and correct coordination with other insurance plans.
4. To reserve the right to appeal to the Department, the BadgerCare Plus and Medicaid SSI provider must exhaust all appeal rights with the HMO if they disagree with the HMO's appeal response. Failure to follow the provider appeal process with the HMO will result in the appeal denial being upheld.
5. How to appropriately appeal to the Department and the required timelines for doing so. Provide the ForwardHealth Provider Appeal Portal website and refer to ForwardHealth Online Handbook topics #384 and #385.

IX. Member Grievances and Appeals

HMOs are required to implement and enforce all of the requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F which is fully incorporated herein by reference.

A. General Requirements

1. Grievance and Appeal System
    a. The HMO must:
        i. Have a grievance and appeal system in place for members. Non-emergency medical transportation PAHPs are not subject to this requirement. The grievance and appeal system must:
        ii. Ensure that members have the option to appeal any adverse benefit determination, or file a grievance expressing their dissatisfaction about any matter other than an adverse benefit determination, to the Board of Directors of the HMO. The HMO Board of Directors may delegate the authority to review grievances and appeals to the HMO grievance appeal committee, but the delegation must be in writing.
            a) If a grievance and appeal committee is established, the member Advocate must be a member of the committee.
        iii. Ensure that individuals with the authority to require corrective actions are involved in the grievance process.
        iv. Have written policies and procedures that detail what the grievance and appeal system is and how it operates.
        v. Identify a contact person in the HMO to receive grievances and appeals and be responsible for routing and processing.
        vi. Inform members about the existence of the grievance and appeal processes and how to use them.
        vii. Attempt to resolve issues and concerns without formal hearings or reviews whenever possible. When a member presents a grievance or appeal, the member Advocate must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible.
2. Level of Appeals
    a. The HMO may have only one level of appeal for members.
3. Filing Requirements

a. A member may file a grievance and request an appeal with the HMO. A member may request a State fair hearing only after receiving notice that the adverse benefit determination has been upheld by the HMO (see Article IX.D).

b. If the HMO fails to adhere to the notice and timing requirements in Article IX.D, the member is deemed to have exhausted the HMO's appeals process, and the member may initiate a State fair hearing.

c. A provider or an authorized representative may request an appeal, file a grievance, or request a State fair hearing on behalf of a member, provided there is documented consent from the member. For the purposes of this Article, when the term "member" is used, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request the continuation of benefits as specified in Article IX.F.2.

4. Member Filing Timeframes

a. Grievance: A member may file a grievance with the HMO at any time.

b. Appeal: A member has 60 calendar days from the date on the adverse benefit determination notice to file a request for an appeal to the HMO.

5. Procedures

a. Grievance: The member may file a grievance either orally or in writing. The member must file a grievance with the HMO. The date of the HMO's receipt of the member's oral or written grievance request is the start date of the acknowledgement and decision timeframes described under Article IX.D.2.a.

b. Appeal

The member may request an appeal either orally or in writing. The date of the HMO's receipt of the member's oral or written appeal request is the start date of the acknowledgement and decision timeframes described under Article IX.D.2.b.

B. Notice of Adverse Benefit Determinations

1. Notice of Adverse Benefit Determination Requirement

a. The HMO must give members timely and adequate notice of an adverse benefit determination in writing consistent with the requirements of Article IX.B.2 and in Article VI, "Marketing and Member Materials". This includes adverse benefit determinations made by the HMO, providers, or its subcontractors. It also includes:

i. Determinations on services that were authorized by the HMO the member was previously enrolled in, as consistent with the

requirements of 42 CFR § 438.62(a)-(b) and HMO contract Article VII.G.8.

b. Denial of a request for an item meeting the definition of durable medical equipment or appliances, or disposable medical supplies, shall be treated by the HMO as an adverse benefit determination, regardless of whether the item is on the Forward Health Durable Medical Equipment Index or the Wisconsin Medicaid Index of Disposable Medical Supplies or other indices of coverable medical equipment and supplies used by the HMO.

2. Content of Notice

a. The HMO must submit to the Department all notice language for approval prior to its use.

i. The Department has provided template letters and mandatory language to be included in member letters. The template letters are available at https://www.forwardhealth.wi.gov/WIPortal/content/Managed Care Organization/Contracts/Home.htm.spage .

b. The initial notice must explain the following:

i. The adverse benefit determination the HMO has made or intends to make.

ii. The reasons for the adverse benefit determination and the right of the member to be provided reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination free of charge. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

iii. The member's right to request an appeal of the HMO's adverse benefit determination, including information on exhausting the HMO's one level of appeal described in Article IX.A.2.a and the right to request a State fair hearing consistent with Article IX.A.3.a.

iv. The procedures for exercising the rights specified in Article IX.C.2.

v. The circumstances under which an appeal process can be expedited and how to request it, including the fact that an expedited timeframe requires a medical provider or the HMO to verify that delay can be a health risk.

vi. The member's right to have benefits continue while the appeal resolution is pending, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services (see Article IX.F.4.)

vii. The member's right to have a representative assist at any point in the grievance or appeal process including reviews or hearings, and how to request that assistance.

viii. The member's right to present "new" information before or during the grievance and appeal process including reviews or hearings.

ix. The fact that retaliatory action will not be taken against a member, a member's authorized representative or a provider who appeals the HMO's decision.

x. The fact that the member can receive help filing a grievance or appeal by calling the member Advocate, the Ombuds, or the SSI External Advocate.

xi. The address and telephone number of the member Advocate and Ombuds. The External Advocate must also be listed for Medicaid SSI members.

3. Timing of Notice

The HMO must mail the notice within the following timeframes:

a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified below (as found in 42 CFR §§ 431.211, 431.213, and 431.214).

i. The HMO must send a notice at least 10 days before the date of action, (as defined in 42 CFR § 431.201) except as permitted under Article IX.B.3.a.ii and Article IX.B.3.a.iii.

ii. The HMO may send a notice not later than the date of action if any of the following occur:

a) The HMO has factual information confirming the death of a member.

b) The HMO receives a clear written statement signed by a member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates understanding that this must be the result of supplying that information.

c) The member has been admitted to an institution and has become ineligible under the plan for further services.

d) The member's whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address (See 42 CFR § 431.231 (d) for procedure if the beneficiary's whereabouts become known).

e) The HMO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

f) A change in the level of medical care is prescribed by the member's physician.

g) The notice involves an adverse determination made with regard to the preadmission screening requirements of §1919(e)(7) of the Social Security Act.

iii. The HMO must send notice as soon as practicable before a member will be transferred or discharged when:

a) The safety or health of individuals in the facility would be endangered.

b) The resident's health improves sufficiently to allow a more immediate transfer or discharge.

c) An immediate transfer or discharge is required by the resident's urgent medical needs.

d) A resident has not resided in the nursing facility for 30 days.

iv. The agency may shorten the period of advance notice to 5 days before the date of action if both of the following conditions are met:

a) The agency has facts indicating that action should be taken because of probable fraud by the member.

b) The facts have been verified, if possible, through secondary sources.

b. For denial of payment, at the time of any action affecting the claim.

c. For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service.

i. One extension of up to 14 days may be allowed if either of the following conditions are met:

a) The member or the provider requests an extension.

b) The HMO justifies the need for additional information and how the extension is in the member's interest. Determinations must be made within the timeframe specified in Article IX.B.3.c and will be available to the Department upon request.

d. If the HMO meets the criteria in Article IX.B.3.c.i.b for extending the timeframe for standard service authorization decisions it must do both of the following:

i. Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

ii. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

e. For expedited service authorization decisions, as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

i. The expedited timeframe may be extended by up to 14 calendar days if the criteria listed under Article IX.B.3.c are met.

f. Service authorization decisions not reached within the timeframes specified in Article IX.B.3.c. and Article IX.B.3.e. are considered an adverse benefit determination. In these situations, notice must be mailed no later than the date that the timeframes expire.

C. Handling of Grievances and Appeals

1. General Requirements

a. In handling grievances and appeals, the HMO must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

2. Requirements for Adverse Benefit Determinations

The HMO's process for handling member grievances and appeals of adverse benefit determinations must:

a. Acknowledge in writing receipt of each grievance and appeal. If being sent to a provider, written notices may be sent by mail or electronically via secure provider portal.

b. Ensure the individuals who make decisions on grievances and appeals are individuals:

i. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

ii. Who are health care professionals with appropriate clinical expertise, if deciding any of the following:

a) An appeal of a denial that is based on lack of medical necessity.

b) A grievance regarding denial of expedited resolution of an appeal.

c) A grievance or appeal that involves clinical issues.

iii. Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

c. Provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The HMO must inform the member orally of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in Article IX.D.2 and Article IX.D.3.

i. If the member is presenting evidence in person, the HMO must inform the member in writing of the time and place of the meeting at least seven days before the meeting. In expedited appeals, the HMO must also notify the member orally.

d. Provide the member and if applicable, the member's representative, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the HMO (or at the direction of the HMO) in connection with the appeal. This includes information or documentation generated by the HMO's providers, and subcontractors.. The information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in Article IX.D.2 and Article IX D.3.

e. Include as parties to the appeal, the member and the member's representative, or the legal representative of a deceased member's estate.

D. Resolution and Notification

1. Basic Rule

The HMO must resolve and provide notice for each grievance and appeal as expeditiously as the member's health condition requires, and within the timeframes specified in this Article.

2. Acknowledgement and Resolution Timeframes

a. Standard Resolution of Grievances

For standard resolution of a grievance, the HMO must send a written acknowledgement of receipt of the grievance to the member within 10 business days of receipt of the grievance (oral or written) and a final written decision resolving the grievance within 30 calendar days of

receiving the grievance (oral or written). This includes member grievances that were resolved during the initial phone call to the HMO.

b. Standard Resolution of Appeals

For standard resolution of an appeal, the HMO must send a written acknowledgement of receipt of the appeal to the member within 10 business days of receipt of the appeal (oral or written) and a final written decision resolving the appeal within 30 calendar days of receiving the appeal (oral or written). This timeframe may be extended under the conditions outlined in Article IX.D.3.

c. Expedited Resolution of Appeals

For expedited resolution of an appeal, the HMO must make reasonable effort to provide oral notice and issue a written disposition of an expedited hearing decision within 72 hours of receiving the verbal or written request for an expedited resolution. This timeframe may be extended under the conditions outlined in Article IX.D.3 .

d. Grievances and Appeals Submitted by Individuals Purporting to be an Authorized Representative

If a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the HMO does not have the documented consent of the member for the individual to act as the member's representative on file, then the HMO must do the following:

i. Upon receipt of the grievance or appeal request, attempt to contact the member to confirm the member's desire for the grievance or appeal to proceed.

ii. If contact is made with the member and the member confirms, either verbally or in writing, that they desire the grievance or appeal to proceed, inform the member of the need to provide written consent for an individual to act as the member's authorized representative in the grievance or appeal and that, in the absence of such documented consent, the grievance or appeal will be processed as a request from the member.

iii. Initiate the appeal or grievance resolution process as of the date the member confirms that they wish to proceed with the appeal or grievance.

iv. Send the written acknowledgement letter to the member (and, if the member's documented consent is obtained prior to the acknowledgment letter being sent out, to the member's authorized representative) within the timeframes described under Article IX.D.2.a, b or c. The HMO's receipt of the member's grievance or appeal with respect to these timeframes is the date of the member's

confirmation that they wish to proceed with the grievance or appeal.

v. Complete the appeal or grievance resolution process and issue a written resolution decision within the timeframes described under Article IX.D.2.a, b or c. The HMO's receipt of the member's grievance or appeal with respect to these timeframes is the date of the member's confirmation that they wish to proceed with the grievance or appeal.

a) If the HMO does not receive documented consent from the member for the purported authorized representative to act as the member's representative prior to the appeal or grievance resolution decision deadline, send the written decision resolving the grievance or appeal to the member.

b) If the HMO receives documented consent from the member for the purported authorized representative to act as the member's representative prior to the appeal or grievance resolution decision deadline, send the written decision resolving the grievance or appeal to the representative and the member.

c) If contact is made with the member and the member does not wish to proceed with the grievance or appeal, dismiss the grievance or appeal and send a written notice to that effect to the member.

d) If no contact is made with the member within 30 calendar days of receipt of the grievance or appeal from the purported representative, dismiss the grievance or appeal and send a written notice to that effect to the member.

3. Extension of Timeframes

a. The HMO may extend the timeframes from Article IX.D.2 by up to 14 calendar days if any of the following occur:

i. The member requests the extension.

ii. The HMO shows that there is need for additional information and how the delay is in the enrollee's interest. Documentation regarding this determination must be available to the Department upon request.

b. The total timeline for the HMO to finalize a formal grievance or appeal may not exceed 45 days from the date of the receipt.

4. Requirements Following Extension

If the HMO extends the timeframes not at the request of the member, it must complete all of the following:

a. Make reasonable efforts to give the member prompt oral notice of the delay.

b. Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

5. Deemed Exhaustion of Appeals Processes

If the HMO fails to adhere to the notice and timing requirements in this Article, the member is deemed to have exhausted the HMO's appeals process and the member may initiate a State fair hearing.

6. Format of Notices

a. Grievances

The HMO must provide written notice of resolution of a grievance in a format and language that, at a minimum, meet the standards described in Article VI.

b. Appeals

i. For all appeals, the HMO must provide written notice of resolution in a format and language that, at a minimum, meet the standards described in Article VI.

ii. The HMO must issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member. For example, if two adverse benefit determinations are made by the HMO at the same time, the HMO must send out two separate adverse benefit determinations to the member. If the member appeals both adverse benefit determinations, the HMO must issue two separate notices of appeal resolution.

iii. For notice of an expedited resolution, the HMO must also make reasonable efforts to provide oral notice.

7. Content of Notice for Appeal Resolution

a. The HMO must submit to the Department all notice language for approval prior to its use

i. The Department has provided template letters and mandatory language to be included in member letters. The template letters are available at https://www.forwardhealth.wi.gov/WIPortal/content/Managed Care Organization/Contracts/Home.htm.spage .

b. The written notice of the resolution must include the following:

i. The results of the resolution process and the date it was completed.

ii. For appeals not resolved wholly in favor of the member:

a) The right to request a fair hearing with the Division of Hearing and Appeals (DHA), and how to do so.

b) The right to request and receive benefits while the hearing is pending, and how to make the request.

c) That the member maybe held liable for the cost of those benefits if the hearing decision upholds the HMO's adverse benefit determination (Article IX.F.4.).

8. Requirements for State Fair Hearings

a. A member may request a State fair hearing with the DHA only after receiving notice that the HMO is upholding the adverse benefit determination.

b. If the HMO fails to adhere to the notice and timing requirements in Article IX.D.2-5, the member is deemed to have exhausted the HMO's appeals process and the member may initiate a State fair hearing.

c. The member must request a State fair hearing no later than 90 calendar days from the date of receipt of the HMO's notice of resolution. Receipt of notice is presumed within 5 calendar days of the date the notice was mailed.

d. The parties to the State fair hearing include the Department, the HMO, and the member and the member's representative, or the representative of a deceased member's estate.

e. Upon request for information regarding a State fair hearing, the HMO must provide all relevant materials to appropriate parties (including the member, the member's appointed representative (if applicable), the Department, the state's fiscal agent, or DHA) within 5 business days, or sooner if possible. This includes:

i. The HMO denial letter.

ii. All pertinent medical or dental records.

iii. Any other pertinent documentation, as determined by the Department.

f. Per 42 CFR § 431.244, State fair hearing decisions will be reached within the specified timeframes:

i. Standard Resolution

Within 90 calendar days of the date the member filed the appeal with the HMO, not including the number of days the enrollee took to subsequently file for a State fair hearing.

ii. Expedited Resolution

Within three (3) working days from Department receipt of a hearing request for a denial of a service that:

a) Meets the criteria for an expedited appeal process but was not resolved using the HMO's appeal timeframes, or

b) Was resolved wholly or partially adversely to the member using the HMO's expedited appeal timeframes.

E. Expedited Resolution of Appeals

1. General Rule

The HMO must establish and maintain an expedited review process for appeals, when the HMO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

2. Punitive Action

The HMO and its contracted providers must ensure that punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal, including but not limited to a member, authorized representative, or provider.

3. Action following denial of a request for expedited resolution

If the HMO denies a request for expedited resolution of an appeal, it must:

a. Transfer the appeal to the timeframe for standard resolution in accordance with Article IX.D.2.b.

b. Follow the requirements in Article IX.D.4.

F. Continuation of Benefits During the Appeal and State Fair Hearing Process

1. Definition of Timely Filing

As used in this Article:

Timely filing means the member has filed for continuation of benefits on or before the later of the following:

a. Within 10 calendar days of the HMO sending the notice of adverse benefit determination.

b. The intended effective date of the HMO's proposed adverse benefit determination.

2. Continuation of Benefits

The HMO must continue the member's benefits if all of the following occur:

a. The enrollee files the request for an appeal timely in accordance with Article IX.A.3 and Article IX.A.4.

b. The appeal involves the termination, suspension, or reduction of previously authorized services.

c. The services were ordered by an authorized provider.

d. The period covered by the original authorization has not expired.

e. The member or their authorized representative timely files for continuation of benefits. (Per Article IX.A.3.c providers cannot request that benefits be continued).

3. Duration of Continued or Reinstated Benefits

a. If, at the member's request, the HMO continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs:

i. The member withdraws the appeal or request for state fair hearing.

ii. The member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the HMO sends the notice of an adverse resolution to the member's appeal under Article IX D.2.b.

iii. The DHA issues a hearing decision adverse to the member.

4. Member Responsibility for Services Provided

a. If the DHA upholds the HMO's adverse benefit determination, the HMO may pursue reimbursement from the member for the cost of services provided to the member while the HMO appeal and state fair hearing was pending, to the extent that they were provided solely because of the requirements of this Article.

G. Reversed Appeal Resolutions

1. Services not provided while the appeal is pending

a. If the HMO or the DHA reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the HMO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

2. Services provided while the appeal is pending.

a. If the HMO or the DHA reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the HMO must pay for those services.

H. Recordkeeping Requirements

1. Recordkeeping System
   a. The HMO must maintain records of grievances and appeals and must submit them in accordance with requirements detailed in Article IX.H.
   b. The recordkeeping system must include a copy of the original grievance or appeal, the response, and the resolution.
2. Record Information Requirements
   a. Records must distinguish BadgerCare Plus or Medicaid SSI members from commercial members.
      i. If the HMO serves both BadgerCare Plus and Medicaid SSI members, the records must distinguish between the two populations.
   b. The record of each grievance or appeal must contain, at a minimum, all of the following information:
      i. A general description of the reason for the grievance or appeal.
      ii. The date received.
      iii. The date of each review or, if applicable, review meeting.
      iv. Resolution at each level of the appeal or grievance, if applicable.
      v. Date of resolution at each level, if applicable.
      vi. Name of the covered person for whom the grievance or appeal was filed.
3. Record Maintenance
   a. The record must be accurately maintained in a manner accessible to the Department and available upon request to CMS.

I. Monitoring of Grievances and Appeals

1. Department Review of Timely Notification
   a. Per 42 CFR § 438.228(b), the Department will conduct random reviews of the HMO and its providers or subcontractors to ensure that they are adhering to the timely notice requirements detailed in Article IX.
2. Submission of Reports
   a. The HMO must submit quarterly reports to the Department of all grievances and appeals. The HMO must forward all reports under Article IX.I.3 to the Department within 30 days of the end of the quarter in the format specified.

b. Failure on the part of the HMO to submit the quarterly grievance and appeal reports in the required format within five days of the due date may result in any or all actions provided under Article XIV.D.

c. The quarterly grievance and appeal report must include any member grievances and appeals processed by any subcontractors.

3. Member Grievance and Appeal Reporting Form

a. The HMO must submit to the Department each appeal and grievance received in the past quarter using the forms found at https://dhs.wisconsin.gov/library/collection/F-03112 and https://dhs.wisconsin.gov/library/collection/F-03112A .

4. Changes to Appeal and Grievance Reporting Requirements

a. The Department may revise elements to be included in the quarterly appeal report or grievance report and shall give the HMO notice of new elements to include in the report consistent with Article XIV.E.1.b.

J. Information To Providers And Contractors

1. The HMO must distribute to its, providers and subcontractors the Ombuds Brochure on member grievance and appeal rights at the time the contract is entered.

2. When a new Ombuds Brochure is available, the HMO must distribute copies to its providers or subcontractors within three weeks of receipt of the new brochure.

3. The HMO must ensure that its providers and subcontractors have written procedures for describing how members are informed of denied services. The HMO will make copies of the providers' and subcontractors' appeals and grievance procedures available for review upon the Department's request.

X. Quality Assessment and Performance Improvement (QAPI)

A. QAPI Requirements

The HMO Quality Assessment and Performance Improvement (QAPI) program must conform to the requirements of 42 CFR Part 438, Medicaid Managed Care Requirements, Subpart E, Quality Measurement and Improvement. At a minimum, the program must comply with 42 CFR § 438.330 (b) which states that the HMO must:

1. Conduct performance improvement projects designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time in clinical care areas.
2. Collect and submit performance measurement data.
3. Have in effect mechanisms to detect both underutilization and overutilization of services.
4. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

B. QAPI Program

The HMO must have a comprehensive QAPI program that protects, maintains and improves the quality of care provided to BadgerCare Plus and Medicaid SSI program members.

1. The HMO must evaluate the overall effectiveness of its QAPI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its BadgerCare Plus and Medicaid SSI population.
2. The HMO must document all aspects of the QAPI program and make it available to the Department for review upon request. The Department may perform off-site and on-site QAPI audits to ensure that the HMO is in compliance with contract requirements. The review and audit may include:
    a. On-site visits;
    b. Staff and member interviews;
    c. Medical record reviews;
    d. Review of all QAPI procedures, reports, committee activities, including credentialing and re-credentialing activities;
    e. Remediation and corrective action plans;
    f. Peer review process;
    g. Review of the results of the member and provider satisfaction surveys; and
    h. Review of staff and provider qualifications.

3. The HMO must have a written QAPI work plan that is ratified by the board of directors and outlines the scope of activity and the goals, objectives, and time lines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies and results from member satisfaction surveys and performance measures. The QAPI work plan must include:
    a. Annual plan to meet its Pay-for-Performance (P4P) goals and submit NCQA audited P4P results to the Department on time;
    b. Annual Performance Improvement Projects (PIPs) topic selection, implementation, monitoring, and final report submission to the Department and to the Department's External Quality Review Organization (EQRO).
4. The HMO governing body is ultimately accountable to the Department for the quality of care provided to HMO members. Oversight responsibilities of the governing body include, at a minimum:
    a. Approval of the overall QAPI program;
    b. An annual QAPI plan, designating an accountable entity or entities within the
    c. Review of written reports from the designated entity on a periodic basis, which include a description of QAPI activities;
    d. Progress on objectives, and improvements made;
    e. Formal review on an annual basis of a written report on the QAPI program; and
    f. Directing modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the HMO.
5. The QAPI committee must be in an organizational location within the HMO such that it can be responsible for all aspects of the QAPI program. The committee membership must be interdisciplinary and be made up of both providers and administrative staff of the HMO, including:
    a. A variety of health professions (e.g., physical therapy, nursing, etc.)
    b. Qualified professionals specializing in mental health and substance abuse on a consulting basis.
    c. Qualified professionals specializing in dental care on a consulting basis when an issue related to this area arises.
    d. A variety of medical disciplines (e.g., medicine, surgery, radiology, etc.)
    e. An individual with specialized knowledge and experience with persons with disabilities.
    f. HMO management or governing body.

6. Members of the HMO must be able to contribute input to the QAPI Committee. The HMO must have a system to receive member input on quality improvement, document the input received, document the HMO's response to the input, including a description of any changes or studies it implemented as the result of the input and document feedback to members in response to input received. The HMO response must be timely.

7. The committee must meet on a regular basis, but not less frequently than quarterly. The activities of the QAPI Committee must be documented in the form of minutes and reports. The QAPI Committee must be accountable to the governing body. Documentation of Committee minutes and activities must be available to the Department upon request.

8. QAPI activities of the HMO's providers and subcontractors, if separate from HMO QAPI activities, must be integrated into the overall HMO/QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter data, are incorporated into all provider and subcontractor contracts and employment agreements. The HMO QAPI program shall provide feedback to the providers and subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QAPI efforts. Other management activities (utilization management, risk management, customer service, grievances and appeals, etc.) must be integrated with QAPI program. Physicians and other health care practitioners and institutional providers must actively cooperate and participate in the HMO's quality activities.

   The HMO remains accountable for all QAPI functions, even if certain functions are delegated to other entities. If the HMO delegates any activities to contractors, the conditions listed in Article XIV.A "Delegations of Authority" must be met.

9. There is evidence that HMO management representative and providers participate in the development and implementation of the QAPI plan of the HMO. This provision shall not be construed to require that HMO management representatives and providers participate in every committee or subcommittee of the QAPI program.

10. The HMO must designate a senior executive to be responsible for the operation and success of the QAPI program. If this individual is not the HMO Medical Director, the Medical Director must have substantial involvement in the QAPI program. The designated individual shall be accountable for the QAPI activities of the HMO's own providers, as well as the HMO's subcontracted providers.

11. The qualifications, staffing level and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of important aspects of care and services, utilization monitoring, facilitating appropriate use of preventive services, monitoring provider performance, provider credentialing, involving members in QAPI initiatives and conducting performance improvement projects.

Written documentation listing the staffing resources that are directly under the organizational control of the person who is responsible for QAPI (including total FTEs, percent of time dedicated to QAPI, background and experience, and role) must be available to the Department upon request.

C. Monitoring and Evaluation

1. The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Important aspects of care (i.e., acute, chronic conditions, high volume, high-risk preventive care and services) must be studied and prioritized for performance improvement and updating guidelines. Standardized quality indicators must be used to assess improvement, ensure achievement of minimum performance levels, monitor adherence to guidelines, and identify patterns of over and underutilization. The Department will use the latest available HEDIS specifications for measurement year (MY) and measures will be defined in annual HMO Quality Guide.
2. The HMO must use appropriate clinicians to evaluate clinical data and serve on multi-disciplinary teams tasked with analyzing and addressing data issues.
3. HMOs must mandate provider identification of provider preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR s. 434.6(a)(12) and 42 CFR s. 447.26. HMOs must report all identified provider-preventable conditions through its encounter data.

   Health care acquired conditions for non-payment include hospital-acquired conditions as identified by Medicaid other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) with total knee replacement surgery in pediatric and obstetric patients.

   Other provider-preventable conditions for non-payment are identified as:

   a. Wrong surgical or other invasive procedure performed on a patient;
   b. Surgical or other invasive procedure performed on the wrong body part;
   c. Surgical or other invasive procedure performed on the wrong patient.
4. The HMO must also monitor and evaluate care and services in certain priority clinical and non-clinical areas. Non-clinical areas of monitoring and evaluation must include member satisfaction.
5. The HMO must make documentation available to the Department upon request regarding quality improvement and assessment studies on plan performance, which relate to the enrolled population. See reporting requirements in "Performance Improvement Priority Areas and Projects."
6. The HMO must develop or adopt best practice guidelines in accordance with 42 CFR 438.236 (b)that meet the following requirements:

a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field, including the Advisory Committee on Immunization Practices (ACIP), U.S. Preventative Services Task Force published recommendations, and Bright Futures prevention and health promotion for infants, children, adolescents, and their families.

b. Consider the needs of the HMO members.

c. Are adopted in consultation with network providers.

d. Are reviewed and updated periodically as appropriate.

The HMO must disseminate the guidelines to all providers and, upon request, to members and potential members.

The HMO's guidelines must be available to their provider networks via the HMO Provider Manual and the HMO's website.

Decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply must be consistent with the guidelines.

7. Cooperation with Monitoring and Evaluation

a. The State will arrange for an independent, external review of the quality of services delivered under each HMO's contract with the State. The review will be conducted for each HMO contractor on an annual basis in accordance with Federal requirements described in 42 CFR Part 438, Subpart E, Quality Measurement and Improvement; External Quality Review. The entity which will provide the annual external quality reviews shall not be a part of the State government, HMOs, or an association of any HMOs.

b. The HMO must assist the Department and the external quality review organization (EQRO) in identifying and collecting information required to carry out on-site or off-site reviews and interviews with HMO staff, providers, and members.

c. In the event that a review by the Department or the EQRO results in findings that the Department determines are unsatisfactory, the HMO must cooperate in:

i. further investigation or remediation;

ii. Corrective action within a time frame to be specified in the notice;

iii. Additional review by the Department or by the HMO to determine the extent and causes of the noted problems;

iv. Action as provided under Article XIV.D; and

v. Contract termination

D. Health Promotion and Disease Prevention Services

1. The HMO must identify at-risk populations for preventive services and develop strategies for reaching BadgerCare Plus and/or Medicaid SSI members included in this population. Public health resources can be used to enhance the HMO's health promotion and preventive care programs.
2. The HMO must have mechanisms for facilitating appropriate use of preventive services and educating members on health promotion. At a minimum, an effective health promotion and prevention program includes HMO outreach to and education of its members, tracking preventive services, practice guidelines for preventive services, yearly measurement of performance in the delivery of such services, and communication of this information to providers and members.
3. The Department encourages the HMO to develop and implement disease management programs and systems to enhance quality of care for individuals identified as having chronic or special health care needs known to be responsive to application of clinical practice guidelines and other techniques.
4. The HMO agrees to implement systems to independently identify members with special health care needs to utilize data generated by the systems or data that may be provided by the Department to facilitate outreach, assessment and care for individuals with special health care needs.

E. Provider Selection (Credentialing) and Periodic Evaluation (Recredentialing)

1. The HMO must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides services to the HMO's members, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under Medicaid. The HMO's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.
2. The HMO must complete the credentialing process within 90 days after receipt of all necessary documents required by providers.
3. The HMO must submit a quarterly report to its Managed Care Analyst that includes the following information:
    a. Date a provider's application to join the HMO network is received;
    b. Date the provider supplied all necessary documents to the HMO;
    c. Date the provider was credentialed by the HMO.
4. The HMO cannot credential or recredential individual providers employed by a Narcotic Treatment Service (NTS) certified under Wis. Admin. Code s. DHS 75.15. These providers must be enrolled in the Wisconsin Medicaid Program to be reimbursed for services provided to Wisconsin Medicaid members per Wis. Admin. Code s. DHS 105. The HMO can rely upon NTS providers' status as

Medicaid-enrolled instead of credentialing at the provider level. HMOs may have credentialing and recredentialing policies for facilities certified under Wis. Admin. Code s. DHS 75.15.

The HMO may not employ or contract with providers debarred or excluded in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

5. The HMO must periodically monitor (no less than every three years) the provider's documented qualifications to ensure that the provider still meets the HMO's specific professional requirements.

6. The HMO must also have a mechanism for considering the provider's performance. The recredentialing method must include updating all the information (except medical education) utilized in the initial credentialing process. Performance evaluation must include information from the QAPI system, reviewing member complaints, and the utilization management system.

7. The selection process must not discriminate against providers such as those serving high-risk populations, or specialize in conditions that require costly treatment. The HMO must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners in the HMO's network.

   If the HMO declines to include groups of providers in its network, the HMO must give the affected providers written notice of the reason for its decision.

8. If the HMO delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.

9. The HMO must have a formal process of peer review of care delivered by providers and active participation of the HMO's contracted providers in the peer review process. This process may include internal medical audits, medical evaluation studies, peer review committees, evaluation of outcomes of care, and systems for correcting deficiencies. The HMO must supply documentation of its peer review process upon request.

10. The HMO must have written policies that allow it to suspend or terminate any provider. The HMO must have a written appeal process available to providers that conforms to the requirements of the HealthCare Quality Improvement Act of 1986 (42 USC 11101 etc. Seq.).

    a. The Department is responsible for monitoring and terminating providers from the Medicaid program for reasons listed under Wisconsin Admin. Code § DHS 106.06 as well as the reasons listed below in Article X.E.10.b and d. The Department will inform the HMO when a provider is terminated from the Wisconsin Medicaid program for cause and the HMO must terminate that provider from its network.

b. The HMO must terminate a provider for cause if the HMO learns of the following provider misconduct:

i. Criminal Conviction. The provider or any person with a 5 percent or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted (as defined in 42 CFR § 1001.2) of a Federal or State criminal offense related to that person's involvement with Medicare, Medicaid or CHIP. This requirement applies unless the HMO receives permission from the Department to not terminate the provider as identified in X.E.10.c.

ii. Failure to Comply with Screening Requirements. Where any person with a 5 percent or more direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR § 455.416(a).

iii. Failure to Submit Fingerprints. Where the provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Department within 30 days of a CMS or the Department request. This requirement applies unless the HMO receives permission from the Department to not terminate the provider as identified in X.E.10.c.

iv. Failure to Submit Timely and Accurate Information. The provider or a person with an ownership control interest, an agent, or managing employee of the provider fails to submit timely and accurate information. This requirement applies unless the HMO receives permission from the Department to not terminate the provider as identify X.E.10.c.

v. Onsite Review. The provider fails to permit access to provider locations for any site visit. This requirement applies unless the HMO receives permission from the Department to not terminate the provider as identified in X.E.10.c.

vi. Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment. The provider's enrollment has been terminated or revoked "for cause" by Medicare or another state's Medicaid program.

vii. Provider Conduct. The provider or any owner, or managing employee, of the provider is excluded from the Medicare or Medicaid programs.

c. The HMO must terminate a provider due to a reason in Article X.E.10.b.i and iii-v, unless the HMO obtains approval from the Department to not terminate the provider. This process is not available for an HMO when a

provider must be terminated due to a reason in Article X.E.10.b.ii or vi. The HMO must contact its Managed Care Analyst to request permission to not terminate the provider. The Managed Care Analyst shall alert the DHS OIG of the request. The DHS OIG will determine whether the termination can be waived.

d. The HMO may terminate a provider for cause in all the following circumstances:

i. Abuse of Billing Privileges. The provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service including when the beneficiary is deceased, where the directive physician or the beneficiary is not in the state when the services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

ii. Billing with Suspended License. Billing for services furnished while the provider's license is in a state of suspension.

iii. Improper Prescribing Practices. The HMO determines that a provider has a pattern of practice of prescribing drugs that is abusive, as defined in 42 C.F.R.§ 455.2, or represents a threat to the health and safety of members.

iv. Misuse of Billing Number. The provider knowingly sells to or allows another individual or entity to use its billing number, other than a valid reassignment of benefits.

v. Noncompliance with Licensure Standards. When the provider has been subject to an adverse licensure action resulting in the loss of license. This does not include license expiration.

vi. Prescribing Authority. The provider's Drug Enforcement Administration Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any state in which the provider practices suspends or revokes the provider's ability to prescribe drugs.

11. The HMO must notify DHS OIG and the Managed Care Analyst when it terminates a provider for cause. See Article XII.L.8 for reporting requirements. The HMO must report to other entities as required by law (42 USC 11101 et. Seq.).

12. The HMO must determine and verify at specified intervals that:

a. Each provider, other than an individual practitioner is licensed to operate in the state, if licensure is required, and in compliance with any other applicable state or federal requirements; and

b. The HMO verifies if the provider claims accreditation, or is determined by the HMO to meet standards established by the HMO itself.

13. These standards do not apply to:

a. Providers who practice only under the direct supervision of a physician or other provider, and

b. Hospital-based providers such as emergency room physicians, anesthesiologists, and other providers who provide services only incident to hospital services.

These exceptions do not apply if the provider contracts independently with the HMO.

F. Member Feedback on Quality Improvement

1. The HMO must have a process to maintain a relationship with its members that promotes two way communications and contributes to quality of care and service. The HMO must treat members with respect and dignity.

2. The HMO must demonstrate monitoring of member satisfaction as an input to improving quality of care and service.

3. Member Advisory Council

By January 1, 2025, the HMO must create and support a Member Advisory Council to advise the HMO on its policies and operations, how it is meeting the needs of members and how operations and outcomes may be improved. The Council shall in addition be a vehicle for members to participate in the HMO's quality management program under Article X.

a. The Council shall include at least a reasonably representative sample of members from the HMOs culturally diverse membership, or other individuals representing those members covered under this contract.

b. The Member Advisory Council shall meet at least twice per year.

c. The HMO shall maintain documentation of the Council's meetings and actions, such as attendance records, minutes, votes, recommendations, and HMO responses, to document the types and level of the Council's participation in the Quality Management program and other aspects of HMO oversight. It shall make this documentation available to the Department upon request.

4. The HMO is encouraged to find additional ways to involve members in quality improvement initiatives and in soliciting member feedback in quality of care and services the HMO provides. Other ways to bring members into the HMO's efforts to improve the health care delivery system include but are not limited to focus groups, member participation on the governing board, the QAPI committees or other committees, or task forces related to evaluating services. All efforts to solicit feedback from members must be approved by the Department.

5. Consumer Member Feedback on Quality Improvement

The HMO may reference the annual HMO Quality Guide for additional details about the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program and surveys.

a. CAHPS Survey Requirement

Annually, the HMO must administer HEDIS CAHPS surveys through an NCQA-certified HEDIS CAHPS survey vendor, as specified in the Quality Guide.

b. CAHPS Survey Results Submission

i. The HMO must submit CAHPS Surveys results annually during the June submission period to AHRQ's survey database. The HMO should visit the CAHPS survey database website for more information: https://www.ahrq.gov/cahps/cahps-database/hp-database/participate.html.

ii. The HMO must agree that the AHRQ database information will be shared with CMS for inclusion in Wisconsin's aggregate Child and Adult Core Set scores.

iii. The HMO must notify the Department in writing at least ten business days before the end of the submission period, if the HMO cannot timely submit the results.

a) The notification must include a plan for how the HMO will complete a timely submission the following year.

b) The Department will share the HMO's notification with CMS as part of the mandatory measure exemption request process.

G. Medical Records

1. Per 42 CFR § 438.208(b)(5), the HMO must have written policies and procedures for participating provider health records content and documentation that have been communicated to providers and a process for evaluating its providers' medical records based on the HMO's policies. The HMO should encourage use of Certified Electronic Health Record Technology (CEHRT) by clinicians for documenting and sharing clinical information as well as use of the Office of National Coordinator's (ONC) Interoperability Standards Advisory best available standards to share information electronically across the continuum of care. These policies must also address patient confidentiality, data organization and completeness, tracking, and important aspects of documentation such as accuracy, legibility, and safeguards against loss, destruction, or unauthorized use. The HMO must also have confidentiality policies and procedures that are applicable to administrative functions that are concerned with confidential patient information. Those policies must include information with respect to disclosure of member-

identifiable medical record and/or enrollment information and specifically provide:

a. That members may review and obtain copies of medical records information that pertains to them.

b. That members have the right to request and receive a copy of their medical records, and to request that they be amended or corrected.

c. That policies above must be made available to members upon request.

2. Patient medical records must be maintained in an organized manner (by the HMO, and/or by the HMO's subcontractors) that permits effective patient care, reflect all aspects of patient care and be readily available for patient encounters, administrative purposes, and Department review.

3. Because the HMO is considered a contractor of the state and therefore (only for the limited purpose of obtaining medical records of its members) entitled to obtain medical records according to Wis. Adm. Code, DHS 104.01(3), the Department requires BadgerCare Plus and/or Medicaid SSI enrolled providers to release relevant records to the HMO to assist in compliance with this section. The HMO that has not specifically addressed photocopying expenses in their provider contracts or other arrangements, are liable for charges for copying records only to the extent that the Department would reimburse on a FFS basis.

4. The HMO must have written confidentiality policies and procedures in regard to individually-identifiable patient information. Policies and procedures must be communicated to HMO staff, members, and providers. The transfer of medical records to out-of-plan providers or other agencies not affiliated with the HMO(except for the Department) are contingent upon the receipt by the HMO of written authorization to release such records signed by the member or, in the case of a minor, by the member's parent, guardian or authorized representative.

5. The HMO must have written quality standards and performance goals for participating provider medical record documentation and be able to demonstrate, upon request of the Department, that the standards and goals have been communicated to providers. The HMO must actively monitor compliance with established standards and provide documentation of monitoring for compliance with the standards and goals upon request of the Department.

6. Health records must be readily available for HMO-wide Quality Assessment and Performance Improvement (QAPI) and Utilization Management (UM) activities.

7. The HMO must have adequate policies in regard to transfer of medical records to ensure continuity of care. When a member switches HMOs or providers, it is the responsibility of the HMO to facilitate and/or broker the transfer of medical records between a member's previous and current providers upon provider request.

The HMO policy regarding transfer of medical records to ensure continuity of care policies must include:

a. When members are treated by more than one provider.

b. The provider-to-provider transfer may be facilitated and/or brokered between HMOs on behalf of providers.

c. How provider requests for records are received and processed.

d. The process for transmitting and receiving provider records to both other HMOs and providers.

e. This may also include transfer to local health departments subject to the receipt of a signed authorization form as specified in Article X.G.4.(with the exception of immunization status information which does not require member authorization.

Direct provider-to-provider exchanges are permitted if both providers are in agreement. It is then the responsibility of the agreeing providers to administrate the member medical record transfer, including HMO notification of the transfer.

The Department requires HMO participation in Wisconsin Statewide Health Information Network (WISHIN), the state-designated entity for health information exchange, to facilitate exchange of medical records between health plans and providers. The Department considers HMOs compliant with the medical record requirements in Article X.G.7. by participating in WISHIN. All HMOs must participate in WISHIN, specifically including subscribing to the WISHIN Pulse community health record, submitting a member roster as specified by WISHIN, and subscribing to the WISHIN Patient Activity Report (PAR) or other event-notification service offered by or through WISHIN. SSI HMOs must submit member care plans as detailed in Article III.C.3.

8. Requests for completion of residual functional capacity evaluation forms and other impairment assessments, such as queries as to the presence of a listed impairment, must be provided within 10 business days of the request (at the discretion of the individual provider and subject to the provider's medical opinion of its appropriateness) and according to the other requirements listed above.

9. Minimum medical record documentation per chart entry or encounter must conform to the Wis. Adm. Code, Chapter DHS 106.02(9)(b) medical record content.

H. Utilization Management (UM)

1. The HMO and its subcontractors must have documented policies and procedures for all UM activities that involve determining medical necessity and processing requests for initial and continuing authorization of services (42 CFR § 438.210(b)(1)).

The HMO must communicate to providers the criteria used to determine medical necessity and appropriateness. The criteria for determining medical necessity may not be more stringent than what is used in the State Medicaid program, as set forth in Wis. Adm. Code § DHS 101.03(96m), including any quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other published State policy and procedures. Documentation of denial of services must be available to the Department upon request.

Pursuant to 42 CFR § 438.210(b)(2), the HMO must:

a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

b. Consult with the requesting provider for medical services when appropriate.

When reviewing requests for authorization of services, qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s). The HMO may not deny coverage, penalize providers, or give incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or results in the under-utilization of services.

2. If the HMO delegates any part of the UM program to a third party, the delegation must meet the requirements in this Contract.

3. If the HMO utilizes telephone triage, nurse lines or other demand management systems, the HMO must document review and approval of qualification criteria of staff and of clinical protocols or guidelines used in the system. The system's performance will be evaluated annually in terms of clinical appropriateness.

4. The HMO's policies must specify time frames for responding to requests for initial and continued service authorizations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. In addition, the HMO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (interrater reliability).

   a. Within the time frames specified, the HMO must give the member and the requesting provider written notice of:

      i. The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision.

      ii. The member's grievance and appeal rights as detailed in this Contract.

      iii. Denial of payment, at the time of any action affecting the claim.

The notice(s) must adhere to the timing and content requirements as detailed in this Contract.

b. Authorization decisions must be made within the following time frames and in all cases as expeditiously as the member's condition requires:

i. Within 14 days of the receipt of the request, or

ii. Within 72 hours if the provider indicates, or the HMO determines, that following the ordinary time frame could jeopardize the member's health or ability to attain, maintain, or regain maximum function.

One extension of up to 14 days may be allowed if the member requests it or if the HMO justifies the need for more information.

On the date that the time frames expire, the HMO gives notice that service authorization decisions are not reached. Untimely service authorizations constitute a denial and are thus adverse benefit determinations.

5. Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence, current standards of medical practice, or a consensus of relevant health care professionals, and are regularly updated. This includes HMO utilization management practice for emergency and post-stabilization services.

6. The HMO oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

7. Postpartum discharge policy for mothers and infants must be based on medical necessity determinations. This policy must include all follow-up tests and treatments consistent with currently accepted medical practice and applicable federal law. The policy must allow at least a 48-hour hospital stay for normal spontaneous vaginal delivery, and 96 hours for a cesarean section delivery, unless a shorter stay is agreed to by both the physician and the member. The HMO may not deny coverage, penalize providers, or give incentives or payments to providers or members. Post hospitalization follow-up care must be based on the medical needs and circumstances of the mother and infant. The Department may request documentation demonstrating compliance with this requirement.

I. Dental Services Quality Improvement (Applies to capitated service areas)

The HMO QAPI Committee and QAPI coordinator will review subcontracted dental benefit administrator programs quarterly to ensure dental care standards, access, and availability standards are monitored, and deficiencies addressed.

J. Accreditation

1. BadgerCare Plus and Medicaid SSI HMOs must be accredited by the National Committee for Quality Assurance (NCQA) in their Medicaid lines of business and

have the NCQA Multicultural Healthcare Distinction or Health Equity Accreditation for the entire term of this contract.

2. HMOs must report to DHSDMSHMO@dhs.wisconsin.gov within 10 days if they lose any NCQA accreditation.

3. BadgerCare Plus and Medicaid SSI HMOs that do not meet the requirements outlined in Article X.J.1 for the entire term of this contract are subject to action as provided under Article XIV.D and termination of the contract, as defined in Article XIV.E. The HMO must post that it does not meet the Department's NCQA Accreditation requirements on its public facing website. The Department will also post when an HMO does not meet NCQA Accreditation requirements on the Department's public facing website.

4. Per 42 CFR § 438.332, the HMO must report to the Department if it is accredited by a private independent accrediting agency (AAAHC, NCQA, and URAC). HMOs that have received accreditation by a private independent accrediting agency must provide the state with a copy of its most recent accreditation review, as part of the HMO certification application process. This copy must contain:

   a. HMO accreditation status;

   b. Name of the CMS-recognized accreditation entity;

   c. The effective start and end dates of accreditation;

   d. The lines of business / specific member population for which the accreditation was achieved (e.g., commercial and/or Medicaid, etc.);

   e. The specific accreditation status of the HMO, including survey type and level (as applicable); and

   f. Accreditation results from the accreditation entity, including recommended actions or improvements, correction action plans and summaries of findings.

   The Department will post the accreditation status of all HMOs on its website including the accreditation entity, accreditation program, and the accreditation level. The Department will update this accreditation status annually.

K. Performance Improvement Priority Areas and Projects

Per 42 CFR § 438.330, the HMO must have an ongoing program of performance improvement projects (PIPs) to address the specific needs of it's members . The PIPs must address one clinical and one non-clinical performance areas that are expected to have a favorable effect on health outcomes and member satisfaction.

The Department will permit the development of collaborative relationships among the HMOs, local health departments, community-based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services in priority areas. The Measurement Year (MY) starts on January 1 and ends on December 31 of the applicable contract year.

1. All HMOs are required to submit two PIPs each year, one clinical and one non-clinical.
    a. HMOs that serve only the BadgerCare Plus population are required to submit two PIP proposals on two different topics.
    b. HMOs that serve both BadgerCare Plus and SSI populations are required to submit two PIPs that satisfy the following requirements:
        i. one PIP for the BadgerCare Plus population, and one PIP for the SSI population, or
        ii. One PIP for either the BadgerCare Plus **or** the SSI population and a second PIP that applies to both populations with data reported separately for each population
2. The State has the authority to select a particular topic for the PIPs. Additionally, CMS, in consultation with the State and stakeholders, may specify performance measures and topics for performance improvement projects. HMOs that fail to meet their Pay-for-Performance (P4P) or other performance measure goals are encouraged to select those areas as PIP topics, in consultation with DHS. All HMOs are required to develop and implement PIPs with a goal to identify and reduce disparities. Additional details regarding measure selection and PIP components are included in the HMO Quality Guide.
    a. If an HMO met all the performance goals in the prior calendar year, it can choose other study topics relevant to its population. The HMO may propose alternative performance improvement topics during the preliminary topic selection summary process; approval is at the Department's discretion.
3. Health plans should submit PIPs which use objective quality indicators to measure the effectiveness of the interventions. Per 42 CFR § 438.330(d)(2), HMOs should submit PIPs which include the planning and initiation of activities for sustaining or continuing PIP improvement over time. Plans should not submit baseline studies which are designed to evaluate whether a problem exists.
4. The HMO must submit a preliminary PIP proposal summary that meets the PIP guidelines issued by the EQRO as described in the HMO Quality Guide for the applicable MY, and state the proposed topic, the study question/project aims with a measurable goal, study indicators, study population, sampling methods if applicable, data collection procedures, improvement strategies, sustained improvement plan, and the prospective data analysis plan. The preliminary PIP proposal must be submitted to the Department by email to DHSDMSHMO@dhs.wisconsin.gov and the EQRO by the first business Day of November.
    a. The Department and the EQRO will review the preliminary PIP proposals and meet with the HMO to give feedback to the HMO on the PIP proposal. The Department will determine if the PIP proposals are

approved. Suggestions arising from the EQRO and HMO dialogue should be given consideration as the HMO proceeds with the PIP implementation.

b. If the proposal is rejected by the Department, the HMO must re-submit a new or revised PIP proposal within the timeframe specified by the Department. Re-submission will be reviewed again by the Department and the EQRO.

5. After receiving the State's approval, the HMO may communicate with the EQRO throughout the implementation of the project if questions arise.

6. The HMO should perform ongoing monitoring of the project throughout the year to evaluate the effectiveness of its interventions.

7. After implementing the PIP over one calendar year, the HMO must submit to the Department by email to DHSDMSHMO@dhs.wisconsin.gov and the EQRO their completed PIP reports utilizing the format provided by the Department by the first business day of July.

8. The EQRO will schedule a conference call with the HMO to review the EQRO feedback on the final PIP report.

9. Per 438.330(e)(1), if an HMO submits a multi-year PIP, it must submit annual proposals and final reports, which the EQRO will review and report on results trended over multiple years.

10. The Department will consider that the plan failed to comply with PIP requirements if:

    a. The plan submits a final PIP on a topic that was not approved by the Department and the EQRO.

    b. The EQRO finds that the PIP does not meet federal requirements:

        i. The PIP does not define a measurable goal using clear and objective quality indicators.

        ii. The PIP does not include the implementation of systemic interventions to improve quality of care.

        iii. The PIP does not evaluate systematically the effectiveness of the interventions.

        iv. The PIP does not reflect the adoption of continuous cycles of improvement through which the HMO can sustain quality improvement.

    c. The HMO does not submit the final PIP by its due date of the first business day of July of the year in which it's due. The Department may grant extensions of this deadline, if requested prior to the due date.

    d. Failure to comply with PIP requirements may result in action provided under Article XIV.D.

L. Additional Services for Pregnant Members

1. Tobacco Cessation

   The HMO shall encourage providers to screen every pregnant member for tobacco use during their initial prenatal visit, regardless of when this visit occurs. This information should be documented in the medical record, the member should be advised to quit and a referral made to a smoking cessation program, e.g., First Breath, Wisconsin Quit Line or other appropriate cessation assistance program. The member's cessation efforts should be assessed at every prenatal visit and at the post-partum visit.

2. Mental Health and Substance Abuse Screening

   Wisconsin Medicaid and BadgerCare Plus covers a separate mental health and substance abuse screening benefit for all pregnant members (see ForwardHealth online handbook Topic #4442). The purpose of this benefit is to identify and assist pregnant members at risk for mental health or substance abuse problems during pregnancy. The benefit has two components:

   a. Screening for mental health (e.g., depression and/or trauma) and/or substance abuse problems.

   b. Brief preventive mental health counseling and/or substance abuse intervention for pregnant members identified as being at risk for experiencing mental health or substance abuse disorders.

3. Vaccines for Pregnant and Postpartum Members

   The HMO shall encourage providers to screen every pregnant and postpartum member to determine whether they needs an influenza or Tdap vaccine and to strongly recommend all vaccines needed.

M. Improving Birth Outcomes

1. HMOs must meet the following requirements with regard to members at high risk of a poor birth outcome. For this purpose, these members include:

   a. Members with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death)

   b. Members with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension)

   c. Members under 18 years of age

2. The BadgerCare Plus HMO must implement the OB Medical Home initiative as detailed in Article IV.H of the contract, in the following counties: Dane, Rock, Milwaukee, Kenosha, Racine, Ozaukee, Washington, Waukesha. Medicaid SSI HMOs may choose to enroll Medicaid SSI pregnant members in participating clinics in these counties.

3. The HMO's Medical Director, or Department-approved representative, must participate in DHS' sponsored quality efforts during the period of the contract (e.g., best practices seminars).

4. The HMO must have a plan in place to identify members at high risk of a poor birth outcome. The plan must specifically address options for identifying high-risk members previously unknown to the BadgerCare Plus and Medicaid SSI program, (e.g., use of pregnancy notification form). The HMO may use the Department's Birth Outcome Registry Network (BORN) to identify members who are at risk of having a poor birth outcome or had a previous poor birth outcome.

5. The HMO must ensure that these members receive early and continuous care throughout the pregnancy and post-partum period. The HMO must ensure that appropriate referrals and timely follow-up are made for all identified needs (e.g. nutrition counseling, smoking cessation, or behavioral health).

6. The HMO must have strategies in place for post-partum care, including depression screening and family planning services. Contraception options should be explored and the initial appointment for post-partum care should be made prior to discharge.

7. The HMO must have a plan in place for interconception care to ensure that the member is healthy prior to a subsequent pregnancy. At a minimum, the plan must address the needs of high-risk members with chronic conditions such as diabetes and hypertension.

N. HMO Pay-for-Performance (P4P) program and Core Reporting:

1. Goal

   The HMO P4P program and Core Reporting aim to improve the quality of care received by BadgerCare Plus and Medicaid SSI members, related to preventive, chronic, mental health and substance abuse, birth-related and other healthcare services.

2. Geographic Coverage

   The HMO P4P program and Core Reporting are applicable across the State of Wisconsin, i.e., all Medicaid HMO rate regions.

3. Timeframe

   The Measurement Year (MY) starts on January 1 and ends on December 31 of the applicable contract year.

4. Benefit Plans in Scope

   BadgerCare (and Medicaid SSI Plan, as described in the "HMO Quality Guide" (the Quality Guide) for the MY.

5. HMO P4P Withhold

The Department will withhold 2.5 percent of each HMO's monthly capitation payments (including administrative payments) for the P4P program, as defined in the Quality Guide. The withhold, HEDIS measures, PIP requirements, and P4P methodology are defined in the Quality Guide for HEDIS P4P. HMOs will be able to earn this withhold back by meeting quality performance targets for a specific set of measures, as described in the Quality Guide. Depending on the relative performance of each HMO, highest-performing HMOs on P4P HEDIS measures may be eligible for a bonus of up to 2.5 percent of their capitation payments in addition to earning back their withhold. Please see the Quality Guide for details.

6. HMO P4P Measures and Targets

   The program will use HEDIS measures as finalized by the Department and as described in the Quality Guide. Targets for each measure will be defined by the Department using NCQA's Quality Compass results as defined in the Quality Guide. This provision includes both public and private contractors and does not require participation in any intergovernmental transfer agreements. Further details of the methodology for setting targets, including definitions, are specified in the Quality Guide.

7. Quality Reporting

   Quality Reporting focuses on providing the Department healthcare quality data for a broad set of conditions and related measures. It does not include a withhold, though requires HMOs to report data on specific quality measures listed in the Quality Guide. If HMOs do not report this data to the Department, they could be subject to a $10,000 penalty per measure not reported.

8. P4P and Quality Reporting Data Submission

   HMOs will be asked to submit their HEDIS data and results, after authentication by their HEDIS auditor and NCQA's IDSS, to the Department by dates listed in the Quality Guide.

9. P4P Performance Measurement Methodology

   Detailed methodology used to measure the performance of each HMO is described in the Quality Guide.

O. Potentially Preventable Readmissions (PPR)

1. Per 42 CFR 438.6(b)(2), contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound. The 105% limitation will be applicable cumulatively across various incentives such as P4P and PPRs.

2. BadgerCare Plus HMOs may be eligible for an incentive based on the reduction of excess readmission for members. This incentive supports reduction of

avoidable non-value added care as outlined in the Wisconsin Medicaid Managed Care Quality Strategy, Section 4.a.ii. HMOs must work with their public and private hospital and non-hospital providers (e.g., community based providers, home health providers, among others) to reduce their PPR rates.

3. The Measurement Year starts on January 1,and end on December 31, of the applicable contract year.
4. The Department will calculate the baselines PPR rates for each BadgerCare Plus HMO and set PPR target rates applicable to each HMO, as specified in the Quality Guide.
5. The Department will calculate and share PPR results and associated information with HMOs.
6. HMOs may keep a maximum of 15% of incentive earned for administrative expenses; the rest must be shared with providers.
7. An HMO may dispute the Department's PPR calculations by sending a written communication, with supporting documentation, to the DHSDMSBRS@dhs.wisconsin.gov mailbox no later than 30 days after receiving the PPR calculations.

P. Public Reporting

The Department will publicly report various quality and other performance metrics for HMOs via a website and other media, per 42 CFR § 438.608 Requirement 42 CFR § 438.340.

Q. Health Disparity Plan

Per 42 CFR § 438.340(b)(6) the State is required to create and implement a "plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The Department must identify this demographic information for each Medicaid member and provide available information to the HMO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability."

As part of the Performance Improvement Projects, the HMO has developed a health disparities reduction plan and must continue to make progress in identifying and addressing health disparities within its membership as part of its ongoing QAPI workplan.

XI. HMO Administration

A. Certificate of Authority

The HMO shall retain at all times during the period of this Contract a valid Certificate of Authority to write disability insurance issued by the State of Wisconsin Office of the Commissioner of Insurance.

B. Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and rules and regulations that are in effect when the Contract is signed, or that come into effect during the term of the Contract. This includes, but is not limited to, Title XIX of the Social Security Act, Title XXI, SCHIP, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, The Rehabilitation Act of 1973, The American with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and Title 42 of the CFR.

Changes to BadgerCare Plus and/or Medicaid SSI covered services mandated by federal or state law subsequent to the signing of this Contract will not affect the Contract services for the term of this Contract, unless agreed to by mutual consent, or unless the change is necessary to continue to receive federal funds or due to action of a court of law.

The Department may incorporate into the Contract any change in covered services mandated by federal or state law effective the date the law goes into effect, if it adjusts the capitation rate accordingly. The Department will give the HMO at least 30 days' notice before the intended effective date of any such change that reflects service increases, and the HMO may elect to accept or reject the service increases for the remainder of that contract year.

The Department will give the HMO 60 days' notice of any such change that reflects service decreases, with a right of the HMO to dispute the amount of the decrease within 60 days. The HMO has the right to accept or reject service decreases for the remainder of the Contract year. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in the state budget.

Federal funds must not be used for lobbying. Specifically, and as applicable, the Contractor agrees to abide by the Copeland-Anti Kickback Act, the Davis-Bacon Act, federal contract work hours and safety standards requirements, the federal Clean Air Act and the federal Water Pollution Control Act. The HMO is not endorsed by the federal or state government, CMS, or similar entity.

C. Organizational Responsibilities and Duties

1. Ineligible Organizations

Upon obtaining information or receiving information from the Department or from another verifiable source, the HMO must exclude from participation in the HMO all organizations that could be included in any of the categories defined in Article XI.C.1.a.(references to the Act in this section refer to the Social Security Act).

a. Entities that could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has direct or indirect ownerships or control interest of 5% or more in the entity has:

   i. Been convicted of the following crimes:

      a) Program related crimes (i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid). (Section 1128(a)(1) of the Act.)

      b) Patient abuse (i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care). (Section 1128(a)(2) of the Act.)

      c) Fraud (i.e., a state or federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government). (Section 1128(b)(1) of the Act.)

      d) Obstruction of an investigation (i.e., conviction under state or federal law of interference or obstruction of any investigation into any criminal offense described in Subsections a), b), or c). (Section 1128(b)(2) of the Act.)

      e) Offenses relating to controlled substances (i.e., conviction of a state or federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance. (Section 1128(b)(3) of the Act.)

   ii. Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person described in Article XI.C.1.a. above from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

   iii. Been assessed a civil monetary penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A

authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (Section 1128(b)(8)(B)(ii) of the Act.)

b. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in Article XI.C.1.a. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

i. The administration, management, or provision of medical services.

ii. The establishment of policies pertaining to the administration, management, or provision of medical services.

iii. The provision of operational support for the administration, management, or provision of medical services.

c. Entities that employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A, for the provision (directly or indirectly) of health care, utilization review, medical social work or administrative services. For the services listed, the HMO must refrain from contracting with any entity that employs, contracts with, or contracts through an entity that has been debarred or excluded from participation in Medicaid by the Secretary of Health and Human Services under the authority of Section 1128 or 1128A of the Act.

d. Foreign Entities

i. Pursuant to 42 C.F.R. § 438.602(i), the State is prohibited from contracting with an HMO located outside of the United States. In the event an HMO moves outside of the United States, this contract will be terminated.

ii. Pursuant to 42 C.F.R. § 438.602(i), no claims paid by an HMO to a network provider, out-of-network provider, subcontractor or financial institution outside of the United States will be considered in the development of actuarially sound capitation rates.

The HMO attests by signing this Contract, that it excludes from participation in the HMO all organizations that could be included in any of the above categories.

2. Contract Representative

The HMO is required to designate a staff person to act as liaison to the Department on all issues that relate to the Contract between the Department and the HMO. The contract representative will be authorized to represent the HMO regarding inquiries pertaining to the Contract, will be available during normal business hours, and will have decision making authority in regard to urgent

situations that arise. The Contract representative will be responsible for follow-up on contract inquiries initiated by the Department.

3. Attestation

The HMO's Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or designee must attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department. This includes encounter data, ventilator dependent member data, provider and facility network submissions, comprehensive exam reports and health data indicators and any other data regarding claims the HMO paid.

4. Affirmative Action (AA) and Equal Opportunity, and Civil Rights Compliance (CRC)

All recipients of federal and/or state funding to administer programs, services and activities through the Department must comply with the Department's CRC Plan requirements. Information about these requirements can be found at http://dhs.wisconsin.gov/civilrights/Index.HTM .

Certain Recipients and Vendors must also comply with Wis. Stats., s.16.765, and Administrative Code (ADM) 50, which require the filing of an Affirmative Action Plan (AA Plan). The Affirmative Action Plan is NOT part of the CRC Plan.

a. Affirmative Action Plan

i. For agreements where the HMO has 50 employees or more and will receive $50,000 or more, the HMO shall complete the AA plan. The HMO with an annual work force of less than 50 employees or less than $50,000 may be exempt from submitting the AA plan.

The AA Plan is written in detail and explains the HMO's program. To obtain instructions regarding the AA Plan requirements go to http://vendornet.state.wi.us/vendornet/contract/contcom.asp

ii. The HMO must file its AA plan every 3 years and includes all programs. The plan must be submitted to:

Department of Health Services
Division of Enterprise Services
Bureau of Procurement and Contracting
Affirmative Action Plan/CRC Coordinator
1 West Wilson Street, Room 672
P.O. Box 7850
Madison, WI 53707
dhscontractcompliance@dhs.wisconsin.gov

Compliance with the requirements of the AA Plan will be monitored by the DHS, Office of Affirmative Action and Civil Rights Compliance.

b. Civil Rights Compliance (CRC) Plan

i. The HMO receiving federal and/or state funding to administer programs, services and activities through DHS must file a Civil Rights Compliance Letter of Assurance (CRC LOA). All HMOs with fifty (50) or more employees AND who receive over $50,000 in funding must complete a Civil Rights Compliance Plan (CRC Plan). The CRC Plan is to be kept on file and made available upon request to any representative of the Department. The instructions and template to complete the requirements for the CRC Plan are found at http://dhs.wisconsin.gov/civilrights/Index.HTM .

For technical assistance on all aspects of the Civil Rights Compliance, the HMO is to contact the Department at:

Department of Health Services
Civil Rights Compliance
Attn: Civil Rights Compliance Officer
1 West Wilson Street, Room 651
P.O. Box 7850
Madison, WI 53707-7850
Telephone: (608) 267-4955 (Voice)
711 or 1-800-947-3529 (TTY)
Fax: (608) 267-1434
Email: DHSCRC@dhs.wisconsin.gov

ii. HMOs subcontracting federal or state funding to other entities must obtain a CRC LOA from their subcontractors. The CRC LOA must be kept on file and produced upon request or at the time that an on-site monitoring visit is conducted. Subcontractors with fifty (50) or more employees AND who receive over $50,000 in funding must complete a CRC Plan. The CRC Plan is to be kept on file and produced upon request by the DHS AA/CRC Office, a representative of the DHS or at the time the HMO conducts an on-site monitoring visit.

iii. The HMO agrees to not discriminate in the provision of services or benefits on the basis of age, color, disability, national origin, race, religion or sex/gender. This policy covers enrollment, access to services, facilities, and treatment for all programs and activities. All employees of the HMO are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

iv. The HMO agrees not to exclude qualified persons from employment otherwise. The HMO agrees to not discriminate on the basis of the conscience rights of health care providers as established and protected following Federal Health Care Provider

Conscience Protection Laws: the Church Amendments; the Public Health Service Act Section 245; the Weldon Amendment; and the Affordable Care Act.

v. The HMO agrees to comply with all of the requirements contained in the Department CRC Plan and to ensure that their subcontractors comply with all CRC requirements during this Contract period. The instructions and template to complete the CRC Plan requirements can be found at http://dhs.wisconsin.gov/civilrights/Index.HTM .

vi. The Department will monitor the Civil Rights and Affirmative Action compliance of the HMO. The Department will conduct reviews to ensure that the HMO is ensuring compliance by its subcontractors or grantees. The HMO agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the HMO, interview with staff, clients, and applicants for services, subcontractors, grantees, and referral agencies. The reviews will be conducted according to Department procedures. The Department will also conduct reviews to address immediate concerns of complainants.

vii. The HMO agrees to cooperate with the Department in developing, implementing, and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

5. Non-Discrimination in Employment

The HMO must comply with all applicable federal and state laws relating to non-discrimination and equal employment opportunity including Wis. Stats., s.16.765, Federal Civil Rights Act of 1964, regulations issued pursuant to that Act and the provisions of Federal Executive Order 11246 dated September 26, 1985, and ensure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable Department regulations (45 CFR part 84) and all guidelines and interpretations issued pursuant thereto, and the provisions of the Age Discrimination and Employment Act of 1967 and Age Discrimination Act of 1975.

Wis. Stats., §16.765, requires that in connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take

affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the non-discrimination clause.

Contractor further agrees not to subject qualified persons to discrimination in employment in any manner or term or condition of employment on the basis of arrest record, conviction record, genetic testing, honesty testing, marital status, military service, pregnancy or childbirth, or use of legal products during non-work hours outside of the employer's premises, except as otherwise authorized by applicable statutes.

All HMO employees are expected to support goals and programmatic activities relating to non-discrimination and non-retaliation in employment.

With respect to provider participation, reimbursement, or indemnification, the HMO will not discriminate against any provider who is acting with the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This shall not be construed to require the HMO to contract with providers beyond the number necessary to meet the needs of the BadgerCare Plus and/or Medicaid SSI population. This shall not be construed to prohibit the HMO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities. If the HMO declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.

6. Provision of Services to the HMO Members

   The HMO must provide contract services to BadgerCare Plus and/or Medicaid SSI members under this Contract in the same manner as those services are provided to other members of the HMO.

   The HMO must provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under Medicaid fee for services as set forth in 42 CFR § 438.210(a)(2) and 42 CFR § 440.230.

   Per 42 CFR § 438.210(a)(3), the HMO:

   a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished to members in Medicaid fee for service.

   b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

7. HMO Staffing Level to Support Providers

At the time of contract renewal and at service area expansion request, the HMO must have appropriate staffing levels for the entire service area to support contracted provider participation and timely claim payment.

The HMO must:

a. Have adequate customer service and help desk staff to answer inquiries from providers (via phone or email); adequate home office or regional provider representatives to provide training to new and ongoing providers on HMO policy, communication methods, correct claim submission and appeal process.

b. Clearly communicate to providers the availability of support resources provided through the HMO website or Provider Manual, including but not limited to the methods used by the HMO to communicate policy changes, electronic claim submission, claim reconsideration, internal appeal process, and how to appeal to the Department.

The Department reserves the right to request a staffing plan from the HMO at the time of contract renewal and at service area expansion request to demonstrate the HMO has appropriate staffing levels for its entire service area to support provider participation and timely claim payment.

8. Access to Premises

The HMO must allow duly authorized agents or representatives of the state or federal government access to the HMO's or HMO subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the HMO's or subcontractor's contractual activities and shall produce all records requested as part of such review or audit within a reasonable time, but not more than 10 business days. Upon request for such right of access, the HMO or subcontractor must provide staff to assist in the audit or inspection effort, and adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits must be conducted in a manner as will not unduly interfere with the performance of HMO's or subcontractor's activities. The HMO will have 30 business days to respond to any findings of an audit before the Department finalizes it. All information obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

9. Liability for the Provision of Care

Remain liable for provision of care for that period for which capitation payment has been made in cases where medical status code changes occur subsequent to capitation payment.

10. Subcontracts

The HMO must ensure that all subcontracts are in writing, comply with the provisions of this Contract that are appropriate to the service or activity, and

ensure that all subcontracts do not terminate legal liability of the HMO under this Contract. The HMO may subcontract for any function covered by this Contract, subject to the requirements of Article XIV.B.

11. Coordination with Community-Based Health Organizations, Local Health Departments, Division of Milwaukee Child Protective Services, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, School-based Mental Health Services, Birth to Three Program Providers, and Healthy Wisconsin

    Per Article III.A. the HMO must have a system in place to coordinate the services it provides to member with services a member receives through community and social support providers.

    a. Community-Based Health Organizations

        The Department encourages the HMO to contract with community-based health organizations for the provision of care to BadgerCare Plus and/or Medicaid SSI members in order to ensure continuity and culturally appropriate care and services. Community-based organizations can provide HealthCheck outreach and screening, immunizations, family planning services, and other types of services.

        The Department encourages the HMO to work closely with community-based health organizations. Community-based health organizations may also provide services, such as WIC services, that the HMO is required by federal law to coordinate with and refer to, as appropriate.

    b. Federally Qualified Health Centers (FQHC)

        HMOs must make at least two good faith written and documented efforts to contract at a reasonable market rate with FQHCs located within their service area for the provision of care to BadgerCare Plus and/or Medicaid SSI members.

    c. Local Health Departments

        The Department encourages the HMO to contract with local health departments for the provision of care to members. Local health departments can provide HealthCheck outreach and screening, immunizations, blood lead screening services, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases.

        The Department encourages the HMO to work closely with local health departments. Local health departments have a wide variety of resources that could be coordinated with the HMO to produce more efficient and cost-effective care for the HMO members. Examples of such resources are ongoing medical services programs, materials on health education, prevention, and disease states, expertise on outreaching specific sub-

populations, communication networks with varieties of medical providers, advocates, community-based health organizations, and social service agencies, and access to ongoing studies of health status and disease trends and patterns.

d. Child Welfare Coordination

HMOs must designate at least one staff member to serve as a contact with county child welfare agencies and the Division of Milwaukee Child Protective Services (DMCPS), in the Wisconsin Department of Children and Families. If the HMO chooses to designate more than one contact person the HMO should identify the service area for which each contact person is responsible. The Department encourages HMOs to designate a staff member with at least two years of experience working in a child welfare agency, or who has attended child welfare training through the Wisconsin Child Welfare Training Partnership.

In Milwaukee County, HMOs must provide all BadgerCare Plus and/or Medicaid SSI covered mental health and substance abuse services to individuals identified as clients of DMCPS. Disputes regarding the medical necessity of services identified in the Family Treatment Plan will be adjudicated using the dispute process, except that the HMO must provide court-ordered services.

Outside of Milwaukee County, HMOs shall coordinate with the appropriate county human services agency for the provision of services to members involved with the county.

e. Prenatal Care Coordination (PNCC) Agencies

The HMO must coordinate services with a MA certified PNCC agency providing MA services to HMO-enrolled members. To ensure coordination, the HMO shall:

i. Sign a memorandum of understanding (MOU) with PNCC providers in the HMO service area upon request of the PNCC provider. The Department provides a template MOU that can be found at ForwardHealth Online Wisconsin Managed Care and Medicaid Handbook Topic #16917. The HMO may require a PNCC agency to demonstrate to the HMO that all other criteria under Wis. Admin. Code DHS § 105.52(4) have been met prior to signing the MOU.

ii. Assign an HMO representative to coordinate member services and care with the PNCC agency.

f. School-Based Services (SBS) Providers

The HMO must use its best effort and document attempts to sign a MOU with all SBS providers in the HMO service area to ensure continuity of

care and to avoid duplication of services. School based services are paid FFS when provided by a BadgerCare Plus enrolled SBS provider. However, in situations where a member's course of treatment is interrupted due to school breaks, after school hours or during the summer months, the HMO is responsible for providing and paying for all BadgerCare Plus covered services. The HMO must not consider SBS (e.g. physical, occupational, and speech and language therapy services) as automatically duplicative when it is considering the medical necessity of a requested community based service.

MOUs must be signed every three years as part of certification. If no changes have occurred, then both the school and the HMO must sign off that no changes have occurred and documentation to this effect must be submitted to DHS upon request. HMOs must conduct outreach to schools that do not have a MOU with the health plan, at a minimum, every two years. The HMO must submit evidence that it attempted to obtain a MOU or contract in good faith.

g. Targeted Case Management (TCM) Agencies

The HMO must interface with the case manager from the TCM agency to identify what BadgerCare Plus and/or Medicaid SSI covered services or social services are to be provided to a member. The HMO is not required to pay for medical services directed outside of their provider network by the case manager unless prior authorized by the HMO.

h. School-based Mental Health Services

The Department encourages the HMO to contract with community-based mental health agencies and/or school-based providers for the provision of mental health care to BadgerCare Plus children in the school setting. The HMO is encouraged to assist with the coordination of covered mental health services to its members (including those children with an IEP who may have mental health needs) with the school, mental health provider, and family as appropriate.

i. Birth to 3 Program Providers

The HMO is required to contract with Birth to 3 Program service providers that have a contractual agreement with the Birth to 3 Program agencies within its service area to authorize and pay claims for its members enrolled in the Birth to 3 Program. Birth to 3 Program services include physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services.

The HMOs reimburse for Birth to 3 Program services when a member under the age of 3 receives an initial evaluation and assessment, as well as an Individualized Family Service Plan (IFSP), and the provider is employed by or under contract with a Birth to 3 Program Agency. The

HMO must reimburse for the initial evaluation and assessment, as well as re-evaluations, even when a member does not qualify for the Birth to 3 Program. HMOs cannot apply multiple procedure payment reduction (MPPR) logic to payments for Birth to 3 PT, OT, or SLP.

The HMO must authorize PT, OT, or SLP services that are provided with an initial evaluation and assessment and that are identified in and requested at the same frequency, intensity, and duration listed in the member's IFSP. The HMO should not impose additional medical necessity criteria for Birth to 3 Program services. The HMO is encouraged to follow ForwardHealth policy for prior authorization of Birth to 3 Program services by not requiring Birth to 3 Programs to frequently re-submit authorization requests to the HMO.

To approve non-Birth to 3 Program prior authorization requests for therapeutic services, the HMO should verify that the provider request includes confirmation that the child has been referred to the Birth to 3 Program per Wis. Admin. Code § 90.07(3)(b). Such confirmation includes caregiver discussion regarding the availability of the Birth to 3 Program, review of member medical records with confirmed referral in the record, or direct referral by the therapy provider to the Birth to 3 Program. The HMO may also accept the IFSP or Child Enrollment Status Regarding Birth to 3 Program form from PTs, OTs or SLPs as a method of confirmation but the IFSP and Child Enrollment Status Regarding Birth to 3 Program form are not required to be submitted for children ages 0-3 years.

Generally, the State or Birth to 3 Program must obtain parental consent before the State or Birth to 3 Program can disclose a child's personally identifiable information to the Department. As allowed by federal regulations, parents or guardians may refuse consent to bill their commercial health insurance for services received through the Birth to 3 Program. Birth to 3 Program services are an exception to Medicaid being the payor of last resort.

If a provider's Birth to 3 Program services are provided in the member's natural environment, the provider must receive an enhanced reimbursement rate. A child's natural environment includes settings that are natural and normal for the child's age peers who have no disability as defined in 34 FCR 303 and Wis. Admin. Code. § DHS 90.03(25). Natural environments may include the child's home, family childcare, community settings (e.g., YMCA), early childhood education settings, inclusive childcare centers, or other settings where most of the children do not have disabilities. Natural environments do not include medical facilities such as therapy clinics, physician clinics, rehabilitation agencies, outpatient hospitals, or other center-based settings where most of the participating

children have disabilities. HMOs are encouraged to develop MOUs with county Birth to 3 Program agencies in their service area.

The HMO is encouraged to follow the ForwardHealth policy for prior authorization of therapy services provided outside the Birth to 3 Program. HMOs may impose their standard medical necessity criteria when authorizing therapy services outside the Birth to 3 Program for a child under 3.

The HMO can find a list of county contacts for Birth to 3 Program on the Department website.

j. Healthy Wisconsin

The Department encourages HMOs to serve as partners in Healthy Wisconsin, the state's health assessment and health improvement plan. This includes the HMO working towards objectives that influence the health of the public and long-term goals for the decade. More information on Healthy Wisconsin can be found at:

https://healthy.wisconsin.gov/content/about-us

k. Local WIC Agencies

The WIC Program provides nutrition services, supplemental foods, breast feeding promotion and support, and immunization screening. Some Local WIC Agencies are enrolled in Wisconsin Medicaid as HealthCheck – Other Services providers .

i. HMOs may contract with local WIC Agencies for blood lead poisoning screenings performed during the WIC appointment.

ii. HMOs are encouraged to enter into an agreement with Local WIC Agencies within the HMO's service area for the purpose of coordination of care.

iii. HMOs are required to refer all WIC categorically eligible HMO members to the Local WIC Agency.

l. Homeless Assistance Coalition Collaboration

HMOs are required to appoint a staff person to serve as a liaison between the HMO and homeless assistance coalitions that serve the same counties as the HMO. This person can act in a role already established at the HMO.

The liaison will participate in homeless assistance coalition meetings, keep updated information on coordinated entry points of contacts, assist coalition members in connecting people they serve to HMO staff and resources, and provide coalition information to other HMO staff serving people experiencing or at risk for homelessness.

12. Clinical Laboratory Improvement Amendments (CLIA)

The HMO must use only laboratories that have a valid CLIA certificate along with a CLIA identification number, and comply with federal CLIA regulations as specified by 42 CFR § 493. Those laboratories with certificates must provide only the types of tests permitted by 42 C.F.R. § 493 .

13. HMO Responsibilities in the Event of a Federal or State Declared Emergency:

HMOs are required to submit an annual plan, to maintain business operations in the event of a state or federal declaration of disaster or State of Emergency by June 30th. The HMO must cooperate with DHS' efforts to ensure minimal disruption to the ForwardHealth program and the members served.

a. Continuity of Operations

i. Business Continuity Plan

The health plan must maintain a business continuity plan which includes a collection of resources, actions, procedures, and information that is developed, tested, and held in readiness for use to continue operations in the event of a major disruption of operations due to a federal or state declared disaster or State of Emergency. Business Continuity Plans shall address, at a minimum, the following:

a) A description of how the health plan will organize and assign the urgency with which activities and processes will need to be resumed in the event of a disruption including:

1) Member's access to services. The health plan must:

A) Establish provisions to ensure that members are able to see Out-of-Network Providers if the member has a permanent address in the federal or state declared disaster areas and are unable to access In-Network providers.

B) Establish provisions to ensure that members are able to use telehealth services if the member has a permanent address in the federal or state declared disaster areas.

C) Provide detailed plans it will use to ensure that prior authorizations are extended and transferred without burden to new providers if directed by DHS, and the means by which the health plan will identify the location of members who have been displaced.

D) Report status of members and issues regarding member access to covered services as directed by DHS.

b) Claims Payment

1) A description of how the health plan will address the following activities:

A) Timely provider claims processing and payment consistent with DHS contract requirements and health plan-provider contract policies.

B) Establishing provider contract language that addresses relaxed health plan timely filing requirements for provider service claims provided in good faith with reasonable submission delay due to a Federal or State declared disaster or emergency and submit to DHS for review.

C) Honoring unauthorized provider claims consistent with ongoing treatment due to demonstrated patient need or urgent patient need occurring during a Federal or State declared disaster or emergency period where heath plan authorization communications and processes were delayed or failed.

D) Providing a communication and interim plan for approval by DHS should they experience a disruption that risks the ability to meet the claims processing/payment timeline requirements.

c) Inclusion of a business impact analysis and risk assessment. This will address each continuity management strategy both at the corporate and key functional area separately and will identify, quantify and qualify areas that will be used to continue the organization's business impacts of a disruption to determine at what point in time the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.

d) Inclusion of a risk assessment that reviews the probability and impact of various threats to the health plan's operations. This involves stress testing the health plan's

business processes and business impact analysis assumptions with various threat scenarios. The results of the risk assessment should assist the health plan in refining its business impact analysis and in developing a business continuity strategy.

e) Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.

1) Health Plans must ensure that proper training is provided for each role under this provision.

f) Criteria for executing the business continuity plan, including escalation procedures.

1) A detailed communication plan with members, employees, providers, the Department, and other stakeholders including: Coordinating with DHS or any other local, state, or federal agencies as needed during the disaster or emergency response. This coordination may vary based on type of situation; however, anticipated coordination includes, but is not limited to:

A) Designating a Point of Contact (POC) for continuity of operations specifically related to disaster preparedness in order to communicate the health plan's response to the DHS emergency preparedness POC.

B) Designating a POC to support members residing in Tribal Lands where applicable.

C) Participating in meetings with DHS or other agencies

D) Assisting with impacted member or provider communications

E) Facilitate effective communication with members, providers and staff regarding the impact of the disaster as well as a process by which inquiries may be submitted and addressed.

F) Implementing policy, process, or system changes at the direction of DHS, keeping

DHS informed on the progress of the implementation

G) Additional communication and/or reporting requirements through the duration of the emergency

H) The health plan must notify DHS of any contract flexibilities or extensions needed during the course of the emergency or disaster. DHS will maintain a health plan emergency/disaster response guide to document any such approved flexibilities or revised deadlines, outside the contract amendment process.

I) Permission from DHS, contingent on approval of content, to do one-time member outreach via text message to those who have not opted into text messaging, to inform members about the disaster or emergency, offer HMO resources or contact information, and instructions on how to opt into text messaging.

g) Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event.

1) Including the ability of providers and suppliers to provide ongoing services for maintaining critical operations, and

2) The level of ongoing monitoring and oversight provided by the HMO.

h) Recovery time for each major business function, based on priority.

i) Business workflow and workaround procedures, including alternate processing methods and performance metrics.

j) Recording and updating business events information, files, and data, once business processes have been restored.

k) Documentation of security procedures for protection of data through web-based cloud application.

l) Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.

m) A description of an annual testing and evaluation plan.

n) A description of the health plan familiarity with and involvement in the emergency government plan of the counties in which they are providing services. The health plan will negotiate the role of the health plan and the county roles in emergency response.

1) Health plans must ensure annually the readiness of the plan by conducting exercises carrying out the plan's provisions, evaluate its performance and make necessary updates. The health plan must coordinate with local emergency management departments, local agencies and DHS prior to an event to understand local emergency management departments or agencies, and identify mechanisms for assistance at the local level.

o) A description of the steps that will be taken to ensure and preserve member safety and wellbeing in the event of a disruption or disaster.

1) Care Coordination

A) The health plan must ensure that care coordination for all members are compliant with the health plan's emergency recovery plan. In particular, care coordination for members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if covered service are disrupted or interrupted.

p) Emergency Recovery Plan

1) The Emergency Recovery Plan shall address, at a minimum, the following recovery aspects related to the management information system and where appropriate, use web-based cloud applications:

A) Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.

B) Communication plan for critical personnel, key stakeholders and business partners involved in the health plan's management information system.

i) Including the health plan's ability to provide continuous services to members and maintain critical operations in the even employees are unavailable to work remotely for extended periods of time.

C) Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system operations, and user documentation (e.g., electronic, non-electronic, incremental, full).

D) Full and complete back-up copies of all data and software.

E) Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.

F) Policies and procedures for purging outdated backup data.

G) Plan that supports the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.

q) Upon DHS request, health plans shall submit an 'After Emergency Report' to DHS after the federal or state declared disaster is completed to provide feedback on success and challenges faced during the emergency.

14. Interoperability and Access to Health Information – Patient Access Application Programming Interface (API, Provider Directory API, and Payer-to-Payer Data Exchange)

The HMO shall implement requirements from the CMS "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care

Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers" final rule (85 FR 25510). The HMO shall implement these interoperability requirements in accordance with the applicable specifications of the Office of the National Coordinator's (ONC's) "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" companion final rule (85 FR 25642).

The HMO shall implement:

a. Patient Access Application Programming Interface (API): The HMO shall provide members with the ability to access their own personal health information, including structured claims and encounter information, costs, and a defined sub-set of their clinical information as outlined at 42 CFR § 422.119, 42 CFR § 431.60, 42 CFR § 457.730, and 45 CFR § 156.221, specifically for the Patient Access API, and current version of the United States Core Data for Interoperability (USCDI) dataset. The HMO will be responsible for the Patient Access API, including all applicable technology standards, supporting technology infrastructure, and security protocols required to conform with the CMS final rule. This information shall be provided via an HL7 FHIR compliant standards-based API available to third-party applications of the member's choice.

b. Provider Directory API: The HMO shall make their Member-enrolled HMO provider directory information publicly available via an HL7 FHIR complaint standards-based API per the requirements outlined at 42 CFR § 438.242(b)(6) and 42 CFR § 457.1233(d). At a minimum, the HMO must make the provider names, addresses, phone numbers, and specialties available.

c. Payer-to-Payer Data Exchange: The HMO shall provide members with the ability to exchange certain patient clinical data (specifically the current version of the U.S. Core Data for Interoperability (USCDI) data set). Members shall have the ability to request the transfer of all clinical data from an assigned payer to a future payer to enable health data portability. The HMO is required to conform with 42 CFR 438.62(b)(1)(vi) & (vii) for Medicaid managed care plans (and by extension under § 457.1216 CHIP managed care entities) and implement a process for this data exchange beginning January 1, 2022.

d. HMO shall review the **ONC 21st Century Cures Act Final Rule** to determine its obligation to comply with the final rule. Specifically, HMO shall review the terms "Health Information Exchange" (HIE) and "Health Information Network" (HIN) which are defined in 45 CFR § 171.102, and the exceptions to information blocking as amended by Section 4004 of the Cures Act and as found in 42 USC § 300jj-52, in relation to their contractual and financial relationships. If the HMO meets the definition for an HIE/HIN as it pertains to information blocking, HMO shall comply with all the requirements set forth in the rule.

e. Access to Educational Materials: Pursuant to 42 CFR § 431.60(f) and 42 CFR § 457.730(f), HMO shall develop educational resources regarding privacy and security, including information regarding the possible risk of sharing their data with third-party app and how members can protect the privacy and security of their health information in non-technical, simple and easy-to-understand language. The HMO shall publish these resources on its publicly accessible website.

HMOs must make documentation related to implementation of these requirements as required in the CMS final rule (85 FR 25510) available to Wisconsin Division of Medicaid Services upon request.

15. Availability of Dual Eligible Special Needs (D-SNP) Plans from SSI HMOs

If the HMO is an SSI HMO, then the HMO must have a D-SNP plan available under the same parent organization to facilitate coordination of care between Medicare and Medicaid for dually eligible members.

D. Confidentiality of Records and HIPAA Requirements

The parties agree that all information, records, and data collected in connection with this Contract will be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, Wis. Stats., DHS 108.01, Wis. Adm. Code, 42 CFR Part 431 Subpart F, 42 CFR Part 438 Subpart F and 45 CFR Parts 160, 162, and 164 and any other confidentiality law to the extent that these requirements apply. Except as otherwise required by law, rule or regulation, access to such information shall be limited by the HMO and the Department to persons who, or agencies which, require the information in order to perform their duties related to this Contract, including the U.S. Department of Health and Human Services and such others as may be required by the Department.

1. Duty of Non-Disclosure and Security Precautions

HMO shall not use Confidential Information for any purpose other than the limited purposes set forth in the Agreement. HMO shall hold the Confidential Information in confidence, and shall not disclose such Confidential Information to any persons other than those directors, officers, employees, and agents ("Representatives") who have a business related need to have access to such Confidential Information in furtherance of the limited purposes of this Agreement and who have been apprised of, and agree to maintain, the confidential nature of such information in accordance with the terms of this Agreement. HMO shall be responsible for the breach of this Agreement by any of its Representatives.

HMO shall institute and/or maintain such procedures as are reasonably required to maintain the confidentiality of the Confidential Information, and shall apply the same level of care as it employs to protect its own confidential information of like nature.

HMO shall ensure that all indications of confidentiality contained on or included in any item of Confidential Information shall be reproduced by HMO on any

reproduction, modification, or translation of such Confidential Information. If requested by the State, HMO shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed.

If requested by the State, HMO shall return or destroy all Individually Identifiable Health Information and Personally Identifiable Information it holds upon termination of this Agreement.

2. Limitations on Obligations

The obligations of confidentiality assumed by HMO pursuant to this Agreement shall not apply to the extent HMO can demonstrate that such information:

a. is part of the public domain without any breach of this Agreement by HMO;

b. is or becomes generally known on a non-confidential basis, through no wrongful act of HMO;

c. was known by HMO prior to disclosure hereunder without any obligation to keep it confidential;

d. was disclosed to it by a third party which, to the best of HMO's knowledge, is not required to maintain its confidentiality;

e. was independently developed by HMO; or

f. is the subject of a written agreement whereby the State consents to the disclosure of such Confidential Information by HMO on a non-confidential basis.

3. Legal Disclosure

If HMO or any of its Representatives shall be under a legal obligation in any administrative, regulatory or judicial circumstance to disclose any Confidential Information, HMO shall give the State prompt notice thereof (unless it has a legal obligation to the contrary) so that the State may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, HMO and its Representatives shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

4. Unauthorized Use, Disclosure, or Loss

If HMO becomes aware of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Contract, or if any Confidential Information is lost or cannot be accounted for, HMO shall notify the Department's (Contract Manager/Contact Liaison/Privacy Officer) within the same business day the HMO becomes aware of such use, disclosure, or loss. Such notice shall include, to the best of the HMO's knowledge at that time, the persons affected, their identities, and the Confidential Information disclosed.

The HMO shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The HMO shall reasonably cooperate with the Department's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its Confidential Information, including complying with a reasonable Corrective Action Plan.

If the unauthorized use, disclosure, or loss is of Personally Identifiable Information, or reasonably could otherwise identify individuals, HMO shall, at its own cost, take any or all of the following measures that are directed by the Department as part of a Corrective Action Plan:

a. Notify the affected individuals by mail or the method previously used by the State to communicate with the individual. If the HMO cannot with reasonable diligence determine the mailing address of the affected individual and the State has not previously contacted that individual, the HMO shall provide notice by a method reasonably calculated to provide actual notice.

   i. Notify consumer reporting agencies of the unauthorized release.

   ii. Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the State for one year from the date the individual enrolls in credit monitoring.

   iii. Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as established by the State.

   iv. Adequately staff customer service telephone lines to assure an actual wait time of less than five (5) minutes for callers.

5. Trading partner requirements under HIPAA

For the purposes of this section Trading Partner means the HMO.

a. Trading Partner Obligations

   i. Trading Partner must not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation (45 CFR § 162.915(a)).

   ii. Trading Partner must not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR § 162.915(b)).

   iii. Trading Partner must not use any code or data elements that are either marked “not used” in the HHS Transaction Standard’s implementation specifications or are not in the HHS Transaction Standard’s implementation specifications (45 CFR § 162.915(c)).

iv. Trading Partner must not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications (45 CFR § 162.915(d)).

v. Trading Partner must submit a new Trading Partner profile form in writing if any of the information provided as part of the Trading Partner profile form is modified.

b. Trading Partner understands that there exists the possibility that the Department or others may request an exception from the uses of a standard in the HHS Transaction Standards. If this occurs, Trading Partner must participate in such test modification (45 CFR § 162.940 (a) (4)).

c. Trading Partners or Trading Partner's Business Associate have responsibilities to adequately test business rules appropriate to their types and specialties.

d. Trading Partner or their Business Associate agrees to cure transaction errors or deficiencies identified by the Department.

e. Trading Partner or Trading Partner's Business Associate understands that from time-to-time HHS may modify and set compliance dates for the HHS Transaction Standards. Trading Partner or Trading Partner's Business associate must incorporate by reference any such modifications or changes (45 CFR § 160.104).

f. The Department and the Trading Partner agree to keep open code sets being processed or used for at least the current billing period or any appeal period, whichever is longer (45 CFR § 162.925 (c)(2)).

g. Privacy

i. The Trading Partner or the Trading Partner's Business Associate will comply with all applicable state and federal privacy statutes and regulations concerning the treatment of Protected Health Information (PHI).

ii. The Department and the Trading Partner or Trading Partner's Business Associate will promptly notify the other party of any unlawful or unauthorized use or disclosure of PHI that may have an impact on the other party that comes to the party's attention, and will cooperate with the other party in the event that any litigation arises concerning the unlawful or unauthorized disclosure or use of PHI.

iii. The Department retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by the Trading Partner, Trading Partner's Business Associate, or any agent, HMO or third Party that received PHI from the Trading Partner.

h. Security

i. The Department and the Trading Partner or Trading Partner's Business Associate must maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, security access codes, envelope, backup files, and source documents. Each party will immediately notify the other party of any unauthorized attempt to obtain access to or otherwise tamper with data, data transmissions security access codes, envelope, backup files, source documents other party's operating system when the attempt may have an impact on the other party.

ii. The Department and the Trading Partner or Trading Partner's Business associate must develop, implement, and maintain appropriate security measures for its own operating system. The Department and the Trading Partner or Trading Partner's Business Associate must document and keep current its security measures. Each party's security measure will include, at a minimum, the requirements and implementation features set forth in 'site specific HIPAA rule' and all applicable HHS implementation guidelines.

6. Indemnification

In the event of a breach of this Section by the HMO the HMO shall indemnify and hold harmless the State of Wisconsin and any of its officers, employees, or agents from any claims arising from the acts or omissions of the HMO, and its subcontractors, employees and agents, in violation of this Section, including but not limited to costs of monitoring the credit of all persons whose Confidential Information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the State in the enforcement of this Section. In addition, notwithstanding anything to the contrary herein, the HMO shall compensate the State for its actual staff time and other costs associated with the State's response to the unauthorized use or disclosure constituting the breach.

7. Equitable Relief

The HMO acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury will not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the State, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Agreement or under applicable law.

8. Financial Penalties

The HMO agrees that an unauthorized use or disclosure of Confidential Information may result in damage to the Department's reputation and ability to serve the public interest in its administration of programs affected by this Contract. Such amounts of damages which will be sustained are not calculable with any degree of certainty and thus shall be the amounts set forth herein. Assessment under this provision is in addition to other remedies under this Contract and as provided in law or equity. The Department shall assess damages as appropriate and notify the HMO in writing of the assessment. The HMO shall automatically deduct the damage assessments from the next appropriate monthly invoice, itemizing the assessment deductions on the invoice.

Financial penalties shall be as follows:

a. $100 for each individual whose Confidential Information was used or disclosed;

b. $100 per day for each day that the HMO fails to substantially comply with the Corrective Action Plan under this Section.

c. Damages under this Section shall in no event exceed $50,000 per incident.

9. Compliance Reviews

The State may conduct a compliance review of the HMO's security procedures to protect Confidential Information.

10. Survival

This Section shall survive the termination of the Agreement.

11. Party in Interest

The HMO agrees to report to the state and, upon request, to the Secretary of the U.S. Department of Health & Human Services (DHHS), the Inspector General of the U.S. DHHS, and the Comptroller General a description of transactions between the HMO and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

a. Any sale or exchange, or leasing of any property between the HMO and such a party.

b. Any furnishing for consideration of goods, services (including management services), or facilities between the HMO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

c. Any lending of money or other extension of credit between the HMO and such a party.

E. Declaration of National or State Emergencies/Disasters:

In the event of a Federal or State declared emergency or disaster, DHS has the ability to modify or waive contractual obligations and regulations on health plans that are

necessary to address the emergency or disaster. DHS will maintain documentation of any modifications to or waivers of contract requirements, including effective and end dates for each change. DHS reserves the right to identify flexibilities or waivers of contract requirements for DHS responsibilities, if DHS is impacted by the emergency or disaster. This may include, but is not limited to, extension of deadlines or timeframes for DHS or subcontractor activities.

The health plan must follow all relevant ForwardHealth Updates or other DHS communications issued during a federal or state disaster to ensure members continue to receive all medically necessary services.

XII. Reports and Data

A. Required Use of the Secure ForwardHealth Portal and Secure File Transfer Protocol

1. Secure ForwardHealth Portal

   a. The HMO must request a secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions and other business with DHS. When the HMO requests an account, the designated HMO contact will receive a PIN via their email address. The PIN is used to access specific HMO information on the secure ForwardHealth Portal.

   b. The HMO must assign users roles/permissions within the secure ForwardHealth Portal account to ensure only authorized users have access to data and functions provided. The HMO must ensure all users understand and comply with the terms and conditions found in Article XI.D, Confidentiality of Records and HIPAA Requirements, of this contract.

   Detailed information for how to grant roles and permissions can be found at:

   https://www.forwardhealth.wi.gov/WIPortal/Account/Setup/tabId/111/Default.aspx

2. Secure File Transfer Protocol

   a. The HMO must request a secure file transfer protocol account (SFTP) directory (Host Name: ftpb.forwardhealth.wi.gov; Port 22) to submit encounter data, including data related to ventilator payments, and other reports specified by the Department.

   b. The HMO must designate a single person as the security administrator for the SFTP directory and inform the Department of this person's name, telephone number, and email address. The HMO must also designate a back-up person for the security administrator and inform the Department of the backup's name, telephone number, and email address. The role of the security administrator is to add and delete user accounts accessing the HMO's SFTP directory.

   c. The HMO must ensure user accounts are purged from the SFTP upon the termination of a covered employee or business associate, whether the termination is voluntary or involuntary, and when a current covered employee or business associate no longer has a business need to access the SFTP.

d. The HMO must ensure all users understand and comply with the terms and conditions found in Article XI.D, Confidentiality of Records and HIPAA Requirements, of this contract.

B. Access to and/or Disclosure of Financial Records

The HMO and any subcontractors must make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the HMO or subcontractors that relate to the HMO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this Contract. The HMO must comply with applicable record keeping requirements specified in Wis. Adm. Code ss. DHS 105.02(1)-(7) as amended.

C. Access to and Audit of Contract Records

Throughout the duration of this Contract, and for a period of ten years after termination of this Contract, the HMO must provide duly authorized representatives of the state (including the Office of the Inspector General) or federal government access to all records and material relating to the HMO's provision of and reimbursement for activities contemplated under the Contract. Such access shall include the right to inspect, audit and reproduce all such records and material, including but not limited to computer records system, invoices, and to verify reports furnished in compliance with the provisions of this Contract. All information so obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations. Refusal to provide required materials during an audit may subject the HMO to actions as provided under Article XIV.D.

D. Encounter Data and Reporting Requirements

The HMO is responsible for complying with the Department's data storage and reporting requirements and must submit compliant encounter data files. HMO staff will participate with the Department in the planning and development of data reporting requirements for implementation during the term of this contract consistent with all HIPAA and MSIS/TMSIS requirements applicable to the HMO. This participation includes attending technical calls, contract administrator meetings, workgroup meetings, and individual HMO meetings with the Department to address changes in requirements, local applications or databases. The HMO must cooperate with the Department on data submission protocol and testing. The Department or its designees reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract and anytime thereafter. Per 42 CFR 438.602(e), the Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each HMO no less frequently than once every three years.

1. Data Management and Maintenance: The HMO must have a system that is capable of processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, and meeting reporting requirements. The required formats and timelines are specified in Article XII.J.

a. The HMO must participate in HMO encounter technical workgroup meetings scheduled by the Department.

b. The HMO must capture and maintain a claim record of each service or item provided to members, using CMS 1500, UB-04, HIPAA transaction code sets, or other claim, or claim formats that are adequate to meet all reporting requirements of this Contact. The original claim submitted by the provider must be stored and retrievable upon request by either the Department or CMS.

c. The database must be a complete and accurate representation of all services the HMO provided during the Contract period.

d. The HMO is responsible for monitoring the integrity of the database, and facilitating its appropriate use for such required reports as encounter data and targeted performance improvement studies.

e. The HMO is responsible for maintaining unique identifiers assigned by the Department or its designee such as the identification number assigned to each submitted encounter. The HMO must maintain all national code sets and Department specific fields as defined in ForwardHealth and the HMO Encounter User Guide.

f. The HMO is responsible for updating and testing new versions of national codes sets and/or state specific code set.

g. The HMO must submit adjudicated clean claims as encounters no later than 120 days after the date the HMO adjudicates the claim. If an HMO paid encounter is denied within the Department's Medicaid Management Information System (MMIS), the HMO has 90 days to resolve the encounter to priced status within the system. HMOs are not subject to the penalty under Article XII.E.6. for failure to submit encounter within 120 days after the date the HMO adjudicates the claim.

h. The HMO shall not alter encounters with dates of service older than two years of the current year. For example, if the current calendar year is 2015, the HMO must not alter encounters with a date of service of 2012 or older.

2. Program Integrity and Data Usage: The HMO shall establish written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable data processing and safeguarding requirements and standards under the contract, and all applicable Federal and state requirements. This documentation must be kept current and be provided to the department upon request.

a. This requirement extends to all subcontractors to the extent that the subcontractor is delegated responsibility by the HMO. The HMO is responsible for ensuring that data usage agreements and procedures are in place with providers and contractors that facilitate complete, accurate and timely encounter submissions to the Department.

b. The Department retains the right to analyze encounter data and use it for any purpose it deems necessary. The Department will ensure that the analysis does not violate the integrity of the reported data submitted by the HMO.

3. Testing and Certification Requirements: The electronic test encounter data files are subject to Department review and approval before production data is accepted by the Department. Production encounters or other documented encounter data must be used for the test data files.

   a. The HMO must notify the Department of all significant personnel changes and system changes that may impact the integrity of the data, including new claims processing vendors and significant changes in personnel.

   b. A new HMO must test the encounter data set until the Department is satisfied that the HMO is capable of submitting valid, accurate, and timely encounter data according to the schedule and timetable. A new HMO must become certified to submit compliant encounters within six months of their start date.

   c. The HMO must provide a three month notice to the Department in advance of transition to a new claims processing system and/or third party administrator. The new system must become certified by the Department or its designee to submit compliant encounters within six months of its start date.

4. Data Exchange Requirements: All encounter submissions must be in a HIPAA compliant ASC X12 transaction format.

   a. The HMO must follow the data specifications defined in the Encounter User Guide and must submit encounters that conform to national standards as well as specific Departmental requirements.

   b. The HMO must enter itself as an other payer on the encounter, identifying the amount and the date the HMO paid its provider.

   c. The HMO must process all the HMO specific files as defined in the HMO Report Matrix on ForwardHealth. All enrollment, encounters, response, capitation, provider, error reports and special program files must be processed in a timely and accurate manner.

5. Encounter Data Certification Requirements:

   a. The HMO must submit accurate, complete, and truthful encounter data that the Department can use for rate-setting, P4P, Federal Reporting, special programs and any other purpose deemed necessary by the Department.

   b. During the rate development process, upon receiving encounter data summaries from the Department or its actuarial accounting firm, the HMO must review the encounter data and encounter data extracts for accuracy

and immediately report inaccuracies or discrepancies to the Department and the Department's actuarial accounting firm prior to agreeing to new rates.

c. These requirements for certifying encounter data apply only to the encounter data in files uploaded to an HMO's encounter reporting SFTP directory.

d. Pursuant to 42 CFR § 438.606, the HMO must attest that, based on best information, knowledge, and belief, the data, documentation, and information reported to the Department is accurate, complete, and truthful. The attestation must be made by the Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

i. The HMO must assign the person attesting and a backup person the role of "Encounter Data Certifier" available in the Managed Care Organization Portal Page.

ii. Within ten business days of the end of a month, the person attesting must log into the Encounter Data Certifier account and perform the functions in the Portal Page to certify the encounter data uploaded to the Department via SFTP. Per 42 CFR § 438.606(c), this action must be performed each month, and a month's files must be certified separately from the files of any other month.

iii. The certification statement presented by the secure ForwardHealth Portal to the Attesting Officer reads, "I attest that, based on best information, knowledge, and belief, the data, documentation, and information reported to the Department via SFTP for [MONTH] [YEAR] is accurate, complete, and truthful."

6. Non-Compliance Resolution Process: The Department shall have the right to audit any records of the HMO and to request any additional information. If at any time the Department determines that the HMO has not complied with any requirement in this section, the Department may pursue action against the HMO as provided under Article XIV.D.

E. Encounter Data Quality Criteria

1. HMOs must meet the following encounter data quality criteria on an annual basis.

a. The submitted encounter data for the overlapping year in the base period must not exceed a 5% missing data adjustment as determined by the Department's actuary. An example of an overlapping year in the base

period is: for the CY2018 rates, the two base periods are CY2015 and CY2016. The overlapping year is CY2015 as it was used in both the CY2017 and CY2018 rates.

b. The submitted encounter data for the current year in the base period must not exceed a 10% missing data adjustment as determined by the Department's actuary. An example of a current year in the base period is: for the CY2018 rates, the two base periods are CY2015 and CY2016. The current year is CY2016 as it is the newest base period year.

2. The encounter data quality criteria will be applied starting with the 2019 rate setting process which will use CY2016 as the overlapping year and CY2017 as the current year. In future years, the Department will communicate annually what the overlapping and current base period years are as part of the rate-setting process. If a HMO is unsure what the over-lapping and current years are for rate setting, it is their responsibility to seek clarification from the department.

3. The missing data adjustment is calculated by dividing the HMO's financial report template per member per month (PMPM) for each base period by the corresponding year's HMO paid PMPM reported in the encounter data. For the purposes of the quality calculation, the percentage will be rounded up or down to the nearest whole percentage (e.g. 5.4% rounds to 5% and 5.5% rounds to 6%).

4. The Department will notify each HMO annually as part of the rate setting process what their missing data adjustment is for each of the base periods.

5. Right of Appeal

   a. HMOs will have no more than 45 days from the date they receive their missing data adjustment to submit an appeal letter to the Department.

      The appeal letter can be sent to the BRS email box at: DHSDMSBRS@dhs.wisconsin.gov.

   b. If the Department determines the appeal to be valid, the missing data adjustment will be updated for the rate setting process to reflect the new value. The HMO may also be required to resubmit any of the impacted encounter data or financial template information outlined in the appeal.

6. Failure to Meet the Encounter Data Criteria

   The HMO will be subject to financial penalties for each year in which the HMO fail to meet the encounter data criteria relating to missing data. Penalties will begin with the 2019 rate setting process. In addition to the financial penalties, the HMO will be placed on a corrective action plan (CAP) as a result of the Department finding the HMO out of compliance with encounter data quality standards. Penalties include

   a. First year: $100,000

   b. Second year: $200,000

c. Third year: $500,000. The Department may also elect to end auto-enrollment in addition to the financial penalties above. Or, the Department may separately choose to terminate the contract at its discretion.

d. Fourth year: Contract termination.

7. An HMO must fail the encounter data criteria in consecutive years in order to progress to the higher level penalties. An HMO meeting all of the encounter data criteria for a year resets the penalties to the beginning year. An example of the progressive penalties is outlined below:

a. Example: A HMO fails one of the encounter data criteria for two years in a row. The HMO would be subject to the second year penalty.

b. Example: A HMO fails one of the encounter data criteria for two years in a row. In the third year it successfully meets all of the criteria. In the fourth year it fails one of the criteria and will be assessed the first year penalty.

F. Coordination of Benefits (COB), Encounter Record, Member Grievances and Appeals, and Birth Cost Reporting Requirements

The HMO agrees to furnish to the Department and to its authorized agents, within the Department's time frame and format, information that the Department requires to administer this Contract, including but not limited to the following:

1. Encounter Record for Each Member Service

   An encounter record for each service provided to members covered under this Contract. The encounter data set must include at least those data elements specified in the Encounter User Guide or elements required by the national standards.

2. Member Grievances and Appeals to the HMO

   Copies of all member grievances and appeals and documentation of actions taken on each grievance and appeal.

3. Court Ordered Birth Costs (BadgerCare Plus Only)

If a child's mother is enrolled in the HMO at the time of birth, the County Child Support Agency (CSA) may obtain a court order requiring the father to repay birth costs. The Department of Children and Families (DCF) uses regional averages for birth costs. These averages are updated annually and are available on the DCF webpage. In some counties, a judge will not assign birth costs to the father based upon average costs. In those cases, the HMO must produce a report with the actual birth costs. The HMO must collect and maintain detailed costs and services provided for the delivery of the infant. When requested by the Department of Wisconsin Child Support Agency, the HMO must provide a detailed cost of the delivery of the infant. Birth cost information must be submitted to the DHS within 14 days from the date the request was received by the HMO.

G. Records Retention

The HMO must retain, preserve, and make available upon request all records relating to the performance of its obligations under the Contract, including paper and electronic claim forms, for a period of not less than ten years from the date of termination of this Contract. Records involving matters that are the subject of litigation or audit shall be retained for a period of not less than ten years following the termination of litigation or audit. Copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, if the Department approves the microfilming procedures as reliable and supported by an effective retrieval system.

H. Reporting of Corporate and Other Changes

The HMO must report to the Department through their Managed Care Analyst any change in corporate structure or any other change in information previously reported, such as through the application for certification process. The HMO must report the change upon submission of the Application of Change in Domestic Company Status with the Office of the Commissioner of Insurance.

1. Any change in information relevant to ineligible organizations.
2. Any change in information relevant to ownership and business transactions of the HMO.

I. Financial Template

1. Annual Reporting
    a. The HMO is required to submit financial templates per the schedule and instructions provided in the financial template.
    b. As instructed in the Annual HMO Financial Audit Guide, the HMO is required to submit a Medicaid supplemental schedule along with the financial template. The Medicaid supplemental schedule will specifically segregate the financial results for the BadgerCare Plus and Medicaid SSI contract from other lines of business for the required audit period and be reported on a GAAP basis. The supplemental schedule must provide assurance that the financial template information submitted to DHS by the HMO is verifiable, complete and ties to the other audited financial statements, and must be submitted in accordance with the instructions stated in the HMO Annual Financial Audit Guide.
    c. The internal audit and subsequent Medicaid supplemental schedule must be certified by an independent auditor.
    d. Additionally, the HMO must provide the department all work papers used to verify that the financial template was accurate per the CMS Citation 438.3(m).

e. If the auditor is unable to verify the accuracy of the financial template the HMO must notify the department immediately with a plan which will allow them to submit a template which is verifiable per the CMS citation.

f. The letter and work papers must be submitted to the Department at both DHSDMSBRS@dhs.wisconsin.gov and DHSOIGManagedCare@dhs.wisconsin.gov.

g. The Financial Template can be found on the ForwardHealth Portal.

h. If the HMO is unable to deliver any of the required materials by the due date, they must request an extension within five business days by emailing the request to: DHSDMSBRS@dhs.wisconsin.gov. The HMO must provide an alternative due date as part of the request.

i. The HMO will be responsible for using the most updated version of the guide posted to the website. Questions on the financial reports should be directed by email to: DHSDMSBRS@dhs.wisconsin.gov.

2. Quarterly Reporting

The HMO is required to submit financial information on a quarterly basis to help identify emerging trends in service delivery. A quarterly template will be distributed to the HMO and is to be completed 45 days after the end of each quarter. The HMO will be notified and provided with updated versions as necessary. The HMO is required to submit the quarterly financial report per the schedule and instruction provided in the most recent version of the quarterly financial report template provided by DHS.

3. Financial and Encounter Independent Audit

The Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the financial and encounter data submitted by, or on behalf of, each HMO no less frequently than once every three years.

The HMO must comply timely with all reasonable requests made by the independent auditor. This includes but is not limited to providing them on-site work space and access to materials and staff necessary to perform the audit.

The following costs are excluded from rate setting:

a. Advertising and Marketing, unless permissible as part of the HMO and PIHP Communication, Outreach, and Marketing Guide

b. Lobbying

c. Charitable Contributions and Donations

d. Regulatory Fines and Penalties

e. Travel Costs beyond those necessary to provide member healthcare services or economical administration of the Wisconsin Medicaid program

f. Entertainment

Unallowable costs must be reported in the identified section of the financial reporting template. The department reserves the right to make adjustments to financial submissions for costs deemed unallowable based on Department or auditor review.

J. Contract Specified Reports and Due Dates

The HMO must meet timely submission deadlines for the reports required in this contract as well as additional reports or responses requested by the Department. Failure to meet specified submission deadlines without an approved extension could lead to action against the HMO as provided under Article XIV.D., at the discretion of the Department.

Any reports that are due on a weekend or holiday are due the following business day. The Department electronically produces multiple reports and resources for use by BadgerCare Plus and Medicaid SSI HMOs, which are listed at the following website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/HMOAdministrators.aspx

K. Communicable Disease Reporting

As required by Wis. Stats. 252.05, mandated providers affiliated with a BadgerCare Plus and/or Medicaid SSI HMO shall report the appearance, suspicion or diagnosis of a communicable disease or death resulting from a communicable disease to the local health department for any member treated or visited by the provider. Reports of human immunodeficiency virus (HIV) infection shall be made directly to the State Epidemiologist. Such reports shall include the name, sex, age, residence, communicable disease, and any other facts required by the local health department and Wisconsin Division of Public Health. Such reporting shall be made within 24 hours of learning about the communicable disease or death or as specified in Wis. Adm. Code DHS 145. Charts and reporting forms on communicable diseases are available from the local health department. Each laboratory subcontracted or otherwise affiliated with the HMO shall report to the local health department the identification or suspected identification of any communicable disease listed in Wis. Adm. Code DHS 145. Reports of HIV infections shall be made directly to the State Epidemiologist.

L. Program Integrity

1. Compliance Program Requirements

   The HMO must have documented administrative and management arrangements, written procedures, a mandatory compliance plan, and a Fraud Waste and Abuse (FWA) Strategic Plan that are designed to guard against fraud, waste and abuse. The HMO must cooperate with the Department on fraud, waste and abuse investigations.

   a. Administrative Management Arrangements:

      The HMO's arrangements must at a minimum include the following:

i. An organizational chart depicting the designation of a Compliance Officer and a Regulatory Compliance Committee that is accountable to senior management.

a) The Compliance Officer is responsible for the following activities:

1) Operating the HMO's compliance program and overseeing HMO and employee compliance with all provisions

2) Assessing the HMO's operations, policies and reporting and oversight system to mitigate risk and ensure the HMO and network providers are performing their duties in compliance with its respective contracts.

3) Developing a risk profile that evaluates current risks facing the HMO.

4) Working with the organizations employees to develop appropriate internal controls to mitigate identified risks.

5) Coordinating investigations and audits with appropriate organization employees.

ii. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level. The Regulatory Compliance Committee must, at a minimum:

a) Oversee the HMO's compliance program, including enforcement of the compliance plan, and its compliance with contract requirements.

b) Include governing board members and other senior management (such as the Chief Financial Officer and/or the Chief Operating Officer), and include individuals with a variety of backgrounds, including auditing, clinical, legal, and statistical experience.

c) Reflect the size and scope of the HMO's responsibilities under its contract with the State.

d) Clearly articulate its role in the Compliance Plan.

e) Have consistent and objective, oversight of the HMO and function with the HMO's overall compliance and program integrity activities.

f) Meet at least quarterly to ensure reasonable oversight of the compliance program.

g) Develop strategies to promote compliance and the detection of any violations.

h) Review and approve compliance and training on fraud, waste and abuse and ensure that training and education are effective and appropriately completed.

i) Assist with the creation and implementation of a compliance risk assessment and compliance monitoring and auditing work plan.

j) Review the effectiveness of the system of internal controls designed to ensure compliance with federal and state requirements in daily operations.

k) Support the Compliance Officer's need for sufficient staff and resources to carry out duties.

l) Ensure that the HMO has up to date compliance policies and procedures.

m) Ensure that the HMO has a method for members to report potential fraud, waste and abuse.

n) Ensure that the HMO has a system for employees and contractors to seek assistance with compliance issues and report noncompliance or potential fraud, waste and abuse confidentially without fear of retaliation.

o) Review and address reported issues and focus audits on at risk areas for the HMO and ensure associated corrective action plans are implemented and monitored for effectiveness.

p) Provide the HMO's governing body with regular and ad hoc reports on the status of compliance, including recommendations for improvement.

iii. The assignment of dedicated staff responsible for identifying, mitigating, and preventing fraud, waste, and abuse.

a) The activities and performance of the assigned staff are subject to audit and review by the DHS Office of the Inspector General (DHS OIG).

2. Written Policies, Procedures and Standards of Conduct

The HMO written policies, procedures, and standards of conduct must include:

a. Articulation of the HMO's commitment to comply with all applicable federal and state laws and rules.

b. A schedule of annual training and education for the Compliance Officer, the HMO's senior management, and the HMO's employees for the federal and state laws, rules and requirements, including program integrity under the contract.

c. Documented lines of communication between the compliance officer, senior management and the HMO's employees.

d. Disciplinary guidelines for enforcement of program integrity standards and schedule for publicizing the guidelines.

e. The establishment and implementation of documented procedures and a system with dedicated staff for:

    i. Routine internal monitoring and auditing of compliance risks related to provider network, including both prepayment and post-payment program integrity strategies:

        a) Post-payment program integrity strategies must include network provider audits of medical records for verification of actual provision of services. The Department may request formal audit or review by the HMO of specific providers for FWA issues identified by DHS OIG.

        b) HMO may use network provider audits to evaluate the efficacy of other internal HMO functions, such as prior authorization. The HMO may not seek recoupment for findings that are rooted in performance errors of HMO employees.

        c) The HMO's contract with its network providers must explain the audit process including authority used by the HMO for audit citations as well as the authority to recoup overpayments, extrapolate audit findings, or take other actions.

        d) If the HMO uses extrapolation as a program integrity tool, the sampling and extrapolation methodologies must be compliant with Wis. Admin. Code DHS § 105.01 (3)(f).

        e) The Department is not a party to complaints, lawsuits, or other actions taken due to action taken by the HMO, because the contract between the HMO and the network provider is between two private entities.

        f) Cost avoidance or prepay strategies must include a method of quantifying, documenting, and reporting savings to the

HMO and/or the Department. Cost avoidance strategies should be properly reported on the Cost Avoidance Log of the quarterly program integrity report.

ii. Prompt response to compliance issues, both internal and related to the provider network, as they are raised.

iii. Timely investigation of potential compliance issues, both internal and related to the provider network, identified during self-evaluation and audits.

iv. Prompt and thorough correction of such issues to reduce the potential for recurrence.

v. Ongoing compliance with the requirements under the contract.

f. If the HMO makes or receives annual payments under the contract of at least $5,000,000, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about right of employees to be protected as whistleblowers.

i. Whistleblowers should report program integrity concerns to the DHS OIG. Whistleblowers may make a report through the hotline (877-865-3432) or through the online portal: (https://www.reportfraud.wisconsin.gov/RptFrd).

ii. The HMO is responsible for ensuring employees have access to this information.

g. Policies and Procedures to implement all payment suspensions imposed by DHS OIG.

3. Compliance Plan

a. The HMO is responsible for developing an annual compliance plan which must, at minimum, covers the requirements in Article XII.L.1. and M.2. of this contract and was previously submitted as part of the certification application process. This is separate from the Fraud, Waste, and Abuse Strategic Plan.

b. The compliance plan must be approved annually by DHS OIG by December 31st or the last business day of the calendar year.

i. The HMO must submit their current compliance plan with a crosswalk identifying any changes from the previous year no later than November 15th via the DHS OIG SharePoint site.

ii. The DHS auditor will review the compliance plan according to the requirements outlined in Article XII.L.1 and L.2. of this contract, and either approve the plan or return it to the HMO for changes.

iii. If changes are necessary, the HMO must implement the changes and resubmit the compliance plan back to the DHS auditor via the DHS OIG SharePoint site for additional review.

4. Annual Fraud, Waste and Abuse (FWA) Strategic Plan

   a. The HMO is responsible for developing an annual FWA strategic plan which meets the requirements outlined in Addendum VII.

   b. The FWA strategic plan must be approved annually by DHS OIG by the last business day of the calendar year.

      i. The HMO must submit a draft of their proposed FWA Strategic Plan by November 15th via the DHS OIG SharePoint site.

      ii. The DHS auditor will review the FWA strategic plan according to the requirements outlined in Addendum VII and either approve the plan or return it to the HMO for changes.

      iii. If changes are necessary, the HMO must implement the changes and resubmit the FWA Strategic Plan back to the DHS auditor via the DHS OIG SharePoint site for additional review.

   c. Failure to submit a plan meeting the requirements outlined in Addendum VII may result in action against the HMO as provided under Article XIV.D.

   d. The HMO must document and be prepared to submit evidence of completion of all activities included in the annual FWA strategic plan during DHS's annual audit of the FWA strategic plan.

   e. The HMO implemented their first annual FWA strategic plan on January 1, 2023, and will implement a new plan annually thereafter.

   f. HMOs found to be out of compliance with their annual FWA strategic plan or in need of improvement will receive technical assistance following the first review by The Department. The Department will provide technical assistance through a variety of means including but not limited to monthly meetings and written documentation.

   g. The Department may pursue action against the HMO as provided under Article XIV.D for HMOs who fail to engage in technical assistance or in The Departments audit process.

   h. The HMO must communicate any mid-year changes to the annual FWA strategic plan to DHS and submit an updated plan for DHS approval.

5. FWA Strategic Plan Annual Evaluation

   a. The Department will evaluate, on an annual basis, the HMO's compliance with their FWA strategic plan in the year following the end of the contract year's strategic plan.

b. The Department will evaluate the FWA Strategic Plan for compliance with the plan's reported data analytics activities, program integrity initiatives, prepayment activities, post payment activities and verification of services.

c. The HMO must comply with all requests from the Department for documents necessary to complete the FWA Strategic Plan Annual Evaluation. The Department may request documents including but not limited to:

   i. Analytics reports.

   ii. Recoupment reports.

   iii. Prepayment and post payment summary reports.

   iv. Summary reports for individual program integrity initiatives.

   v. Network provider audit reports.

   vi. Fraud, waste, and abuse investigation reports.

d. The Department will use the following process to complete the Annual FWA Strategic Plan Evaluation:

   i. The Department requests documentation specific to the HMO's FWA Strategic Plan.

   ii. The Department reviews the submitted documentation.

   iii. The Department provides the HMO with feedback including any findings and instructions for submitting rebuttal including a due date.

   iv. HMO provides rebuttal within the specified timeframe. If rebuttal is not received within the specified timeframe, the Department issues the final evaluation report.

   v. The Department reviews additional information submitted by the HMO.

   vi. The Department issues a final evaluation report including any mitigation strategies which may include but are not limited to technical assistance, prescribed activities in the next plan, enhanced monitoring, or action as provided under Article XIV.D.

   vii. DHS OIG will request the Division of Medicaid Services (DMS) issue financial penalties when:

      a) An HMO has refused to engage in technical assistance provided by DHS OIG in response to a determination that the HMO is out of compliance with their FWA strategic plan; or

      b) An HMO has refused to engage in the audit process.

6. Suspected Fraud, Waste and Abuse

Investigations of suspected or substantiated fraud, waste and abuse develop when a provider is suspected of having received Medicaid reimbursement for which they are not entitled or causing the unnecessary expenditure of Medicaid funds through unnecessary utilization or other means. All cases of suspected or substantiated fraud, waste, or abuse must be reported to DHS OIG.

The HMO must cooperate with the Department on investigations of fraud, waste, and abuse. Failure on the part of the HMO to report fraud, waste or abuse may result in action as provided under Article XIV.D. Pursuant to 42 CFR § 455.23, the authority of determining credible allegations of fraud rests with the Department.

a. Prompt Reporting of Suspected Fraud, Waste and Abuse

i. For each identified or reported case of suspected fraud, waste, or abuse the HMO must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

ii. All cases of suspected fraud, waste, and abuse must be reported to DHS OIG through the hotline (877-865-3432) or online portal (https:www.reportfraud.wisconsin.gov/RptFrd) within 2 business days of the conclusion of the preliminary investigation.

iii. The preliminary investigation must include:

a) Date the suspected fraud, waste, and abuse was identified or reported to the HMO.

b) A detailed summary of the actions taken to investigate the issue.

c) A determination of whether the fraud, waste, and abuse issue is substantiated or unsubstantiated.

d) A detailed explanation of the facts supporting the determination.

e) An explanation of whether a full investigation will be conducted.

f) A detailed explanation of the facts supporting whether a full investigation will or will not be conducted.

g) Planned next steps.

iv. A case of suspected fraud, waste, or abuse is referred to as a complaint.

a) Subject matter for complaints includes any issue or risk that has the capacity to develop into a credible allegation of

fraud, which includes but is not limited to complaints, tips, trend analysis, pre-payment review, billing errors, and audits.

b) Do not report violations that occurred in the HMO's non-Medicaid lines of business that did not result in the loss, or potential loss, of Wisconsin Medicaid funds.

c) Reports of suspected and substantiated fraud from an HMO must not be made anonymously.

d) Reports made to the hotline or through the portal may be subject to open records laws.

e) Documentation of preliminary investigations must be retained in accordance with Article XII.L.13 of this contract.

v. The HMO must submit a preliminary investigation summary to DHS OIG, through the hotline or portal, at the time the complaint is filed.

vi. All complaints made to DHS OIG through via the hotline or portal, whether substantiated or unsubstantiated, must be reported on the HMO's QPIR and indicated as an ongoing or completed investigation.

vii. A credible allegation of fraud referral form (F_02296) may be submitted with the complaint if the preliminary investigation substantiates fraud.

viii. The HMO must conduct a full investigation if the preliminary investigation determines the alleged fraud is substantiated.

a) The full investigation is an in-depth review of the alleged fraud which seeks to collect facts and supporting documentation needed for referral to the Wisconsin Department of Justice (DOJ) – Medicaid Fraud Control and Elder Abuse Unit (MFCEAU).

b) At a minimum, for every full investigation the HMO shall document the occurrence, or non-applicability, of the following actions, including dates and a detailed case notes.

1) The information from the original complaint

2) Description of the focus of the investigation

3) Data reviewed

4) Sample requested

5) Date medical records requested

6) Date medical records received, not received, or received incomplete

7) Date medical review initiated

8) Date medical review completed

9) Interviews with members, providers, or other relevant individuals

10) On-site visits or audits

11) Overpayment calculated

12) Extrapolation calculated

13) Communication (written or verbal) with members, providers or other relevant individuals

c) The HMO must continue to report the investigation on the QPIR and indicate whether the case is ongoing or complete.

d) The HMO has 270 days from the date the preliminary investigation was reported to complete the full investigation of the alleged fraud, waste, and abuse and either determine a referral will be submitted to DHS OIG or close the case and take other administrative action as appropriate.

e) The HMO shall notify their OIG representative via email and provide and explanation why any full investigation will not be completed within the required 270 days. OIG may grant an extension for extenuating circumstances.

b. Reporting Substantiated Fraud

i. Fraud is considered substantiated if the allegation has been verified and the allegation has indicia of reliability. The HMO must report all cases of substantiated fraud as a credible allegation of fraud referral using the F-02296 referral form via the DHS OIG SharePoint site or DHSOIGManagedCare@wisconsin.gov email address.

ii. The HMO can submit all supporting information including available data, statements from appropriate parties, audit reports, records, and other materials supporting the allegations as exhibits with the referral form.

iii. The HMO can use the DHS OIG SharePoint site as a secure method to upload the referral form and exhibits. Referrals and exhibits may also be emailed securely to

DHSOIGManagedCare@wisconsin.gov or uploaded directly to the open OIG case through the DHS OIG portal.

iv. Upon receiving an allegation of substantiated fraud, DHS OIG will conduct a preliminary review to determine whether there is sufficient basis to warrant referral to the DOJ.

v. Following the submission of the credible allegation of fraud referral, the HMO may continue to investigate the allegations as appropriate unless otherwise directed by DHS OIG, Department of Justice Medicaid Fraud Control and Elder Abuse Unit (MFCEAU), or other law enforcement or regulatory entity.

vi. The HMO must collaborate with its DHS OIG representative or MFCEAU investigator to provide any additional information or documentation that may be requested for the case.

vii. If an HMO forwards a report of suspected or substantiated Medicaid fraud to any additional state or federal agency, the HMO must notify the DHS OIG of that referral.

viii. The HMO must demonstrate effort through conducting audits and investigations to try to achieve the benchmarks for submitted credible allegation of fraud referrals prescribed in the chart on the DHS OIG SharePoint site. The assigned number of referrals is commensurate to the number of members served by the plan.

a) HMO referrals presented by DHS OIG to DHS OIG management and legal counsel, or are submitted to MFCEAU by OIG on the abbreviated credible allegation of fraud spreadsheet, count towards the benchmark.

b) Compliance with this requirement will be measured through applied effort, as determined by the Department, to meet or exceed the benchmark number of referrals. This will be measured on an ongoing basis through monthly meetings with the DHS OIG auditor and monitoring of the plan's QPIRs and fraud, waste, and abuse strategic plans.

c. Reporting Substantiated Waste and Abuse

i. In accordance with Article XII.L.6.a.ii. the HMO should have previously reported cases of substantiated waste or abuse as a complaint with suspected waste or abuse to DHS OIG within 2 business days of the completion of the preliminary investigation.

ii. The HMO must also report all substantiated and unsubstantiated complaints on the plan's QPIR.

iii. The QPIR entry indicating the case was in the investigation phase should be updated to indicate the investigation is complete and whether waste or abuse was or was not substantiated.

iv. The HMO should also indicate on the QPIR what action will be taken to mitigate the risk. Examples include educating the provider, recouping the overpayment, etc.).

7. Suspension of Provider Payments

The HMO must have policies and procedures in place to implement all payment suspensions imposed by DHS OIG

a. Pursuant to 42 CFR §438.608(a)(8), the HMO is prohibited from paying for an item or service furnished by an individual or entity to whom the state has suspended payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments. The DHS Inspector General must review and authorize any request for a good cause exception.

b. The HMO must have a documented process outlining the HMO's response to information in the provider file from the Department notifying the HMO of suspension of payment. The provider file sent by the Department to the HMO will have a field that will indicate the outcome of the credible allegation of fraud investigation. They are:

i. A- Suspension of payment is currently active. The HMO must suspend payment based on the effective date for the start of the investigation.

ii. C – The provider has been cleared of the credible allegation of fraud investigation. There will be an end date for the investigation.

iii. T – The provider has been terminated due to the outcome of the credible allegation of fraud investigation. The contract's termination date will be listed in the provider file.

c. The HMO must have a written process documenting its response to email notification of provider payment suspensions from the DHS OIG resulting from credible allegations of fraud, including but not limited to how the payments are suspended in the HMO's claims processing system and any required internal communications.

d. The HMOs must have clearly defined criteria, policies, and procedures in place for suspending providers outside of suspensions issued by the DHS OIG.

i. These policies and procedures must include notification of DHS within 24 hours of the suspension of payments using the DHSOIGManagedCare@wisconsin.gov email address.

ii. HMOs must also record these payment suspensions on the Terminations/Sanctions/Suspensions tab of the Quarterly Program Integrity Report (F-02250).

8. Termination or Exclusion of Network Providers

The HMO must report providers terminated for cause by the HMO, as well as providers the HMO identifies as excluded, to DHS OIG.

a. The HMO must report terminated providers within 24 hours of the date the provider was notified of their termination or suspension.

b. The HMO must send an email to DHSOIGManagedCare@wisconsin.gov with "Terminated/Excluded Provider" as the subject line. The body of the email must include the name of the provider, NPI and MA ID numbers, date of termination/exclusion, reason for termination/exclusion and the date the appeal window closes.

c. This information must also be captured on the Termination/Sanctions/Suspension tab in the Quarterly Program Integrity Report (F-02250). DHS OIG may follow up for additional information depending on the reason for termination.

9. Treatment of Overpayment Recoveries – Overpayments Made to Network Providers by the HMO

Pursuant to 42 CFR s 438.608(d), the HMO must attempt to recover all overpayments made to network providers, including those overpayments attributed to fraud, waste, and abuse, identified by the HMO.

a. The HMO recovers the overpayments and retains the funds for all overpayments identified by the HMO or provider.

b. DHS OIG recovers any overpayments identified by DHS OIG or its vendors through network provider audits or other means from the HMO and retains the funds.

c. The HMO must have a documented process requiring the network providers to return any overpayments discovered by the provider, HMO, DHS OIG, or DHS OIG's vendors.

i. The HMO must share the documented process with all providers in the HMO's network.

ii. The HMO must require the network providers to return overpayments within 60 days or less of the provider receiving written notification of the overpayment or, if self-identified by the provider, within 60 days or less of the provider's discovery of the overpayment.

iii. The HMO must require the provider to notify the HMO of the reason for all returned overpayments may be appropriately reported on the overpayment tab of the QPIR.

iv. The HMO must appropriately reflect the recovery of all overpayments in the HMO's encounter data and on the overpayment tab of the Quarterly Program Integrity Report.

v. Provider agreement language must require network providers to follow the same requirements when they self-identify an overpayment they have received.

10. Treatment of Overpayment Recoveries – Overpayments Made to the HMO by the State

a. The HMO is responsible for monitoring ForwardHealth interChange enrollment and capitation payment reports for discrepancies in members the HMO considers enrolled. Any discrepancies which resulted in an overpayment to the HMO from the State must be reported to OIG via e-mail at DHSOIGManagedCare@wisconsin.gov within 30 days after the close of the capitation month in which the overpayment was identified. Examples of capitation discrepancies include but are not limited to:

i. Incorrect HMO.

ii. Member has passed away.

iii. Member is incarcerated.

iv. Incorrect rate region.

v. Incorrect age.

vi. Issues related to enrollment or termination dates.

b. HMOs must submit a monthly report of any capitation payments or other payments in excess of amounts specified in the contract within sixty (60) calendar days of identification as required by 42 CFR 438.608(c)(3). HMOs must submit the report via DHS OIG's SharePoint site. The report must contain the following information:

i. The HMO's name;

ii. The member's Medicaid number;

iii. The member's name;

iv. The month or number of days if partial month;

v. The rate paid;

vi. The correct rate;

vii. The reason for the overpayment, if known;

viii. The original date the overpayment report to DHS; and

ix. The action taken by the HMO, if any.

11. Network Provider Audits

For purposes of Network Provider Audits, DHS OIG includes DHS OIG's contracted program integrity vendors.

a. Process for DHS OIG Notice and Recovery

i. DHS OIG will conduct audits of the HMO's network providers. DHS OIG will utilize the fee-for-service max fee tables when assigning value to services provided in the preliminary stage of the audit.

ii. After DHS OIG reviews any rebuttal submitted by the provider, DHS OIG will send a notice of intent to recover to the provider notifying them of the identified overpayment. The HMO must submit the actual payment amounts made to the provider in advance of the issuance of the notice of intent to recover.

iii. The HMO must respond within 14 days of DHS OIG's request for actual paid amounts. DMS will validate the accuracy of the HMO's submitted cost information.

iv. The HMO must collaborate with DHS OIG on all matters related to these audits including, but not limited to:

a) Coordinating deconfliction efforts relative to scope and sample to prevent a duplication of audit efforts between DHS OIG and the HMO.

1) DHS OIG will notify the HMO by email and upload a deconfliction spreadsheet to the HMO SharePoint for each network provider audit. The deconfliction spreadsheet will contain the scope and sample information pertaining to the potential audit.

2) The HMO must accurately complete all fields whether they are currently investigating the provider(s) and provider type(s) indicated on the deconfliction spreadsheet. DHS OIG will remove any conflicting information from the audit and the HMO should continue with their investigation as planned.

3) As part of the deconfliction process, the HMO must confirm that the findings are

appropriate within the HMO's contract with the network provider.

4) The HMO has 14 business days to review and respond to the deconfliction spreadsheet. The HMO must include in its response any concern over its ability to collect an overpayment identified by DHS OIG from the provider. The HMO must upload its response to the HMO SharePoint site.

b) Sharing claims-level data for PI purposes;

c) Receiving copies of audit related communications between DHS OIG and the network providers;

d) Engaging in audit resolution which may include:

1) Technical assistance to both the plan and provider.

2) Corrective action plans administered by DHS.

3) Referrals to MFCEAU or DSPS.

4) Termination of a network provider's Medicaid certification.

5) Financial penalties administered by DMS, under Article XIV.D.

6) Or other means by which continued issues with the audit findings can be addressed.

e) Voiding encounters within 30 days from recouping the funds from the provider;

f) Ensuring audit findings are addressed across the HMO'S entire network of providers, not just the provider(s) included in DHS OIG's audit;

g) Engaging in the overpayment recoupment process based on DHS OIG's audit findings:

1) DHS OIG will recover all overpayments based upon DHS OIG's audit of the network provider. The HMO will recover the overpayment from the audited network provider.

A) DHS OIG is entitled to keep the overpayment recoupment from the HMO.

B) The HMO is entitled to keep the recovered overpayment from the provider.

C) DHS OIG is responsible for returning the federal share.

2) The HMO must include the following items related to OIG's network provider audit overpayment recoupments in its provider agreements.

A) The provider may appeal to DHS OIG identified overpayments to the HMO.

B) The provider may appeal to the Department, following the process outlined in in Article VIII of this contract, if the provider disagrees with the HMO decision to uphold the overpayment recovery.

C) The HMO does not have appeal rights for any component of the network provider audit process.

D) The HMO cannot influence the provider's decision to file an appeal.

E) The HMO must notify DHS OIG of all provider appeals to the HMO related to the network provider audit within 3 business days.

3) The HMO must document the recovery of any overpayments associated with network provider audits conducted by DHS OIG on the overpayment tab of the Quarterly Program Integrity Report by entering "OIG Audit (OIG case number)" in the column labeled, "Reason for Recovery."

h) Ensuring that provider agreements require the HMO's network providers to collaborate with DHS OIG in the following ways:

1) Network providers must respond to requests for all records made by DHS OIG in a timely manner as specified in any record request letter sent to network providers by DHS OIG.

2) If a network provider would like to submit rebuttal to initial findings for consideration by DHS OIG, the network provider must submit the rebuttal documentation to DHS OIG by the date specified in the preliminary findings letter.

12. Corrective Action Plans and Sanctions

If the Department pursues action against the HMO as provided under Article XIV.D., then the HMO is required to respond within the timeframes specified.

13. Quarterly Program Integrity Reporting

The HMO must submit the Quarterly Program Integrity Report (F-02250) to DHS OIG on a quarterly basis.

a. The log must be completed thoroughly and accurately and is due no later than the last business day of the month following the end of the calendar year quarter (April, July, October, and January).

b. The Quarterly Program Integrity Report consists of the following reporting categories:

i. Program Integrity Log: Captures complaints regarding fraud, waste, and abuse received by the HMO warranting preliminary investigation.

ii. Provider Education Log: Captures education given to network providers and subcontractors related to billing practices, billing errors, or fraud, waste, and abuse. HMOs should differentiate between education that originates from a complaint, training requested by the provider and regular scheduled training opportunities. It is unnecessary to capture education regarding subject matter unrelated to program integrity.

iii. Overpayment Recovery Log: Captures pertinent information regarding all overpayment recoveries, not just those recovered due to fraud, waste, and abuse.

iv. Termination/Sanctions/Suspension Log: Captures all terminations, sanctions, and payment suspension actions taken by the HMO that impact Medicaid network providers.

v. Subcontractor Log must include the following information:

a) All subcontractors who provide any function or service for the HMO's related to securing or fulfilling the HMOS's obligations under the terms of this contract. This is not limited to program integrity subcontractors. Network providers are not considered subcontractors.

b) Compliance of the subcontractor's disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in §§ 455.104 and 438.602(c).

vi. Cost Avoidance/ and Prepay Log: Captures all savings to the program through cost avoidance or prepay strategies which do not have overpayment recoveries associated with the activity. For example, a cost avoidance strategy would be implementing a system edit that prevented the release of improper payments. Prepayment strategies include money withheld during prepayment review for failure to meet program requirements.

vii. Data Program Integrity Log: This optional tab that captures any data activities that have not developed into a case and have not been captured on the Program Integrity Log. If the Program Integrity Log captures all the HMO's data activities, then this tab does not need to be completed.

c. The Quarterly Program Integrity Report must be submitted to the Department via DHS OIG's SharePoint site.

i. DHS OIG will evaluate the submitted reports and may follow up with the HMO to obtain additional information, provide technical assistance, or request further action.

ii. In response to non-compliance with reporting requirements and deadlines, the Department may pursue action against the HMO as provided under Article XIV.D.

14. Quarterly Meetings

OIG facilitates meetings with the HMOs, DOJ MFCEAU, and the Division of Medicaid Services on a quarterly basis. The meetings are conducted virtually, and agendas are provided in advance. OIG will present program integrity information including annual training on payment suspensions and fraud, waste, and abuse detection.

a. The HMO's Compliance Officer or representative must be in attendance to represent their respective HMO.

i. Applicable staff from the HMO's SIU/compliance departments or program integrity subcontractor(s) should attend the meetings. HMO management can evaluate the agenda and determine which staff should attend.

ii. The Compliance Officer or HMO representative(s) must communicate information presented at the meetings to the

applicable staff that aren't in attendance such as SIU employees, compliance employees, or claims processing employees.

b. If an HMO has a program integrity subcontractor who submits complaints on their behalf, the subcontractor must attend any meetings in which information about complaints is presented. DHS OIG will denote these topics on the agenda with an asterisk.

15. HMO Technical Assistance Check-In Meetings

In support of relationship building and accountability, DHS OIG facilitates meetings with each HMO.

a. Meeting topics will focus on collaborating and providing technical assistance on QPIRs, fraud referrals, Annual Fraud, Waste and Abuse Strategic Plans, Compliance Plans and issues identified through network provider audits.

i. Prior to the meeting, DHS OIG will collaborate with the HMO to identify topics for discussion.

b. The HMO's Compliance Officer or representative must attend.

i. Staff from the HMO's SIU/compliance departments or program integrity subcontractor(s) must also attend the meetings as HMO management determines applicable.

ii. The Compliance Officer or HMO representative(s) must communicate information presented at the meetings to the applicable staff that aren't in attendance such as SIU employees, compliance employees, or claims processing employees.

c. If an HMO has a program integrity subcontractor who submits complaints on their behalf, the subcontractor may attend all meetings, but must attend any meetings in which information about complaints is presented. DHS OIG will denote these topics on the agenda with an asterisk.

d. Each HMO must participate in 2 meetings per quarter. A meeting does not need to be held during the same month as the Quarterly Program Integrity Meeting.

i. DHS OIG and each HMO must determine the date and time for the meeting. DHS OIG will email an agenda to each HMO one week prior to the meeting.

ii. In the months a meeting is not held, DHS OIG will continue to monitor program integrity activities by reaching out to each individual HMO in an email to determine if there are any questions or issues that need to be addressed.

iii. DHS OIG or the individual HMO may request an ad hoc meeting in any month a meeting is not scheduled.

16. Records Retention

The HMO must retain records pertaining to all program integrity activities, including but not limited to audits, investigations, review, Quarterly Program Integrity Reports, FWA Strategic Plans, Compliance Plans, and complaints as required in Article XII.G in this contract, which requires documentation to be retained for a period of not less than ten years from the date of termination of this contract.

17. Special Investigation Unit (SIU) Reviews

OIG reviews and provides feedback regarding the quality of the HMO's SIU work through the portfolio of the following activities described in Article XII.L. This phased approach allows for continuous monitoring throughout the year. There is not a specific SIU review document as Articles XII.L.3, XII.L.5, XII.L.11, and XII.L.13 describe the documentation strategies for each of the individual components of the SIU reviews.

a. Compliance Plan Reviews (Article XII.L.3)

b. Evaluations of compliance with the Fraud, Waste, and Abuse Strategic Plans (Article XII.L.5)

c. Network Provider Audits (Article XII.L.11)

d. Reviews of the Quarterly Program Integrity Reviews (Article XII.L.13)

M. Non-Disclosure of Trade Secrets and Confidential Competitive Information

1. The Department shall not disclose, orally or in writing, to any person other than their respective employees, agents, contracted actuary, auditors, or advisors, any confidential or proprietary information, knowledge or data concerning the business, affairs, operations, secrets, dealings, or finances of the HMO furnished directly or indirectly by the HMO to the Department without the prior written consent of the HMO. As used in this Contract, HMO Confidential Information does not include any information which:

   a. at the time of disclosure is generally available to and known by the public (other than as a result of disclosure directly or indirectly by the Department);

   b. was available to the Department on a non-confidential basis from a source other the HMO, provided that such source is not and was not bound by a confidentiality agreement with the HMO; or

   c. has been independently acquired or developed by the Department without violating any of the obligations hereunder.

2. If the Department is requested or required in connection with any legal proceeding to disclose any HMO Confidential Information, the Department will give the HMO prompt written notice of such request or requirement so that the HMO may seek an appropriate protective order or other remedy. If the HMO does

not seek or obtain a protective order or other remedy, the Department will furnish only that portion of the HMO Confidential Information that is legally required to be disclosed or otherwise required by law or ordered by a court.

N. Medical Loss Reporting (MLR)

1. MLR Requirement

   The HMO is required to calculate and report a Medical Loss Ratio (MLR) each year consistent with MLR standards as specified by the Department and described in 42 C.F.R. § 438.8. The MLR is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)). The HMO must submit the MLR on May 30 of the following year with the annual financial reporting submission in the designated worksheet within the HMO Financial Reporting Template. The HMO must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting MLR reports in the required Financial Statement Certification submitted with the required audit submissions. If the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the HMO must recalculate the MLR for all MLR reporting years affected by the change. It must then submit a new MLR report meeting the applicable requirements in the designated worksheet within the HMO Financial Reporting Template in the next scheduled financial reporting submission based on the DHS reporting due dates.

2. MLR Reporting Requirements

   a. Each HMO expense must be included under only one type of expense category defined for MLR reporting, unless a proration between expense categories is required to reflect accuracy and a description of the allocation is provided.

   b. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

   c. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

   d. Shared expenses, including the expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

   e. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

   f. The HMO may add a credibility adjustment, which are published annually by CMS, to a calculated MLR if the MLR reporting year experience is partially credible.

g. The HMO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. Any HMO with enrollment greater than the minimum number of member months set by CMS will be determined to be fully credible.

h. If an HMO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

i. The HMO will aggregate data for all Medicaid eligibility groups covered under the contract with the Department.

j. The HMO's MLR report must include the following:

i. Total incurred claims

ii. Expenditures on quality improving activities

iii. Expenditures related to activities compliant with program integrity requirements

iv. Non-claims costs

v. Premium/capitation revenue

vi. Taxes

vii. Licensing fees

viii. Regulatory fees

ix. Methodology(ies) for allocation of expenditures

x. Any credibility adjustment applied

xi. The calculated MLR

xii. Any remittance owed to the state, if applicable

xiii. A reconciliation of the information reported to the annual financial report

xiv. A description of the aggregation method used to calculate total incurred claims

xv. The number of member months

xvi. Additional description and guidelines for the MLR report are located in the MLR worksheet within the DHS HMO Financial Reporting Template.

The HMO must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the HMO within 180 days of the end of the MLR reporting year or within 30 days of being requested by the HMO, whichever comes sooner, regardless of current contractual limitations, in order to calculate and validate the accuracy of MLR reporting to meet the DHS MLR reporting due date.

O. Supplier Diversity Reporting

Minority-Owned Business Enterprises (MBE) and Disabled Veteran-Owned Businesses (DVB) are certified by the Wisconsin Department of Administration (DOA). This program can be found at: https://doa.wi.gov/Pages/DoingBusiness/SupplierDiversity.aspx

The State of Wisconsin is committed to the promotion of MBEs and DVBs in the State's purchasing program. The HMO is strongly urged to use due diligence to further this policy by awarding Subcontracts to MBEs and DVBs or by using such enterprises to provide goods and services incidental to this Agreement.

The HMO shall furnish appropriate monthly information about its efforts to subcontract with MBEs and DVBs, including the identities of such businesses certified by the Wisconsin Supplier Diversity Program, their contract amount, and spend for each period to DHS. A listing of certified MBEs and DVBs, as well as the services and goods they provide, is available at: https://wisdp.wi.gov/Search.aspx

In accordance with WI Stats. Ch. 16.75 (3m), after completion of this contract, the HMO shall report to DHS any amount of this contract that was subcontracted to DOA certified MBEs and DVBs.

DHS shall have the right to request any information regarding the use of subcontractors including, but not limited to, MBEs and DVBs. The HMO shall provide any such information as requested by DHS and within a time period that is specified by DHS.

The HMO shall submit monthly reports of efforts to subcontract with MBEs, DVBs, and other diverse entities/suppliers to DHS. A link to the Supplier Diversity PowerForm for submitting these reports can be found on the DHS Compliance Documentation page found here: https://www.dhs.wisconsin.gov/business/compliance.htm

For the duration of this Agreement, the HMO shall provide monthly reporting of efforts to subcontract with MBEs and DVBs no later than the 15th of the following month.

For questions about reporting, please contact DHS Contract Compliance at DHSContractCompliance@dhs.wisconsin.gov

P. Out-of-Network Utilization Report

HMOs shall submit to the Department an Out-of-Network Utilization Report. The log will include information as stated in the Out of Network Quarterly report data dictionary. The log must include any out-of-network claims processed by any subcontractors.

Q. Quality Management Workplan

1. Quality Management Workplan Contents:

   The HMO shall submit a written quality management (QM) workplan to DHSDMSHMO@wi.gov by the 4th of Monday January 2024. The QM should outline the scope of activity and the goals, objectives, timelines, and responsible person for the QM workplan for the contract period and contains evidence of the HMO's commitment of adequate resources to carry out the program. The HMO's

annual QM plan shall be based on findings from quality assurance and improvement activities included in the QM program. It shall include the following:

a. Potential problem identification through ongoing monitoring efforts;

b. Identification of quality-related problems and causes;

c. Evaluation of problems to determine severity and whether or not further study is warranted by audit or other means;

d. Designing activities to address deficiencies

e. Development and implementation of corrective action plans; and

f. Follow-up activities to determine whether identified quality issues have been corrected.

R. HMO Newborn Report (BadgerCare Plus Only)

The HMO must complete the HMO Newborn Report for infants born to mothers who are BadgerCare Plus eligible and enrolled in the HMO on the infant's birth date. The report must be completed within sixty (60) days of the date of the infant's birth. HMO must use the online form in the ForwardHealth Portal to submit newborn information for more expedited processing.

The requirements for the Newborn Report are included in the ForwardHealth online handbook. The handbook includes instruction for online reporting, links to the form and submission instructions.

S. Reports: As needed

The HMO agrees to furnish reports which may be required to administer this contract, to the Department and the Department's authorized agents. Such reports include but are not limited to corporate restructuring or any other change affecting the continuing accuracy of information the HMO previously reported to the Department.

T. Annual Compliance Review

The HMO must cooperate with the Department's Annual Compliance Review. Inadequate scores on the Annual Compliance Tool may result in action as provided under Article XIV.D. or contract termination.

XIII. Functions and Duties of the Department

A. Utilization Review and Control

The Department will waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, or other BadgerCare Plus and/or Medicaid SSI restrictions for the provision of contract services provided by the HMO to members, except as may be required by the terms of this contract.

B. Department Audit Schedule

The HMO will be notified approximately 30 days prior to regularly scheduled, routine audits being conducted via a letter from the Department.

C. HMO Review of Study or Audit Results

The Department will provide HMOs a 30 calendar day review period, for HMO audits, HMO report cards, HMO Member Satisfaction Reports, or any other HMO studies the Department releases to the public that identifies the HMO by name.

D. Vaccines for Children (BadgerCare Plus Only)

The Department will assure that HMO providers participate in the Vaccines for Children (VFC) program for administration of immunizations to BadgerCare Plus HMO members according to the policies and procedures in the Wisconsin Health Care Programs Online Handbook. The Department will reimburse the HMO for the cost of new vaccines that are newly approved during the contract year and not yet part of the Vaccine for Children program. The reimbursement of the vaccine shall be the same as the Department reimburses FFS providers during the period of VFC availability. The HMO retains liability for the cost of administering the vaccines.

E. Provision of Data to the HMO

The Department will provide to the HMO immunization information from the Wisconsin Immunization Registry, to the extent available.

F. Conflict of Interest

The Department will maintain state employee conflict of interest safeguards at least equal to federal safeguards (41 USC 423).

XIV. Contractual Relationship

A. Delegations of Authority

The HMO shall oversee and remain accountable for any functions and responsibilities that it delegates to any subcontractor. For all major or minor delegation of function or authority:

1. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate, or out of compliance with HIPAA privacy or security requirements.
2. Before any delegation, the HMO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.
3. The HMO shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review at least once per contract period.
4. If the HMO identifies deficiencies or areas for improvement, the HMO and the subcontractor shall take corrective action.
5. If the HMO delegates selection of providers to another entity, the HMO retains the right to approve, suspend, or terminate any provider selected by that entity.
6. If the HMO delegates processing of appeals, grievances, and/or claims processing to another entity, the HMO must coordinate with the subcontractor to obtain the data needed to meet the HMO's reporting requirements.

B. Subcontracts

This Article does not apply to subcontracts between the Department and the HMO. The Department shall have sole authority to determine the conditions and terms of such subcontracts. Subcontractor (hereinafter identified as subcontractor) agrees to abide by all applicable provisions of the HMO's contract with the Department, hereinafter referred to as the BadgerCare Plus and Medicaid SSI HMO Contract. Subcontract compliance with the BadgerCare Plus and Medicaid SSI HMO Contract specifically includes but is not limited to the requirements specified below.

1. Subcontract Standard Language

   The HMO must ensure that all subcontracts are in writing and include the following standard language when applicable:

   a. Subcontractor uses only BadgerCare Plus and/or Medicaid SSI-enrolled providers in accordance with this Contract.

   b. No terms of this subcontract are valid which terminate legal liability of the HMO.

   c. Subcontractor agrees to participate in and contribute required data to HMO Quality Assessment and Performance Improvement programs.

d. Subcontractor agrees to abide by the terms of this Contract for the timely provision of emergency and urgent care. Where applicable, subcontractor agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by the HMO in accordance with this Contract.

e. Subcontractor agrees to submit HMO encounter data in the format specified by the HMO, so that the HMO can meet the Department specifications required by this Contract. The HMO will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.

f. Subcontractor agrees to comply with all non-discrimination requirements.

g. Per 42 CFR 438.3(k), subcontractor agrees to comply with all audit and record retention and inspection requirements of 42 CFR 438.230(c)(3)(i-iv) and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements. Specifically, the State (including the Office of Inspector General), CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the HMO's contract with the State. This right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

h. Any HMO or its subcontractor that enters into a contract with an entity outside the U.S. must clearly indicate Wisconsin law as jurisdiction for any breach of contract and ensure compliance with state and federal laws allowing for such contracts.

i. Per 42 CFR 438.230, subcontractor agrees to provide representatives of the HMO, as well as duly authorized agents or representatives of the Department (including the Office of the Inspector General) and the federal Department of Health and Human Services, access to its premises and its contracts, medical records, billing (including contractual rates agreed upon between the HMO and the subcontractor), and administrative records. If the State (including the Office of the Inspector General), CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. The Department may pursue action against the HMO as provided under Article XIV.D. for failure of a subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

j. Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in this Contract.

k. Subcontractor agrees to ensure confidentiality of family planning services.

l. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus and/or Medicaid SSI benefits (e.g., COB recovery procedures that delay or prevent care).

m. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

n. Subcontractor agrees not to bill BadgerCare Plus and/or Medicaid SSI members for medically necessary services covered under this Contract and provided during the members' period of HMO enrollment. Subcontractor also agrees not to bill members for any missed appointments while the members are eligible under the BadgerCare Plus and/or Medicaid SSI Programs. This provision will remain in effect even if the HMO becomes insolvent. However, if a member agrees in writing to pay for a non-covered service, then the HMO, HMO provider, or HMO subcontractor can bill.

   The standard release form signed by the member at the time of services does not relieve the HMO and its providers and subcontractors from the prohibition against billing a BadgerCare Plus or Medicaid SSI member in the absence of a knowing assumption of liability for a non-covered service. The form or other type of acknowledgment relevant to BadgerCare Plus or Medicaid SSI member liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus or Medicaid SSI.

o. Within 15 business days of the HMO's request subcontractors must forward medical records pursuant to grievances or appeals to the HMO. If the subcontractor does not meet the 15 business day requirement, the subcontractor must explain why and indicate when the medical records will be provided.

p. Subcontractor agrees to abide by the terms regarding appeals to the HMO and to the Department regarding the HMO's nonpayment for services providers render to members.

q. Subcontractor agrees to abide by the HMO marketing/informing requirements. Subcontractor will forward to the HMO for prior approval all flyers, brochures, letters and pamphlets the subcontractor intends to distribute to its members concerning its HMO affiliation(s), or changes in affiliation, or relating directly to the BadgerCare Plus and/or Medicaid SSI population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the HMO and the Department.

r. Subcontractor agrees to abide by the HMO's restraint policy, which must be provided by the HMO. Members have the right to be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.

s. HMOs shall not prohibit providers outside the parent healthcare system from contracting with another HMO entity.

t. Subcontractor agrees to utilize the Department's EVV system or a certified alternate EVV system

2. Subcontract Submission Requirements

a. Changes in Established Subcontracts

i. The HMO must submit changes in previously approved subcontracts to the Department for review and approval before they take effect. This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services.

a) Technical changes do not have to be approved.

b) Changes in rates paid do not have to be approved, with the exception of changes in the amounts paid to HMO management services subcontractors.

ii. The Department will review the subcontract changes and respond to the HMO within 15 business days.

b. New Subcontracts

The HMO must submit new subcontracts to the Department for review and approval before they take effect.

3. Review and Approval of Subcontracts

The Department may approve, approve with modification, or deny subcontracts under this Contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the state and BadgerCare Plus and/or Medicaid SSI members, including but not limited to the proposed subcontractor's past performance. The Department will:

a. Give the HMO:

i. 120 days to implement a change that requires the HMO to find a new subcontractor, and

ii. 60 days to implement any other change required by the Department.

b. Acknowledge the approval or disapproval of a subcontract within 15 business days after its receipt from the HMO.

c. Review and approve or disapprove each new subcontract before the Contract takes effect. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to this Contract.

d. Ensure that the HMO has included the standard subcontract language as specified in Article XIV.B.1. (except for specific provisions that are inapplicable in specific HMO management subcontract).

4. Transition Plan

The HMO may be required to submit transition plans when a primary care provider(s), mental health provider(s), gatekeeper or dental clinic terminates their contractual relationship with the HMO. The transition plan will address continuity of care issues, member notification and any other information required by the Department to ensure adequate member access. The Department will approve, deny, or modify the transition plan within 15 business days of receipt or prior to the effective date of the subcontract change.

5. Notification Requirements Regarding Subcontract Additions or Terminations

The HMO must:

a. Notify the Department of Additions or Terminations

The HMO must notify the Department within 10 days of subcontract additions or terminations when those changes are substantial and impact member access. Those notifications could involve:

i. A clinic or group of physicians, mental health providers, or dentists,

ii. An individual physician,

iii. An individual mental health provider and/or clinic,

iv. An individual dental provider and/or clinic.

This Department notification must be through the submission of an updated provider network to the SFTP server.

b. Notify the Department of a Termination or Modification that Involves Reducing Access to Care

The HMO must notify the Department within 7 days of any notice by the HMO to a subcontractor, or any notice to the HMO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could substantially reduce member access to care. This Department notification must be to both the HMO's Contract Monitor and through the submission of an updated provider network to the SFTP server.

If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then the Department may invoke the remedies pursuant to this Contract. These remedies include contract termination (notice to the HMO and opportunity to correct are provided for), suspension of new enrollment, and giving members an opportunity to enroll in a different HMO.

In addition to the monthly submission, the HMO must submit an updated provider and facility file when there has been a significant change with respect to network adequacy, as defined by the Department, in the HMO's operations that would affect adequate capacity and services.

c. Notify Members of Provider Terminations

i. The HMO must make a good faith effort to give written notice of termination of a network provider to each member who received primary care from, or was seen in the past 18 months, by the terminated provider.

ii. The HMO must provide the member notice by the later of 30 calendar days prior to the effective date of the termination or fifteen (15) calendar days after receipt or issuance of the termination notice.

iii. The HMO must use a template letter for this notification and obtain the Department's approval of the template before it is sent to members. Any subsequent proposed changes to the template must be approved by the Department.

6. Management Subcontracts

The Department will review HMO management subcontracts to ensure that:

a. Rates are reasonable.

b. They clearly describe the services to be provided and the compensation to be paid.

c. Any potential bonus, profit-sharing, or other compensation, not directly related to the cost of providing goods and services to the HMO, is identified and clearly defined in terms of potential magnitude and expected magnitude during this Contract period. Any such bonus or profit-sharing must be reasonable compared to the services performed. The HMO must document reasonableness. A maximum dollar amount for such bonus or profit-sharing shall be specified for the Contract period.

The requirements addressed in Article XIV.B.6.a-c are not required for non-BadgerCare Plus and/or Medicaid SSI members if the HMO wishes to have separate arrangements for the non-members.

C. Memorandum of Understanding/Agreement

HMOs are required to enter into or make every attempt to enter into an MOU with certain entities. HMOs may include a provision within the MOU that will automatically renew MOUs with these entities. The MOU must include an opt out provision from the automatic renewal.

D. Sanctions, Financial Penalties and Remedial Actions for Violation, Breach, or Non-Performance of Contract

1. Corrective Action Plans (CAPs)

   a. If the Department determines that the HMO is not in compliance with or is deficient in one or more requirements of this contract, then the Department may require the HMO to complete a Corrective Action Plan (CAP).

   b. The HMO must comply with all requirements made by the Department within the time frames specified by the CAP.

   c. If the Department determines that the HMO fails to comply with the CAP, then the Department may pursue action against the HMO as provided under this Article.

   d. Upon receipt of the CAP from the Department and within the timeframe(s) specified by the Department in the CAP,

      i. the HMO must submit a written response to the Department that includes a detailed plan of compliance.

      ii. The HMO may submit a request for informal reconsideration. If submitted timely, the Department shall:

         a) Conduct an informal reconsideration that includes a review of the evidence by the Medicaid Director or their designee; and

         b) Provide the HMO a written decision including the factual and legal basis for the decision.

   e. The Department may deny or postpone a service area expansion request from an HMO on an active CAP.

   f. The Department may require the HMO to post information about any active CAPs on the HMO's website. The Department may also publish information about HMO CAPs on the Department's website.

   g. Provider CAPs

      i. The HMO must issue corrective action when a subcontractor or provider is not in compliance with the contract.

2. Sanctions

a. The Department may impose sanctions when the Department determines that the HMO has violated section 1903(m) or 1932 of the Social Security Act (42 U.S.C. 1396b), 42 CFR 438.700, or any implementing regulations.

   Payment for members of the HMO is automatically denied whenever, and for as long as, federal payment for such members has been denied as a result of such violations.

b. The Department may pursue all sanctions and remedial actions with the HMO when the Department determines, based on findings from surveys, member or other complaints, audits, financial status, or any other source, that an HMO acts or fails to act pursuant to 42 CFR § 438.700:

   i. Fails substantially to provide medically necessary services that the HMO is required to provide, under law or under this contract, to a member covered under the contract.

   ii. Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

   iii. Acts to discriminate among members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to enroll a member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

   iv. Misrepresents or falsifies information that it furnishes to CMS or to the Department.

   v. Misrepresents or falsifies information that it furnishes to members, potential enrollee, or health care provider.

   vi. Fails to comply with the requirements for physician incentive plans.

   vii. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.

c. The Department may pursue sanctions and remedial actions identified in c. with the HMO when the Department determines, based on findings from surveys, member or other complaints, audits, financial status, or any other source, that an HMO failed to:

   i. Comply with quality assurance standards and requirements;

   ii. Provide adequate policies or failing to comply with requirements preventing and protecting against fraud, waste, and abuse; or

iii. Comply with timely claim payment requirements or adequacy of payments.

d. When the Department determines, based on findings from surveys, member or other complaints, audits, financial status, or any other source that an HMO has violated any of the other applicable requirements of sections 1903(m), 1932 or 1905(t)(3) of the Act, or any implementing regulations, then the Department may take any of the following actions pursuant to 42 CFR 438.700(d)(3) and 438.702(a)(3)-(5).

i. Grant members the right to terminate enrollment without cause and notify the affected members of their right to disenroll.

ii. Suspend all new enrollment, including default enrollment, after the date that the Department of Health and Human Services Secretary or the Department notifies the HMO of a determination of a violation of 1903(m), 1932, or 1905(t)(s) of the Act.

iii. Suspend payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposing the sanction no longer exists and is not likely to recur.

e. Per 42 CFR 438.724, the Department must give CMS written notice whenever it imposes or lifts a sanction for one of the violations listed above. This notice must be given no later than 30 days after the Department imposes or lifts a sanction and must specify the affected HMO, the kind of sanction, and the reason for the Department's decision to impose or lift a sanction.

f. The Department may impose sanctions when the Department determines that the HMO has contract deficiencies, including but not limited to the following:

i. Incomplete or inaccurate provider data or failure to submit by the last business day of the month.

ii. Payment of incomplete or inaccurate dental claims.

iii. Failure of a subcontractor to permit a Department or federal DHHS representative access to its premises and its contracts, medical records, billing (including contractual rates agreed upon between the HMO and the subcontractor), and administrative records.

3. Financial Penalties and Civil Monetary Penalties

a. Civil Monetary Penalties

The Department may impose civil monetary penalties in the following specified amounts:

i. A maximum of $25,000 for each determination of

a) failure to provide medically necessary services that the HMO is required to provide, under the law or contract, to a member covered under the contract;

b) misrepresentation or false statements to members, potential members or health care providers;

c) failure to comply with physician incentive plan requirements; or

d) directly or indirectly distributing marketing materials that have not been approved by the Department or that contain false or materially misleading information.

ii. A maximum of $100,000 for

a) each determination of discrimination among members on the basis of their health status or need for health care services; or

b) misrepresentation or false statements to CMS or the Department.

iii. A maximum of $15,000 for each member the Department determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

iv. A maximum of $25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The Department must deduct from the penalty the amount of overcharge and return it to the affected member(s).

b. Financial Penalties

The Department will provide written notice of all financial penalties that explains the basis and nature of the penalties and any due process protections the Department elects to provide.

The Department may impose financial penalties in the follow specified amounts:

i. If the HMO fails to comply with the state and federal compliance requirements for abortions, hysterectomies, and sterilizations, $10,000. For additional details, see Article IV.K.

ii. If the HMO fails to comply with confidentiality of records and HIPAA requirements in Article XI.D.,

a) $100 for each individual whose Confidential Information was used or disclosed;

b) $100 per day for each day that the HMO fails to substantially comply with the Corrective Action Plan under this Section;

c) Damages under this Section shall in no event exceed $50,000 per incident.

iii. A maximum of $50,000 for failure to submit an annual fraud, waste, and abuse plan meeting requirements outlined in Addendum VII.

iv. A maximum of $50,000 for HMOs who fail to engage in OIG technical assistance or the Department's fraud, waste, and abuse audit process

v. A maximum of $50,000 for failing to comply with Quarterly Program Integrity Reporting requirements and deadlines

vi. A maximum of $50,000 for member screening results below established benchmarks for the measurement year

vii. A maximum of $50,000 for inadequate Annual Compliance Tool scores

viii. If a HMO fails to report required Core Reporting measures to the Department, the HMO may be subject to $10,000 per measure not reported.

ix. A maximum of $50,000 per quarter for incomplete or inaccurate provider and/or facility data.

4. Suspension and Reduction of Enrollment

a. Department-Initiated Enrollment Suspension

i. The Department may suspend new enrollment under this Contract when the Department determines that the HMO is out of compliance with this Contract.

ii. The Department must notify the HMO in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension will take effect if the non-compliance remains uncorrected at the end of this period.

iii. The Department may suspend new enrollment sooner than the completion of the 30-day notice period if the Department finds that the member's health or welfare is jeopardized.

iv. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the Contract.

v. The Department may also notify members of the HMO's non-compliance and provide an opportunity to enroll in another HMO.

b. Department-Initiated Enrollment Reductions

i. The Department may reduce the number of current members when the Department determines that the HMO

a) has failed to provide one or more of the services required under the Contract;

b) has failed to maintain or make available any records or reports required under this Contract that the Department needs to determine whether the HMO is providing contract services as required; or

c) has network adequacy deficiencies.

ii. The Department must notify the HMO in writing of the Department's intent to reduce the number of current members at least 30 days prior to initiating enrollment reduction. The HMO will have at least 30 days to correct the non-compliance prior to the Department taking any action set forth in this paragraph.

iii. The Department may reduce enrollment sooner than the completion of the 30-day notice period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized.

5. Withholding of Capitation Payments

In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages.

Notwithstanding the provisions of this Contract, the Department may withhold portions of capitation payments as liquidated damages or otherwise recover damages from the HMO on the following grounds:

a. Medically Necessary Covered Services

i. When the Department determines that the HMO has failed to provide one or more of the medically necessary covered services required under the Contract, the Department may either:

a) order the HMO to provide such service, or

b) withhold a portion of the HMO's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

ii. If the Department orders the HMO to provide services under this section and the HMO fails to provide the services within the timeline specified by the Department, the Department may withhold from the HMO's capitation payments an amount up to 150% of the Fee for Service amount for such services.

iii. When it withholds payments under this section, the Department must submit to the HMO a list of the participants for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

iv. If the Department acts under this section and subsequently determines that the services in question were not covered services:

a) If the Department withheld payments, the Department will restore to the HMO the full capitation payment; or

b) If the Department ordered the HMO to provide services under this section, the Department will pay the HMO the actual documented cost of providing the services.

b. Payment Denials for New Members

i. Payments provided for under the contract will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR § 438.730.

ii. The Department may recommend that CMS impose the denial of payment for new members to an HMO that has a contract to provide BadgerCare Plus and/or Medicaid SSI services if the Department determines that the HMO acts or fails to act pursuant to 42 CFR § 438.700. The Department's determination becomes CMS' determination for purposes of Section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days. When the Department decides to recommend imposing the sanctions described in 42 CFR § 438.730(e), this recommendation becomes CMS' decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days.

iii. If the Department's determination becomes CMS' determination, the Department will take the following options:

a) Give the HMO written notice of the nature and basis of the proposed sanction;

b) Allow the HMO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction;

c) May extend the initial 15-day period for an additional 15 days if:

1) The HMO submits a written request that includes a credible explanation of why it needs additional time;

2) The request is received by CMS before the end of the initial period;

3) CMS has not determined that the HMO's conduct poses a threat to an enrollee's health or safety.

iv. If the HMO submits a timely response to the notice of sanction, the Department will

a) conduct an informal reconsideration that includes review of the evidence by a Department agency official who did not participate in the original recommendation;

b) give the HMO a concise written decision setting forth the factual and legal basis for the decision; and

c) forward the decision to CMS.

v. The Department's decision will become CMS' decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS.

vi. If CMS reverses or modifies the Department decision, the Department sends the HMO a copy of CMS' decision.

c. Required Reports and Data Submissions

i. Encounter Data

If the HMO fails to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such data or information in the required form or format, by the deadline specified by the Department, the Department may immediately impose liquidated damages in the amount of $1,500 per day for each day beyond the deadline that the HMO fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the HMO's capitation payments.

Additionally, if it is found that the HMO failed to submit accurate and complete encounter data prior to the submission deadlines, the Department will be considered damaged. The HMO may be held responsible for reimbursing the Department for the staffing and out-of-pocket costs incurred by the Department and its contractors

associated with reviewing the delayed data submission, and developing and publishing revised rates.

The HMO must meet the Department's aggregate standards for submitting encounter data as outlined in Article XII.D. or liquidated damages may apply based on "erred" data.

The term "erred encounter record" means an encounter record that failed an edit when a correction is expected by the Department, unless the record is otherwise priced and included in the HMO encounter data. This does not apply to records for out-of-state emergency services that are not moved from the erred table due to the inability to match to the provider file. If the HMO fails to correct an error to the encounter record within the time frame specified, the Department may assess liquidated damages of $5 per erred encounter record per month until the error has been corrected or the issue has been resolved to the Department's satisfaction. The liquidated damage amount will be deducted from the HMO's capitation payment. When applied, these liquidated damages will be calculated and assessed on a monthly basis. If upon audit or review, the Department finds that the HMO has removed an erred encounter record without the Department's approval, the Department may assess liquidated damages for each day from the date of original error notification until the date of correction.

a) The Department may assess $5 per record per month until the encounter record has been fixed, for each encounter record found to be different from the provider claim for the procedure code, units of service, diagnosis code, modifier code, charge field, and TPL paid amount.

   At a minimum, HMOs must submit a consistent volume of encounters each month based on a calendar year average.

b) If it is found that an HMO submitted inaccurate or incomplete encounter data that was used in the development of the current rates, the Department may assess damages associated with the reporting error and data that the HMO failed to submit. The damages will be up to the priced amount of the inaccurate encounter records and the estimated amount or actuarial adjustment for the amount that HMO failed to submit.

   Failure to successfully report usable data using the ASC X12 837 HIPAA Compliant Transaction or the Financial Report information may result in a 1% withhold to the HMO's administration rate. The amount will be withheld

from the capitation payment until the HMO is able to submit usable data.

If the HMO is unable to submit usable data by the period of time defined by the Department when withholding the payment, the amount withheld will be forfeited.

If either party terminates the contract during the period that payment is withheld, the amount will be automatically forfeited.

Data is determined usable if it can be used in the rate-setting process in its entirety for the encounter data base years used to establish the rates.

Whenever the Department determines that the HMO has failed to perform the administrative functions, the Department may withhold a portion of future capitation payments sufficient to directly compensate the Department for the program's costs of providing health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.

d. Procedures for Withholding Capitation Payments

Notwithstanding the provisions of this subsection, in any case where the Department deducts a portion of capitation payments under the Contract, the following procedures will be used:

i. The Department will notify the HMO's contract administrator no later than the second business day after the Department's deadline that the HMO has failed to submit the required data or the required data cannot be processed.

ii. Beginning on the second business day after the Department's deadline, the HMO will be subject without further notification to liquidated damages per data file or report.

iii. If the HMO submits encounter data late but submits it within five business days from the deadline, the Department will rescind liquidated damages if the data can be processed according to the criteria published in the HMO Encounter Data User Manual. The Department will not edit the data until the process period in the subsequent month.

iv. If the HMO submits any other required data or report in the required format within five business days from the deadlines, the Department will rescind liquidated damages and immediately process the data or report.

v. If the HMO repeatedly fails to submit required data or reports, or submits data that cannot be processed, the Department will require the HMO to develop a CAP to comply with the Contract requirements that must meet Department approval.

vi. After the corrective action plan has been implemented, if the HMO continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under Article XIV.D.5.a. (Suspension of New Enrollment), or under Article XIV.D.5.b. (Department-Initiated Enrollment Reductions) of this Article, or both, in addition to liquidated damages that may have been imposed for a current violation.

vii. If the HMO notifies the Department that it will discontinue contracting with the Department at the end of a contract period, but reports or data are due for a contract period, the Department retains the right to withhold up to two months of capitation payments otherwise due the HMO that will not be released to the HMO until all required reports or data are submitted and accepted after expiration of the Contract. Upon determination by the Department that the reports and data are accepted, the Department will release the monies withheld.

e. Temporary Management

i. The Department will impose temporary management, as provided in 42 CFR § 438.706, when there is

a) continued egregious behavior by the HMO, including, but not limited to behavior that is described in 42 CFR § 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

b) There is substantial risk to members' health; or

c) The sanction is necessary to ensure the health of the HMO's members while improvements are made to remedy violations under 438.700 or until there is an orderly termination or reorganization of the HMO.

ii. Regardless of any other sanction that the Department may impose, the Department must impose temporary management if the Department finds that an HMO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act, or this section of the contract. The Department must also grant enrollees the right to terminate enrollment.

iii. The Department may not delay imposition of temporary management to provide a hearing before imposing this sanction.

iv. The Department may not terminate temporary management until it determines that the HMO can ensure that the sanctioned behavior will not recur.

f. Nothing precludes the Department from pursuing more than one action under this section if the Department determines, in its sole discretion, that more than one is appropriate.

E. Modification and Termination of Contract

1. Modification

a. Mutual Consent:

This Contract may be modified at any time by mutual written agreement of both the HMO and the Department.

b. Unilateral Modification by the Department:

This contract will be modified by the Department if changes in federal or state laws, rules, regulations or amendments to Wisconsin's CMS approved waivers or the state plan require modification to the contract. In the event of such change, the Department will notify the HMO in writing. If the change materially affects the HMO's rights or responsibilities under the contract and the HMO does not agree to the modification, the HMO may provide the Department with written notice of termination at least ninety (90) days prior to the proposed date of termination. (See Article XIV.E.2.e.ii.)

2. Termination

a. Mutual Consent:

This Contract may be terminated at any time by mutual written agreement of both the HMO and the Department.

b. Unilateral Modification by Department:

i. Authority to Terminate Contract

The Department has the authority to terminate an HMO's contract and enroll that entity's members in other HMOs of the member's choosing, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the HMO has failed to do either of the following:

a) Carry out the substantive terms of this Contract; or

b) Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

ii. Notice and Pre-Termination Hearing:

Before the Department terminates an HMO contract for failing to carry out substantive terms of the contract or to meet applicable requirements in section 1932, 1903(m), or 1905(t) of the Social Security Act, the Department must provide the HMO a pre-termination hearing. The Department will give the HMO written notice of its intent to terminate, the reason for termination, and the time and place of the hearing.

iii. Member Disenrollment During Termination Hearing Process:

Per 42 CFR §438.722, the Department may provide the HMO's members with written notice of its intent to terminate the contract and allow members to disenroll from the HMO immediately without cause.

a) The HMO shall provide assistance to any member electing to terminate their enrollment, by making appropriate referrals and providing the individual's member record to new providers and/or a member's new HMO.

b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new HMO of the member's choosing.

iv. Post-Hearing Notice:

After the hearing, the State will give the HMO written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination. For an affirming decision, the Department will give members of the HMO notice of the termination and information, consistent with 42 CFR § 438.10, on their options for receiving Medicaid services following the effective date of termination.

c. Foreign Entity:

Pursuant to 42 C.F.R. § 438.602(i), the Department is prohibited from contracting with an HMO located outside of the United States. In the event an HMO moves outside of the United States, this contract will be terminated.

d. Unilateral Termination by the HMO

i. Changes to Capitation Rates:

This contract may be terminated by the HMO due to dissatisfaction with the final capitation rates. The HMO must notify the Department within 30 days of notice of the final rates if the HMO intends to terminate its contract with the Department. The HMO must also notify the Department within 30 days if it intends to

decrease its service area due to the final capitation rates. To assure the smooth transition of members, the termination of the Contract or the decrease in service area will be effective no less than 90 days, and no more than 120 days, after HMO notification to DHS of the intent to terminate the Contract or decrease the HMO's service area.

ii. Changes in Reporting Requirements:

If the Department changes the reporting requirements as specified in Article XII.J during the Contract period, the HMO shall have 180 days to comply with such changes or to initiate termination of the Contract.

e. Terminated by either:

i. For Cause

Either party may terminate this Contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this Contract. The party exercising this option must notify the other party in writing of its intent to terminate this Contract and give the other party 30 days to correct the identified violation, breach or non-performance of Contract. If such violation, breach or non-performance of Contract is not satisfactorily addressed within this time period, the exercising party may terminate this Contract. The termination date shall always be the last day of a month. The Contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that member health or welfare is jeopardized by continued enrollment in the HMO.

ii. Changes Mandated by Federal or State Law:

Either party may terminate this Contract at any time, due to modifications to the contract mandated by changes in federal or state laws, rules or regulations that materially affect either party's rights or responsibilities under this Contract (see Article XIV.E.1.b). At least 90 days prior to the proposed date of termination, the party initiating the termination must notify the other party in writing of its intent to terminate this Contract.

iii. Loss of Federal or State Funding:

a) Permanent Loss of Funding

Either party may terminate this Contract if federal or state funding of contractual services rendered by the HMO becomes or will become permanently unavailable and such

lack of funding would preclude reimbursement for the performance of the HMO's obligations. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the HMO will become unavailable, the Department shall immediately notify the HMO, in writing, identifying the basis for the anticipated unavailability of funding and the date on which the funding will end.

b) Temporary Loss of Funding

In the event funding will become temporarily suspended or unavailable, the Department or the HMO may suspend performance of any or all of the HMO's obligations under this Contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or HMO shall attempt to give notice of suspension of performance of any or all of the HMO's obligations by 60 days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. Once the funding is reinstated, the HMO will resume the suspended services within 30 days from the date the funds are reinstated. The contract will not terminate under a temporary loss of funding.

f. Obligations of Contracting Parties Upon Non-Renewal or Termination

i. Transition Plan:

The HMO shall submit a written plan that receives the Department's approval, to ensure uninterrupted delivery of services to HMO members and their successful transition to other applicable programs (e.g., Medicaid fee-for-service). The plan will include provisions for the transfer of all member related information held by the HMO or its providers and not also held by the Department. Additional elements of the transition plan may include, but are not limited to, a communication plan; additional data-sharing reports for transitioning members; and timelines for outstanding financial reconciliation.

a) Submission of the Transition Plan

The HMO shall submit the plan at one of the following times, depending on which applies: no less than ninety (90) calendar days prior to the contract's expiration when the HMO decides to not renew the contract; within ten (10) business days of notice of termination by the Department; or along with the HMO's notice of termination.

b) Management of the Transition

The HMO shall designate a person responsible for coordinating the transition plan and will assign staff as the Department determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as the Department determines is necessary.

c) Continuation of Services

If the HMO has been unable to successfully transition all members to applicable programs by the time specified in the approved transition plan, the HMO shall continue operating as an HMO under this contract until all members are successfully transitioned. The Department will determine when all members have been successfully transitioned to applicable programs.

If the Department determines it necessary to do so, the HMO will agree to extend this contract, in order to continue providing services to members until they are successfully transitioned to applicable programs. During this period the HMO remains responsible, and shall provide, the services in the benefit package, and all terms and conditions of the contract will apply during this period.

d) Costs of Transition Plan

The HMO will be responsible for all expenses related to the transition plan, including, but not limited to costs associated with the Department's enrollment of the HMO's members into other HMOs or the provision of MA benefits to the HMO's members through other options in the event of a unilateral termination by the Department under Article XIV.E.2.b.

ii. Notice to Members and Providers

a) The Department will be responsible for developing the format for notifying all members of the date of non-renewal or termination and process by which the members will continue to receive contract services.

b) The Department will be responsible for the provision of any other necessary notifications to impacted members and providers. Such notifications may include, but are not limited to, mailed notices, ForwardHealth Member and/or Provider Updates and/or phone outreach.

c) Costs of Notice to Members and Providers

The HMO will be responsible for all expenses related to notifications under Article XV.E.ii.a) and b).

iii. Pay for Performance Withhold Reconciliation

If an HMO terminates the contract before sufficient time has elapsed for relevant HEDIS measures to be calculated for that year (e.g., before 11 months of continuous enrollment are completed), the HMO is not eligible for any performance bonuses for the Measurement Year, and is subject to the P4P withhold for the months the HMO had enrollment during the Measurement Year. The Department reserves the right to calculate the HMO's performance against the Measurement Year's benchmarks to determine if the HMO will earn back the withhold by:

a) Applying the HMO's previous measurement year's P4P results to the termination year's performance benchmarks; or

b) If an HMO does not have data that applies under the first and second bullets above, DHS will review P4P calculations on an individual basis.

iv. Return of Advanced Payments:

a) Any payments advanced to the HMO for coverage of members for periods after the date of termination will be returned to the Department within the period of time specified by the Department.

b) Transfer of Information: The HMO will supply all information necessary for the reimbursement of any outstanding BadgerCare Plus and/or Medicaid SSI claims within the period of time specified by the Department.

c) Recoupments: If a contract is terminated, recoupments will be handled through a payment by the HMO to the Department within 90 days of contract termination.

g. HMO Mergers

For the purpose of this section, a merger or acquisition means a change in controlling interest of an HMO, including an asset or stock purchase.

This contract between the HMO and the State of Wisconsin and the monies which may become due may not be assigned, transferred, pledged or hypothecated in any way by the HMO, including by way of an asset or stock purchase by the HMO, without the express prior written approval of the Department.

In the event that the merger or acquisition of an HMO is approved by the Office of the Commissioner of Insurance (OCI), the Department shall allow the surviving HMO to participate in the Medicaid program unless it would be detrimental to Medicaid members or the Medicaid program, as determined by the Department through its certification standards. In order to participate in the Medicaid program, the surviving HMO must meet OCI standards, accept the terms and rates of the current HMO contract, and meet DHS certification requirements.

The Department retains the authority to determine what will occur with the non-surviving HMO's Medicaid enrollees. These determinations will be made on an individualized basis based on what is in the best interests of the membership.

HMOs must notify the Department of any proposed merger or acquisition immediately, but no fewer than 180 days prior to the proposed date of merger or acquisition, unless the Department waives the 180 day requirement at its discretion.

3. If a Medicaid HMO requests termination of one or more Medicaid lines of business, the Department may review any or all other lines of the HMO's Medicaid programs in Wisconsin to ensure continued compliance with all applicable state and federal laws and regulations, including but not limited to certification requirements in Wis. Admin. Code DHS 105.47, requirements in 42 CFR Part 438, and to ensure continued compliance with provisions in this contract. If the Department determines the HMO is out of compliance, the Department may take remedial action as outlined in Article XIV.D and XIV.E of this contract and as allowed by law.

4. Expansion

   HMOs that are certified to provide both BadgerCare Plus and SSI Medicaid must offer both BadgerCare Plus and SSI Medicaid in each county in their service area prior to expanding either program into a new county.

F. Interpretation of Contract Language

When disputes arise, the Department has the right to final interpretation and/or application of the Contract language. The HMO will abide by the interpretation and/or application.

XV. Fiscal Components/Provisions

A. Billing Members

1. Prohibition on Billing Members for Covered Services

The HMO, its providers and subcontractors shall not bill a member for covered services in the benefit package provided during the member's enrollment period in the HMO except if the HMO elects to charge copays to members as required under Sections 1916A(a)(2)(B), 1916A(b)(1)(B)(ii), and 1916A(b)(2)(A) of the Social Security Act, as implemented in 42 CFR § 447.56 (f). The HMO must provide at least a 6 month notice to DHS and submit a member communication plan for approval before implementation to apply copays to covered services.

This provision applies even if one or more of the following exists:

a. The HMO becomes insolvent;

b. The Department does not pay the HMO for covered services provided to the member;

c. The Department or the HMO does not pay the provider that furnishes the services under a referral or other arrangement; and

d. Payment for services furnished under a subcontract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the HMO provided the service directly.

2. Prohibition on Billing in Insolvency

In the event of the HMO's insolvency, the HMO shall not bill members for debts of the HMO or for covered services in the benefit package and provided during the member's period of HMO enrollment.

B. Physician Incentive Plans

1. A physician incentive plan is any compensation arrangement that the HMO pay a physician or physician group and that may directly or indirectly have the effect of reducing or limiting services provided to any enrolled HMO member.

2. Contracts between the HMO and network providers must comply with 42 CFR 422.208 and 422.210, and 42 USC 1395nn.

3. Physician incentive payment contracts between the HMO and network providers must:

a. Have a defined performance period that can be tied to the applicable MLR reporting periods.

b. Be signed and dated by all appropriate parties before the commencement of the applicable performance period.

c. Include clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that the provider must meet to receive the incentive payment.

d. Specify a dollar amount or a percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including a date of payment.

4. Attestations cannot be used as supporting documentation for data that factor into the MLR calculation.

5. The HMO must make any physician incentive plan available and provide adequate and timely information on its physician incentive plan to any member upon request.

6. The HMO must make incentive payment contracts, and any quality metrics related to the incentive payment contracts available to the Department upon request.

C. Enhanced Physician Reimbursement for Medical Home Practice Design

The HMO may provide enhanced reimbursement to primary care provider practices that function as a medical home. If the HMO plans to implement enhanced physician reimbursement, please submit the following strategies:

1. Whether the HMO provides such a reimbursement and if so identify which provider practices are recipients.

2. The criteria the HMO uses to identify practices that function as a medical home and are eligible for this reimbursement.

3. The HMO's process for evaluating practices annually as to whether they meet the criteria.

4. How this reimbursement process is implemented.

5. Evidence that they are supplying their in-network providers with materials that explain in detail what their medical home criteria are, and how a clinic would be reimbursed for functioning as a medical home.

D. Payment Requirements/Procedures

The HMO is responsible for the payment of all contract services provided to members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Rosters generated for the coverage period.

The HMO is also responsible for the provision, or authorizing the provision of, services to members with valid ForwardHealth ID cards indicating HMO enrollment (via Electronic Voice Response or WiCall), without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the enrollment rosters must be reported to VEDSHMOSupport@wisconsin.gov for resolution.

The HMO must continue to provide and authorize provision of all contract services until the discrepancy is resolved, including members who were PENDING on the Initial Roster and held a valid ForwardHealth ID card indicating HMO enrollment for the coverage period (via Electronic Voice Response or WiCall), but did not appear as a CONTINUE on the Final Roster.

If a member shows on the Initial enrollment roster as PENDING and later shows on the Final roster as a DISENROLL, the HMO will not be liable for services after the date the disenrollment is effective.

1. Claims Retrieval

   The HMO must maintain a claim processing system that can upon request identify date of receipt of the claim as indicated by its date stamp, adjudication action on all claims types (i.e., paid, denied, suspended, etc.), and date of adjudication. In addition, the claim processing system must identify, within the individual claim, the services provided and the diagnoses of the members using nationally accepted coding systems as specified in the Encounter User Guide. Finally, the claim processing system must be capable of identifying the provider of services National Provider Identifier (NPI), or atypical identifier if applicable, and their associated taxonomy numbers and CLIA numbers.

2. Thirty Day Payment Requirement

   a. The HMO must pay at least 90% of adjudicated clean claims from providers 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, except to the extent providers have agreed to later payment.

      HMO agrees not to delay payment to a provider pending provider collection of third party liability unless the HMO has an agreement with the provider to collect third party liability.

   b. If the HMO is currently experiencing a delay, anticipates a delay with timely claims processing and payment to providers, or discovers an error within the HMO's claim processing system that delays claims processing longer than 30 days, the HMO must notify the Department via an email to DHSDMSBRS@dhs.wisconsin.gov and the HMO's managed care analyst within 14 days. The HMO must submit a plan to remedy the claims processing error including how the HMO will ensure providers are paid without unnecessary delay. The HMO cannot categorize claims processing errors due to system error in reconsideration or appeal.

3. Payment to a Non-HMO contracted provider for Services Provided to a Disabled Member Less than Three or for Services Ordered by the Courts (BadgerCare Plus Only)

   The HMO must pay for covered services provided by a non-HMO contracted provider to a disabled member less than three years of age, or to any member pursuant to a court order (for treatment), effective with the receipt of a written

request for referral from the non-HMO contracted provider, and extending until the HMO issues a written denial or referral. This requirement does not apply if the HMO issues a written denial of referral within seven days of receiving the request for referral.

4. Payment of HMO Referrals to Non-Affiliated Providers

   For HMO approved referrals to non-affiliated providers, the HMO must either establish payment arrangements in advance, or the HMO is liable for payment only to the extent that BadgerCare Plus and/or Medicaid SSI pays, including Medicare deductibles, or would pay, its FFS providers for services excluding Hospital Access Payments, Hospital P4P Withhold, and Ambulatory Surgery Center Access Payments. Refer to Article VIII for policy on Provider Appeals.

   a. For Non-Affiliated Providers, the Department will adjudicate Provider Appeals according to FFS benefit policy and reimbursement, including PA requirements, emergency and post stabilization definition and other contract provisions. Refer to Article VIII, Provider Appeals.

   b. Should there be an appeal resolution determined by the Department to be in the Provider's favor, the HMO must waive standard timely filing guidelines and allow the provider 60 days to rebill for services.

5. Health Professional Shortage Area (HPSA) Payment Provision

   Primary care, emergency care, and certain obstetric or gynecological services provided to a member living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA must be paid at least the HMO established rate plus the standard enhanced reimbursement as specified in ForwardHealth Topic 648. Refer to ForwardHealth Topic 648 for the procedure codes that qualify for the HPSA enhanced reimbursement.

   The HMO is not required to pay more than the enhanced FFS rate. The HMO shall ensure that the money for HPSA payments is paid to the provider and is not used to supplant funds that previously were used for payment to the provider. The HMO must develop written policies and procedures to ensure compliance with this provision. These policies must be available for review by the Department, upon request.

6. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

   If the HMO contracts with a Medicaid enrolled FQHC or RHC for the provision of services to its members, the HMO must pay at a minimum the Medicaid FFS rate or the equivalent aggregate FFS rate by provider. The HMO must retain records demonstrating that they are meeting this requirement. The records must be available within 30 days of the Department's request for information and be made available to CMS upon request.

   The HMO must pay at least 90% of adjudicated clean claims from FQHC or RHC providers 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, except to the extent that providers have agreed to later payment.

7. Hospitalization at the Time of Enrollment or Disenrollment

   a. Hospitalization in this section is defined as an inpatient stay at a Medicaid-enrolled hospital as defined in Wis. Adm. Code DHS 101.03(76), including covered outpatient hospital observation days if the member was subsequently admitted as an inpatient.

   b. Discharge from one hospital and admission to another within 24 hours for continued treatment shall not be considered a discharge under this section. Discharge is defined here as it is in the UB-04 Manual.

   c. Hospitalization at the time of enrollment

      i. The HMO will not assume financial responsibility for members who are hospitalized at the time of enrollment in the HMO (effective date of coverage) until the date of the hospital discharge.

         a) The Department is responsible for paying on a FFS basis all BadgerCare Plus and/or Medicaid SSI covered services for such hospitalized members during hospitalization.

   d. The HMO is not financially responsible for the portion of a hospital claim after the date of disenrollment. The HMO is financially responsible for the portion of a hospital claim prior to the date of disenrollment. When the HMO receives a hospital claim that span dates of HMO enrollment and after the date of disenrollment, the HMO shall contact VEDS for special handling of the encounter.

      When calculating the HMO liability for the member, the HMO should take the total stay allowed divided by the total number of days hospitalized to determine a daily rate. The daily rate would then be multiplied by the number of days the member was enrolled in the HMO.

8. Calculation of Non-listed Max Fee Rate

   When a rate is not listed on the FFS max fee schedule, the HMO may determine their own payment methodology for determining the rate for affiliated and non-affiliated providers. The Department may request documentation of methodology if a provider appeal is submitted based on this derived payment amount.

9. The HMO is prohibited from making payment to a provider for provider-preventable conditions (42 CFR 438.6(f)(2)(i)).

   All provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made must be reported by all providers to the HMO per 42 CFR 438.6(f)(2)(ii).

   Refer to Article X.C.3 for a comprehensive listing of provider-preventable conditions.

10. 2022 American Rescue Plan Rate Increase

    a. For purposes of this section, "ARPA eligible service provider" are providers of:

        i. alcohol and other drug abuse (AODA) services,

        ii. AODA Day Treatment,

        iii. home health services,

        iv. housing counseling,

        v. mental health day treatment,

        vi. mental health services,

        vii. nursing provided in the home,

        viii. occupational therapy provided in the home,

        ix. personal care,

        x. physical therapy provided in the home,

        xi. respiratory care,

        xii. respite,

        xiii. skilled nursing services (RN/LPN) ,

        xiv. speech and language pathology services provided in the home, and

        xv. transportation as defined in Wis. Admin. Code DHS § 107.23, excluding ambulance.

    b. Providers of services not listed, including but not limited to retail providers, nursing homes and common carrier transportation providers are not ARPA eligible service providers under this section. HMOs are also not eligible service providers.

    c. HMOs are required to provide a unit rate increase to all eligible providers equal to 5% of each eligible provider's rates for the services identified in Article XV.D.12.a.

11. Payments to providers for dental services provided under deep sedation

    HMOs must pay no less than the state plan approved rate for specified level I oral and maxillofacial procedures provided to members under deep sedation (EAPG 367; Procedure code: 41899, modifier U2). The state plan approved rate is available on ForwardHealth Hospital Rates and Weights for the relevant procedure code and modifier. HMOs must follow ForwardHealth policy that procedure code 41899 with modifier U2 denotes that the outpatient hospital service included deep sedation of the member.

12. Payments to providers for complex rehabilitation technology wheelchair repair and accessories

Consistent with 2023 Wisconsin Act 182, HMOs must pay the fee-for service rate for complex rehabilitation technology wheelchair repair and accessories for dates of service beginning 1/1/2025.

Procedure Codes: E0986; E1029; E1030; E2310; E2311; E2313; e2321; E2322; E2323; E2324; E2325; E2326; E2327; E2328; E2329; E2330; E2351; E2398; E2620; E2621; K0739

Link to rates: DHS Interactive Fee Schedule

XVI. Payments to the HMO

A. Actuarial Basis

The capitation rates and non-capitated rates, where appropriate, are calculated on an actuarial basis set forth in 42 CFR § 438.6. Rates are based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 CFR § 457.10.

Payment shall not be made with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

Payment shall not be made with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title; except for "in lieu of" services outlined in this contract.

B. Annual Determination of Capitation Rates

The monthly capitation rates are calculated on an annual basis. The capitation rates are not subject to renegotiation once they have been accepted, unless such renegotiation is required by changes in federal or state laws, rules, or regulations.

C. Capitation Rates

The Department agrees to pay the HMO a monthly prospective payment based on the capitation rates provided that the HMO is in full compliance with all contract requirements. Capitation rates include all Medicaid services that HMOs are required to provide. The capitation rates shall be prospective and based on an actuarially sound methodology as required by federal regulations.

The capitation rate shall not include any amount for recoupment of losses incurred by the HMO under previous contracts. Nor does it include services that are not covered under the State Plan with the exception of in lieu of services which currently include non-acute residential mental health services and inpatient services in an IMD for mental health services for members aged 21 - 64.

The Reimbursement Schedule provides more information about the specific payments and adjustment process can be found on the ForwardHealth Portal in the Managed Care Organization section: https://www.forwardhealth.wi.gov/WIPortal/Default.aspx .

No payment shall be made to a network provider other than by the HMO for services covered under this contract, except when these payments are specifically required by the State in Title XIX of the Act, in 42 CFR chapter IV, or when the State makes direct payments to network providers for graduate medical education costs approved under the State plan.

Except in emergency situations, the HMO must use only Medicaid enrolled providers for the provision of covered services. The Department reserves the right to withhold from the capitation development the cost related to services provided by non-enrolled providers, at

the FFS rate for those services, unless the HMO can demonstrate that it reasonably believed, based on the information provided by the Department, that the provider was Medicaid enrolled at the time the HMO reimbursed the provider for the service provision.

BadgerCare Plus and Medicaid SSI HMOs must comply with ForwardHealth policy regarding the 5% cost share cap for enrolled members, as required under Sections 1916A(a)(2)(B), 1916A(b)(1)(B)(ii), and 1916A(b)(2)(A) of the Social Security Act, as implemented in 42 CFR § 447.56(f)). If the HMO elects to charge copays to members, they must provide at least a 6 month notice to DHS and submit a member communication plan for approval before implementation.

D. Recoupments

The Department will recoup the HMO payments as described below:

1. The Department will recoup HMO current capitation payments for the following situations where a member's HMO status has changed before the first day of a month for which a capitation payment had been made:
    a. Member moves out of the HMO's service area.
    b. Member dies.
    c. Correction of a computer or human error.
2. The Department will recoup the HMO capitation payments for the following situations where the Department initiates a change in a member's HMO status on a retroactive basis, reflecting the fact that the HMO was not able to provide services. In these situations, recoupments for multiple months' capitation payments are more likely.
    a. Correction of a computer or human error, where the person was never really enrolled in the HMO.
    b. Disenrollments of members for continuity of care reasons, or as specified in Article II.B.
    c. Member enters a public institution.
3. If membership is disputed between two HMOs, the Department will be the final arbitrator of HMO membership and reserve the right to recoup an inappropriate capitation payment.
4. If the HMO member moves out of the HMO's service area, the member will be disenrolled from the HMO on the date the member moved as verified by the eligibility worker. If the eligibility worker is unable to verify the member's move, the HMO may mail a "certified return receipt requested" letter to the member to verify the move. The member must sign for the letter. A copy of the letter and the signed return receipt must be sent to the Department or its designee within 20 days of the member's signature date. If the criteria are met, the effective date of the disenrollment is the first of the month in which the certified returned receipt requested letter was sent. Documentation that fails to meet the 20 day criteria will

result in disenrollment the first day of the month that the HMO supplied information to the Department or its designee. This policy does not apply to extended service area requests that have been approved by the HMO unless the member moves out of the extended service area or the HMO's service area. Any capitation payment made for periods of time after disenrollment will be recouped.

5. The Department will recoup HMO non-capitated payments for the following situations:

   a. Correction of a computer or human error.

   b. A reconciliation process.

   c. Per the instructions from a reimbursement guide.

E. Risk adjustment payments or recoupments

Risk adjustment payments or recoupments will be made to the HMO based on chronicity adjustments during the rate development process. The risk adjustment scores will be applied to the rate prospectively and an annual reconciliation will be calculated based on actual enrollment. This may result in additional payments to or recoupments from the HMO.

F. Reinsurance

The HMO may obtain a risk-sharing arrangement from an insurer other than the Department for coverage of members under this Contract, provided that the HMO remains substantially at risk for providing services under this Contract.

G. Coordination of Benefits (COB), Third Party Liability (TPL) and Subrogation

The HMO must actively pursue, collect and retain all monies from all available resources for services to members covered under this Contract except where the amount of reimbursement the HMO can reasonably expect to receive is less than the estimated cost of recovery (this exception does not apply to collections for ventilator dependent patients). For purposes of both COB and TPL, and pursuant to the federal Deficit Reduction Act (P.L. 109-171, Sec. 6035), the HMO shall use cost avoidance when possible, except as otherwise permitted herein. Specifically, HMOs are prohibited from referring enrollees to publicly supported health care resources in order to avoid costs. While the HMO cannot recoup payment pending third party liability recovery, it may request additional information from a provider or member prior to payment in order to determine whether there is a payer that is primary to Medicaid.

1. Cost effectiveness of recovery is determined by, but not limited to time, effort, and capital outlay required to perform the activity. Upon the request of the Department, the HMO must be able to specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which the HMO determines seeking reimbursement would not be cost effective. Recovery activities include COB, TPL and pursuit of the HMO's subrogation rights under Ch. 49 of the WI

Statutes. Pursuant to Ch. 49, Wis. Stat. §609.91 and Wis. Adm. Code DHS 106, the HMO shall have the same COB and collection rights as the Department, and may require providers to code claims for liability in order to assist with recovery efforts.

2. The HMO must also seek to coordinate benefits with other available resources before claiming reimbursement from the Department for all services meeting the cost effectiveness threshold:

   a. Other available resources for benefit coordination and recovery may include, but are not limited to, all other state or federal medical care programs that are primary to BadgerCare Plus and/or Medicaid SSI, group or individual health insurance, ERISAs, service benefit plans, disability insurance policy, the insurance of absent parents who may have insurance to pay medical care for spouses or minor members, subrogation/worker's compensation collections, and any other available medical payments coverage that is issued without regard to liability (even if contained within a liability insurance policy). To the extent medical payments coverage has been issued directly to a member instead of the HMO or provider for reimbursement of specific claims, the HMO may require such claims to be paid by the member out of these funds.

   b. Subrogation collections are any recoverable amounts arising out of the settlement or other resolution of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the HMO under Act 31, Laws of 1989, s. 49.89(9). After attorneys' fees and expenses have been paid, the HMO will collect the full amount paid on behalf of the member (subject to applicable law). Similarly, the HMO shall have the right to require a full accounting of claims already paid by a liability insurer under medical payments coverage prior to its payment to verify that the HMO is not issuing payment on a claim that has already been paid by an alternate funding source. To the extent a claim is undisputed (for example, worker's compensation or personal injury) and the third party insurer is covering related medical expenses, such insurance shall be considered primary to Medicaid for such claims and should make payment on any related claim(s) prior to payment by the HMO.

   c. In accordance with federal law, preventive pediatric services may only be recovered through post-payment billing (pay and chase). Post-payment billing will also be done in situations where the third party liability (TPL) is derived from a parent whose obligation to pay is being enforced by the State Child Support Enforcement Agency and the provider has not received payment within 30 days after the date of service.

3. Section 1912(b) of the Social Security Act must be construed in a beneficiary-specific manner. The purpose of the distribution provision is to permit the beneficiary to retain TPL benefits to which they are entitled except to the extent

that BadgerCare Plus and/or Medicaid SSI (or the HMO on behalf of BadgerCare Plus and/or Medicaid SSI) is reimbursed for its costs. The HMO is free, within the constraints of state law and this Contract, to make whatever case it can to recover the costs it incurred on behalf of its member. It can use the max fee schedule, an estimate of what a capitated physician would charge on a FFS basis, the value of the care provided in the market place, or some other acceptable proxy as the basis of recovery. However, any excess recovery, over and above the cost of care (however the HMO chooses to define that cost), must be returned to the beneficiary. The HMO may not collect from amounts allotted to the beneficiary in a judgment or court-approved settlement, except those related to past medical expenses paid by the HMO. In the event any judgment or settlement is not itemized, the HMO shall be free, subject to applicable law, to work with the member, other insurance, and/or attorneys to resolve the Medicaid lien in a fair and equitable manner.

4. To ensure compliance, the HMO must maintain records of all COB collections and report them to the Department on a quarterly basis. The COB report must be submitted in the format specified in this Contract (Addendum IV., A). The HMO must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for members. The HMO must seek third party coverage information from all available resources.

5. The HMO must seek third party coverage information from all available resources. This includes accessing and reviewing member's TPL/COB information in the ForwardHealth portal. The HMO is required to submit TPL discrepancies to the Department in the format and manner prescribed by the Department.

6. COB and TPL collections are the responsibility of the HMO or its subcontractors. Subcontractors must report COB information to the HMO. The HMO and its subcontractors must not pursue collection from the member, but directly from the third party payer. Access to medical services must not be restricted due to COB collection.

7. The following requirement applies if the Contractor (or the Contractor's parent firm and/or any subdivision or subsidiary of either the Contractor's parent firm or of the Contractor) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organization(s), and/or employer self-insurer health plan(s):

    a. Throughout the Contract term, these insurers and third-party administrators must comply in full with the provision of Wis. Stats., Subsection 49.475. Such compliance must include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule

established by the Department. The type of information provided must be consistent with the Department's written specifications.

b. Throughout the Contract term, these insurers and third-party administrators must also accept and properly process post payment billings from the Department's fiscal agent for health care services and items received by BadgerCare Plus and Medicaid SSI members.

8. If at any time during the Contract term any of the insurers or third party administrators fail, in whole or in part, to collect from third party payers, except as otherwise permitted herein, the Department may take the remedial measures specified in this Contract.

9. In accordance with 42 CFR § 438.3(t), the HMO must enter into a Coordination of Benefits Agreement (COBA) with Medicare, participate in the automated claims crossover process, and execute all deliverables in the agreement.

H. Ventilator Dependent Members

To qualify for a ventilator dependent payment, a member must require equipment that provides total respiratory support or the member must have died while on total respiratory support. This equipment may be a volume ventilator, negative pressure ventilator, continuous positive airway pressure (CPAP) system, or a Bi (inspiratory and expiratory) PAP. The member may need a combination of these systems. Any equipment used only for the treatment of sleep apnea does not qualify as total respiratory support.

1. Criteria

The member must be inpatient and have total respiratory support for at least 30 days. Total respiratory support must be required for a total of six or more hours per 24 hour period. The total respiratory support does not need to be continuous during that period. Day one is the day that the member is placed on the ventilator. If the member is on the ventilator for less than six hours on the first day, the use must continue into the next day and be more than six total hours. Each day that the member is on the ventilator for part of any day, as long as it is part of the six total hours per 24 hours, it counts as a day for enhanced funding.

If a member is removed from the ventilator to be transferred to home or a hospice/skilled nursing facility prior to the 30 day ventilator requirement and they die within 48 hours of the transfer, the Department will pay all Medicaid covered services to the end of the month or the member's date of death.

The need for total respiratory support must be supported by either:

a. appropriate medical documentation that include:

i. copy of the member's admission history and physical exam,

ii. discharge summary,

iii. physician and nurse's notes that pertain to the member's ventilator use.

b. a signed statement from the physician that includes:

i. member's name, date of birth, Medicaid ID# and the primary diagnosis,

ii. The name of the hospital with the admit/discharge dates,

iii. Dates the member was on a ventilator or CPAP,

iv. Statement must specify whether the member was on a ventilator or CPAP.

If the member is transferred to home or a hospice/skilled nursing facility the Department will need medical documentation that includes the member's date of death and the date of the transfer. Documentation must be submitted at the same time as the request and after the member has been discharged from an acute care setting or has passed away.

2. Reporting Requirements

The HMO must submit a CSV file and a file containing the appropriate documentation outlined in sections '1' and '2' above via the SFTP site to initiate the vent payment request process. More than one member can be included in the CSV file and medical documentation should be in PDF file format with one file per member. The SFTP site will be checked weekly for new submissions. The member must be discharged from the acute care setting prior to a vent request submission. Refer to the 'Encounter Based Payment User Guide' and 'Report Matrix' on ForwardHealth for more details.

Per Wis. Adm. Code § DHS 106.03 payment data or adjustment data must be received within 365 days after the date of the service. The HMO will be given an additional three months plus 10 days to file their vent requests. If the last date of service for an inpatient hospital facility stay occurs within the same timeline specified (365 days plus three months plus 10 days) the Department will reimburse the HMO for the facility charges that entire stay. If the HMO cannot meet these requirements, the HMO must provide documentation that substantiates the delay. The Department will make the final determination to pay or deny the services. The Department will exercise reasonable discretion in making the determination to waive the 365 day filing requirements.

3. Payment Requirements

Approved vent requests will initiate an encounter selection process that will result in encounters with a date of service within the approved ventilator period being paid as an encounter-based payment. Capitations for members with approved vent requests will be adjusted to $0.00 for the month(s) included in the enhanced funding. As specified in 42 C.F.R. § 447.362, the HMO's Medicaid reimbursement will not exceed Medicaid fee-for-service costs of providing

BadgerCare Plus and/or Medicaid SSI covered services to BadgerCare Plus and Medicaid SSI HMO members who meet the ventilator dependent criteria. Reimbursement will only be for Medicaid covered services paid by the HMO. Other associated costs, such as administration or interest, will not be reimbursed.

a. Enhanced Funding

i. Newborns (BadgerCare Plus Only)

The period of enhanced funding for newborns who are on total respiratory support at birth, will begin with the newborn's date of birth and will end on the last day of the month of the qualifying hospital stay. If the newborn dies while on total respiratory support the enhanced funding will end on the date of death. The newborn may be removed from the ventilator to spend time with family and friends prior to his/her date of death.

ii. All Other Members

The period of enhanced funding for all other members who meet the ventilator dependency criteria will begin on the first day of the month the member was hospitalized and will end on the last day of the month of the qualifying hospital stay. If the member dies while on total respiratory support the enhanced funding will end on the date of death. The member may be removed from the ventilator to spend time with family and friends prior to his/her date of death.

b. Dispute Resolution

Disputes regarding the Department's approval or denial of ventilator dependent BadgerCare Plus and/or Medicaid SSI member submissions should be directed to the HMO Support inbox, VEDSHMOsupport@wisconsin.gov.

I. Hospital Access Payment for Non-Critical Access Hospitals

The Department will pay the HMO monthly hospital inpatient BadgerCare Plus and SSI access payments and monthly hospital outpatient BadgerCare Plus and SSI access payments within the limits of the budgeted allocation from the hospital assessment fund. The Department's monthly hospital access payments to the HMOs are made as prospective "per member per month" payments, unadjusted for risk . As with all months, the January payment will be based on January enrollment. However, the January payment will be paid out in February.

The HMO shall make payments to eligible hospitals based on the number of qualifying inpatient discharges and outpatient claims in the previous month. This logic applies to all months except for January. HMOs must use January hospital utilization data for both January and February payment. Payments must be sent to hospitals within 15 calendar days after the HMO receives the monthly amounts from the Department. These payments

are in addition to any amount the HMO is required by agreement to pay the hospital for provision of services to HMO members.

An "eligible hospital" means a Medicaid-enrolled Wisconsin hospital that is not a critical access hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital. A list of qualifying hospitals is available from the Department upon request by emailing DHSDMSBRS@dhs.wisconsin.gov.

"Qualifying inpatient discharges and outpatient claims" are inpatient discharges and outpatient claims for which the HMO made payments to eligible providers in the month preceding the Department's monthly access payment to the HMO for services to the HMO's Medicaid, BadgerCare Plus, and SSI members, other than Childless Adult (CLA) Plan members or members who are eligible for both Medicaid and Medicare. The HMO shall exclude all members who are dually-eligible and all dual-eligible claims. If a third party pays the claim in full, and the HMO does not make a payment, the claim shall not count as a qualifying claim for the hospital access payment. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for the hospital access payment. The HMO must utilize the Wisconsin Medicaid HMO Access Payment Report System (HMO Portal) to enter in qualifying inpatient discharges and outpatient claims as stated in the HMO Access Portal Training Manual. Additional resources can be found on the training section of the HMO Portal https://wihmo.pcghealthservices.com/Dashboard/Training .

When utilizing the HMO Portal to complete utilization reports and payment attestation reports each month, HMOs must acknowledge that, based on best information, knowledge, and belief, the data, documentation, and information provided is accurate, complete, and truthful. The utilization reports must reflect the actual amounts HMOs must pay to each eligible hospital provider every month. By completing the payment attestation reports, the HMO confirms that each payment has been made to each eligible hospital provider and attests that the payment amounts in the HMO Portal are accurate.

1. Method of payment to hospitals

    a. Payments must be sent to eligible hospitals within 15 days of the HMO receiving the hospital access payments from the Department. The HMO shall pay out the full amounts of hospital access payments where utilization has occurred. The HMO will base its hospital payments upon the number of qualifying inpatient discharges and outpatient claims regardless of the amount of the base claims payment for those inpatient discharges and outpatient claims. The HMO shall pay each eligible hospital based upon its percentage of the total number of qualifying inpatient discharges and outpatient claims for all eligible hospitals as stated in the utilization report on the HMO Portal. If the HMO has no qualifying claims for a specific category:

i. A specific category is denied as the separate payment provided by the Department for either BadgerCare Plus or Medicaid SSI and either Inpatient or Outpatient. An example of a Hospital Access Payment specific category for Non-Critical Access Hospital is BadgerCare Plus/Inpatient.

ii. The HMO shall return payment within 15 calendar days after payment is due to providers or within 30 calendar days after the HMO receives the monthly amount from the Department.

a) Return payments should be made in the form of a check, payable to:

Wisconsin Forward Health

Attn: Cash Unit

313 Blettner Blvd

Madison, WI 53784

iii. The return payment must include supporting documentation including details of the associated Department check or EFT number, its purpose, specific category, and the month the Department payment was received.

iv. The HMO must submit notice of returned payment to DHSDMSBRS@dhs.wisconsin.gov with subject: HMO Access Payment Return.

b. An example of the payment methodology is as follows:

HMO A receives $1 million for inpatient access payments and $500,000 for outpatient access payments in the month of June. HMO A distributes inpatient and outpatient access payments to eligible hospitals received from the Department in June according to the following formula:

i. Inpatient: HMO A counts 1,000 inpatient qualifying discharges paid in May (excluding Medicare crossover claims and claims paid for Childless Adult (CLA) Plan members) to three eligible hospitals.

Hospital X was paid for 300 discharges by HMO A in the month of May, and therefore, will receive 30% of the total inpatient access payment HMO A received from the Department in June.

ii. Outpatient: HMO A counts 2,000 outpatient qualifying claims paid in May (excluding Medicare crossover claims and claims paid for Childless Adult (CLA) Plan members) to five eligible hospitals.

Hospital X was paid for 400 claims by HMO A in the month of May, and therefore, will receive 20% of the total outpatient access payment HMO A received from the Department in June.

2. Monthly reporting requirements

   a. The HMO shall send a report along with its monthly payment to each eligible hospital that contains the following information:

      i. The amount of the hospital access payments received from the Department for inpatient discharges;

      ii. The amount of the hospital access payments received from the Department for outpatient claims;

      iii. That hospital's number of qualifying inpatient discharges;

      iv. That hospital's number of qualifying outpatient claims;

      v. The total number of qualifying inpatient discharges for all qualifying hospitals;

      vi. The total number of qualifying outpatient claims for all qualifying hospitals;

      vii. Access payment amount per qualifying inpatient discharge;

      viii. Access payment amount per qualifying outpatient claims;

      ix. The amount of the total payment to that hospital.

   b. The HMO shall use the Access Payment Portal to report all access payments to providers to the Department. The link to the HMO Portal is: https://wihmo.pcghealthservices.com/.

   c. The HMO must complete the payment information within the HMO Portal within 15 calendar days of receipt of payment from the Department.

   d. If the HMO Portal is unavailable for a period of time greater than 48 hours, the HMO must contact the Department immediately upon discovery. The Department will notify all HMOs of an extension and work with the HMO Portal Vendor to resolve any technical issues.

3. Noncompliance

   The Department shall have the right to audit any records of the HMO to determine if the HMO has complied with the requirements in this section I. If at any time the Department determines that the HMO has not complied with any requirement in this section I., the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department's determination of noncompliance. If the HMO fails to comply after an order, the Department may terminate the contract as provided under Article XIV.E.2.

   Upon request, the HMO must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

If the HMO fails to send payment to the hospital within 15 calendar days of receiving the hospital access payment from the Department, the HMO will pay an assessment to the Department equal to three percent of the delayed payment.

4. Payment disputes

   If the HMO or the hospital dispute the monthly amount that the HMO is required to pay the hospital, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The HMO or hospital may request a contested case hearing under Ch. 227 on the Department's determination.

5. Resolution of Reporting Errors

   The HMO shall adjust prior hospital access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient claims. If an error is discovered, HMOs must contact the Bureau of Rate Setting (BRS) with an email sent to DHSDMSBRS@dhs.wisconsin.gov within 15 calendar days of the discovery. When a report is amended, HMOs must alert BRS with an email sent to DHSDMSBRS@dhs.wisconsin.gov within 15 calendar days of when the report was amended. HMOs must make corrections using the HMO Portal functionality. HMOs will be responsible for making these adjustments. If the HMO Portal functionality is unavailable then the HMO must submit a Department-approved plan to address the error.

J. Hospital Access Payment for Critical Access Hospitals (CAH)

Within the limits of the budgeted allocation from the Critical Access Hospital (CAH) assessment fund, the Department will pay the HMO monthly CAH inpatient BadgerCare Plus and SSI access payments and monthly CAH outpatient BadgerCare Plus and SSI access payment. The Department's monthly CAH access payments to the HMOs are made as prospective "per member per month" payments, unadjusted for risk. As with all months, the January payment will be based on January enrollment. However, the January payment will be paid out in February.

The HMO shall make payments to eligible CAHs based on the number of qualifying inpatient discharges and outpatient claims in the previous month. This logic applies to all months except for January. HMOs must use January hospital utilization data for both January and February payments. Payments must be sent to the CAH within 15 calendar days after the HMO receives the monthly amounts from the Department. These payments are in addition to any amount the HMO is required by agreement to pay the CAH for provision of services to HMO members.

An "eligible CAH" means a Medicaid-enrolled Wisconsin CAH that is not an acute care hospital, an institution for mental disease, a rehabilitation hospital, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital.

A list of qualifying CAH is available from the Department upon request by emailing DHSDMSBRS@dhs.wisconsin.gov.

"Qualifying inpatient discharges and outpatient claims" are inpatient discharges and outpatient claims for which the HMO made payments to eligible providers in the month preceding the Department's monthly access payment to the HMO for services to the HMO's Medicaid BadgerCare Plus and SSI members, other than Childless Adult (CLA) Plan members or members who are eligible for both Medicaid and Medicare. HMOs shall exclude all members who are dually-eligible and all dual-eligible claims. If a third party pays the claim in full, and the HMO does not make a payment, the claim shall not count as a qualifying claim for the CAH access payment. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for the CAH access payment. The HMO must utilize the Wisconsin Medicaid HMO Access Payment Report System (HMO Portal) to enter in qualifying inpatient discharges and outpatient claims as stated in the HMO Access Portal Training Manual. Additional resources can be found on the training section of the HMO Portal.

When utilizing the HMO Portal to complete utilization reports and payment attestation reports each month, HMOs must acknowledge that, based on best information, knowledge, and belief, the data, documentation, and information provided is accurate, complete, and truthful. The utilization reports must reflect the actual amounts HMOs must pay to each eligible hospital provider every month. By completing the payment attestation reports, the HMO confirms that each payment has been made to each eligible hospital provider and attests that the payment amounts in the HMO Portal are accurate.

1. Method of payment to hospitals

    a. Payments must be sent to eligible CAH(s) within 15 days of the HMO receiving the CAH access payments from the Department. The HMO shall pay out the full amounts of CAH access payments where utilization has occurred. The HMO will base its CAH payments upon the number of qualifying inpatient discharges and the number of qualifying outpatient claims regardless of the amount of the base claims payment for those discharges and claims. The HMO shall pay each eligible CAH based upon its percentage of the total number of qualifying inpatient discharges and outpatient claims for all eligible CAH(s) as stated in the utilization report on the HMO Portal. If the HMO has no qualifying claims for a specific category:

        i. A specific category is denied as the separate payment provided by the Department for either BadgerCare Plus or Medicaid SSI and either Inpatient or Outpatient. An example of a Hospital Access Payment specific category for Critical Access Hospital is BadgerCare Plus/Inpatient.

        ii. The HMO shall return payment within 15 calendar days after payment is due to providers or within 30 calendar days after the HMO receives the monthly amount from the Department.

a) Return payments should be made in the form of a check, payable to:

Wisconsin Forward Health

Attn: Cash Unit

313 Blettner Blvd

Madison, WI 53784

iii. The return payment must include supporting documentation including details of the associated Department check or EFT number, its purpose, specific category, and month Department payment was received.

iv. The HMO must submit notice of returned payment to DHSDMSBRS@dhs.wisconsin.gov with subject: HMO Access Payment Return.

b. An example of the payment methodology is as follows:

HMO A receives $1 million for inpatient access payments and $500,000 for outpatient access payments in the month of June. HMO A distributes inpatient and outpatient access payments to eligible CAH(s) received from the Department in June according to the following formula:

i. Inpatient: HMO A counts 1,000 inpatient qualifying discharges paid in May (excluding Medicare crossover claims and claims paid for Childless Adult (CLA) Plan members) to three eligible CAH(s).

CAH X was paid for 300 discharges by HMO A in the month of May, and therefore, will receive 30% of the total inpatient access payment HMO A received from the Department in June.

ii. Outpatient: HMO A counts 2,000 outpatient qualifying claims paid in May (excluding Medicare crossover claims and claims paid for Childless Adult (CLA) Plan members) to five eligible CAH(s).

CAH X was paid for 400 claims by HMO A in the month of May, and therefore, will receive 20% of the total outpatient access payment HMO A received from the Department in June.

2. Monthly reporting requirements

a. The HMO shall send a report along with its monthly payment to each eligible CAH(s) that contains the following information:

i. The amount of the CAH access payment received from the Department for inpatient discharges;

ii. The amount of the CAH access payments received from the Department for outpatient claims;

iii. That CAH's number of qualifying inpatient discharges;

iv. That CAH's number of qualifying outpatient claims;

v. The total number of qualifying inpatient discharges for all qualifying CAH(s);

vi. The total number of qualifying outpatient claims for all qualifying CAH(s);

vii. Access payment amount per qualifying inpatient discharge;

viii. Access payment amount per qualifying outpatient claim;

ix. The amount of the total payment to that CAH.

b. The HMO shall use the HMO Portal to report all access payments to providers to the Department. The link to the HMO Portal is: https://wihmo.pcghealthservices.com .

c. The HMO must complete the payment information within the HMO Access Payment Portal within 15 calendar days of receipt of payment from the Department.

d. If the HMO Portal is unavailable for a period of time greater than 48 hours, the HMO must contact the Department immediately upon discovery. The Department will notify all HMOs of an extension and work with the HMO Portal Vendor to resolve any technical issues.

3. Noncompliance

The Department shall have the right to audit any records of the HMO to determine if the HMO has complied with the requirements in this section J. If at any time the Department determines that the HMO has not complied with any requirement in this section J, the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department's determination of noncompliance. If the HMO fails to comply after an order, the Department may terminate the contract as provided under Article XIV.E.2.

Upon request, the HMO must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

If the HMO fails to send payment to the CAH within 15 days of receiving CAH access payment from the Department, the HMO will pay an assessment to the Department equal to three percent of the delayed payment.

4. Payment disputes

If the HMO or the CAH dispute the monthly amount that the HMO is required to pay the CAH, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of

the payment within 60 days after the request for a determination is made. The HMO or CAH may request a contested case hearing under CH. 227 on the Department's determination.

5. Resolution of Reporting Errors

The HMO shall adjust prior CAH access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient claims. If an error is discovered, HMOs must contact the Bureau of Rate Setting (BRS) with an email sent to DHSDMSBRS@dhs.wisconsin.gov within 15 days of the discovery. When a report is amended, HMOs must contact BRS with an email sent to DHSDMSBRS@dhs.wisconsin.gov within 15 calendar days of when the report was amended. HMOs must make corrections using the HMO Portal functionality. If the HMO Portal functionality is unavailable then the HMO must submit a Department-approved plan to address the error.

K. Unauthorized Programs or Activities

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the HMO must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the HMO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the HMO will not be paid for that work. If the state paid the HMO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the HMO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the HMO, the HMO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

L. Payment Method

All payments, recoupments, and debit adjustments for payments made in error, distributed by the Department to the HMO, will be made via Electronic Funds Transfer (EFT) via enrollment through the secure ForwardHealth Portal account.

HMOs are responsible for maintaining complete and accurate EFT information in order to receive payment. If a HMO fails to maintain complete and accurate information and DHS makes a payment to an incorrect account, the Department will be held harmless and will not reissue a payment.

All arrangements between the financial institution specified for EFT and the HMO must be in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.

EFT information provided by the HMOs via their secure ForwardHealth Portal account constitute a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and if any such information is false, criminal, or other penalties may be imposed under these laws.

The requirements and obligations for EFT are in addition to any and all other requirements and obligations applicable to HMO in connection with their contract and their participation in any program that is part of ForwardHealth, including but not limited to requirements and obligations set forth in federal and state statutes and rules and applicable handbooks and updates.

M. Risk Corridor

The Department will utilize a risk corridor mechanism. The risk corridor will address variances in costs for all benefit services. The risk corridor will not address variances in administrative costs.

1. Capitation Rate Target Risk Corridor Loss Ratio

   a. The target Risk Corridor Loss Ratio percentage will be developed by dividing the benefit service component of the rate, by the entire capitation rate including maternity kick payments, gross of pay for performance withholds and net of hospital access payments.

   b. The capitation rate used as the denominator in 1.a. will be calculated specific to the rate cell mix and pricing assumptions for each HMO.

2. Settlement Methodology

   The following methodology will be used to determine risk corridor settlement results:

   a. The numerator for calculating the HMO's actual Risk Corridor Loss Ratio for the rate year will equal total claim costs for benefit services based on HMO financial data reporting.

   b. The denominator for calculating the HMO's actual Risk Corridor Loss Ratio for the rate year will equal all capitation revenue including maternity kick payments, gross of pay for performance withholds, net of hospital access payments, and all retrospective adjustments attributed to the rate year.

   c. The numerator from 2.a will be divided by the denominator in 2.b to calculate the actual Risk Corridor Loss Ratio.

   d. The actual Risk Corridor Loss Ratio will be subtracted from the Capitation Rate Target Risk Corridor Loss Ratio calculated in 2.c. to determine the Risk Corridor Loss Ratio gain or loss.

e. The Department will recoup the Department's share of the HMO's gains and pay out the Department's share of the HMO's losses as a percentage of the HMO's capitation revenue, according to the following schedule:

Gain	HMO Share	Department Share
<= 2.0%	100%	0%
>2.0% to 6.0%	50%	50%
> 6.0%	0%	100%
Loss	HMO Share	Department Share
<= 2.0%	100%	0%
>2.0% to 6.0%	50%	50%
> 6.0%	0%	100%

f. The Department may adjust the risk corridor numerator calculation if, upon review of encounters, financials, or other information associated with such payments, that the HMO's benefit services reimbursements are not at market-based levels and do not incent efficient and high quality care.

g. An interim risk corridor settlement based on 4 months of claims runout will be completed no earlier than 6 months after the rate year has ended.

h. The Department may elect to pay or recoup only a portion for the interim risk corridor settlement.

i. The final risk corridor settlement based on 16 months of claims runout will be completed no earlier than 18 months after the rate year has ended.

3. Related party expenses

Related party is any type of arrangement with an entity that is associated with the HMO through any form of common, privately-held ownership, control, or investment.

a. Related party expenses reported in the numerator must not be materially above the fee-for-service reimbursement rate for services provided, multiplied by the average provider contracting adjustment from the capitation rate development.

b. The Department may waive this requirement if the HMO can demonstrate that:

i. The reimbursement rates to the related party for the services in question do not exceed the rates paid to entities that are not related for the same or similar services, and

ii. A material percentage of its expenditures for the services in question are being paid to entities that are not related.

c. The Department may waive this requirement if the provider can demonstrate that:

i. The reimbursement rates do not exceed the rates that the provider receives from entities that are not related parties, and

d. A material percentage of its reimbursement for the services in question are being received from entities that are not related.

N. Payment for Interpreter Services

1. HMO expenses for employing interpreters may be included in the development of the administrative component of the capitation payment.

2. HMOs may not claim interpreter service expenses, reimbursed via encounter-based payments, as an administrative expense.

O. State Directed Payment for Ambulance Services

1. For dates of service between January 1, 2025 and December 31, 2025, the HMO shall pay an eligible ambulance service for qualifying ambulance services an additional amount as indicated in the table below. The rate add-on amount shall be paid at the time that the base payment is made.

	Emergency Medical Transport	**Non-Emergency Medical Transport**
Providers with ZIP code of their primary business location in a county with population size more than 750,000 (Milwaukee County)	$159.96	$79.78
Providers with ZIP code of their primary business location in a county with population size less than 750,000	$799.79	$399.89

a. An “eligible ambulance service provider” means a Medicaid-enrolled Wisconsin ambulance service provider that has an active license to provide ambulance services in the State of Wisconsin, provides ground emergency medical transports, and is privately owned.

b. “Qualifying Ambulance Services” are ambulance service claims that are billed under the following HCPCS codes for a member:

i. Emergency medical transport, including:

a) A0429 BLS Emergency,

b) A0427 ALS Emergency (Level 1),

c) A0433 ALS Emergency (Level 2),

d) A0434 Specialty Care Transport,

e) A0998 Ambulance response and treatment, no transport,

f) A0225 Neonatal Emergency Transport.

ii. Non--emergency medical transport, including:

a) A0428 BLS Non-Emergency,

b) A0426 ALS Non-Emergency.

c. Qualifying Ambulance services do not include:

i. Services for members who are enrolled in Medicare.

ii. Services for which the HMO does not make any payment.

2. Reporting Requirements

a. The HMO must report to the Department qualifying ambulance payments in a format as prescribed by the Department.

b. The HMO shall send a report to each eligible provider within 120 days of payment containing the following information:

i. That provider's number of qualifying ambulance service (broken out by emergency/non-emergency);

ii. Ambulance service payment amount per qualifying ambulance service claim (broken out by emergency/non-emergency);

iii. The amount of the total payment to that provider.

XVII. HMO Specific Contract Terms

A. Documents Constituting Contract

1. Current Documents

In addition to this base agreement, the Contract between the Department and the HMO includes, existing BadgerCare Plus and/or Medicaid SSI provider publications addressed to the HMO, the terms of the most recent HMO certification application issued by this Department prior to HMO contracts, any questions and answers released pursuant to said HMO certification application by the Department, DHS issued guides and the HMO's signed application. In the event of any conflict in provisions among these documents, the terms of this base agreement will prevail. The provisions in any question and answer document will prevail over the HMO certification application. The HMO certification application terms shall prevail over any conflict with the HMO's actual signed application.

2. Future Documents

The HMO is required by this Contract to comply with all future Wisconsin Health Care Programs Online Handbooks and Contract Interpretation Bulletins issued pursuant to this Contract. The documents listed in this section constitute the entire Contract between the parties. No other oral or written expression constitutes any part of this Contract.

B. Disclosure Statement(s) of Ownership or Controlling Interest in an HMO and Business Transactions

1. Ownership or Controlling Interest Disclosure Statement(s)

a. Pursuant to 42 CFR § 455.104 HMO's, and subcontracted disclosing entities and fiscal agents, must provide the following disclosures to the Department:

i. The name and address of any person (individual or corporation) with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box.

ii. Date of birth and Social Security number (in the case of an individual).

iii. Other tax identification number (in the case of a corporation) with ownership or control interest in the disclosing entity (or fiscal or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest.

Calculation of 5% Ownership or Control is as follows:

a) The percentage of direct ownership or control is the percentage interest in the capital, stock or profits.

b) The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation that owns 80% of the stock of the HMO, the person owns 8% of the HMO.

c) The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest that a person owns in that obligation by the percent of the HMO's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the HMO's assets, the person owns 6% of the HMO.

iv. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity is a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

v. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

vi. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

b. Disclosure from any provider or disclosing entity is due at any of the following times:

i. Upon the provider or disclosing entity submitting the provider application.

ii. Upon the provider or disclosing entity executing the provider agreement.

iii. Upon request of the department during the re-validation of the enrollment process.

iv. Within 35 days after any changes in ownership of the disclosing entity.

c. Disclosure from fiscal agents are due at any of the following times:

i. Upon the fiscal agent executing the contract with the Department.

ii. Upon renewal or extension of the contract.

iii. Within 35 days after any changes in ownership of the fiscal agent.

d. Disclosure from HMO's are due at any of the following times:

i. Upon the HMO executing the contract with the Department.

ii. Upon renewal or extension of the contract.

iii. Within 35 days after any change in ownership of the managed care entity.

e. HMOs must disclose all ownership and controlling interest to the Department upon request or as federally required. The HMO may supply this information on a separate report or submit reports filed with the state's insurance or health regulators as long as these reports provide the necessary information for the prior 12 month period.

f. As directed by the CMS Regional Office (RO), the Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If the HMO has not supplied this information, a contract with the HMO is not considered approved for this period of time and no FFP is available for the period of time preceding the disclosure.

g. As described in 42 CFR 438.608 and 438.610, the HMO must retain, preserve, and make available upon request data, information, and documentation related to disclosure of any prohibited affiliations, including:

i. Individuals, entities, or their affiliates (as defined in 48 C.F.R. §2.101) acting as: a director, officer, partner, or subcontractor (as defined by 42 C.F.R. §438.230) of the HMO; a person with beneficial ownership of five percent or more of the HMO's equity; or a network provider or person with employment, consulting, or other arrangement with the HMO for the provision of items and services that are significant and material to the HMO's contractual obligations with the state if those individuals, entities, or affiliates are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under associated implementing guidelines;

ii. Individuals or entities excluded from participation in any federal health program under section 1128 or 1128A of the Social Security Act.

h. If the Department finds that the HMO has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department:

i. Must notify the Secretary of noncompliance.

ii. May continue an existing agreement with the HMO unless the Secretary directs otherwise.

iii. May not renew or otherwise extend the duration of an existing agreement with the HMO unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

2. Business Transaction Disclosures

The HMO must report to the Department information related to business transactions in accordance with 42 CFR § 455.105. The HMO must be able to submit this information within 35 days of the date of written request from the Department.

a. The ownership of any subcontractors with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

b. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

If the BadgerCare Plus and Medicaid SSI HMO Contract is being renewed or extended, the HMO must disclose information on those business transactions that occurred during the prior contract period. If the Contract is an initial contract with BadgerCare Plus and/or Medicaid SSI, but the HMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving BadgerCare Plus and/or Medicaid SSI enrollment. All of these HMO business transactions must be reported.

3. Disclosure by providers: information on persons convicted of crimes.

In accordance with 42 CFR § 455.106:

a. The HMO must disclose to the Department the identity of any person who:

i. Has ownership or control interest in the provider, or is an agent or managing employee of the provider, and

ii. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or title XX service program since the inception of those programs.

b. The HMO shall report to the Department within 20 working days of receipt of the following:

i. Any information regarding excluded or convicted individuals or entities, including those in Article XVII.B.3.a.ii. above;

ii. Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a provider.

c. Denial or termination or provider participation

i. The Department may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the title XX service Program.

ii. The Department may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under Article XVII.B.3.a.ii. above.

C. Miscellaneous

1. Indemnification

The HMO agrees to defend, indemnify and hold the Department harmless with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees that are related to or arise out of:

a. Any failure, inability, or refusal of the HMO or any of its subcontractors to provide contract services.

b. The negligent provision of contract services by the HMO or any of its subcontractors.

c. Any failure, inability or refusal of the HMO to pay any of its subcontractors for contract services.

2. Independent Capacity of Contractor

The Department and the HMO agree that the HMO and any agents or employees of the HMO, in the performance of this Contract, will act in an independent capacity, and not as officers or employees of Department.

3. Omissions

   In the event either party hereto discovers any material omission in the provisions of this Contract that is essential to the successful performance of this Contract, said party may so inform the other party in writing. The parties hereto will thereafter promptly negotiate the issues in good faith in order to make all reasonable adjustments necessary to perform the objectives of this Contract.

4. Choice of Law

   This Contract is governed by and construed in accordance with the laws of the State of Wisconsin. The HMO shall be required to bring all legal proceedings against the Department in Wisconsin state courts.

5. Waiver

   No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract will impair that right or power or be construed as a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other will not be construed as a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement contained herein.

6. Severability

   If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties will be relieved of all obligations arising under such provision. If such provision does not relate to payments or services to members and if the remainder of this Contract is not affected then each provision not so affected will be enforced to the fullest extent permitted by law.

7. Survival

   The terms and conditions contained in this Contract that by their sense and context are intended to survive the completion of performance shall so survive the completion, expiration or termination of the Contract. This specifically includes, but is not limited to recoupments and confidentiality provisions.

8. Force Majeure

   Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9. Headings

   The article and section headings used herein are for reference and convenience only and do not affect its interpretation.

10. Assignability

Except as allowed under subcontracting, the Contract is not assignable by the HMO either in whole or in part, without the prior written consent of the Department.

11. Right to Publish

The HMO must obtain prior written approval from the Department before publishing any material on subjects addressed by this Contract.

12. Media Contacts

The HMO agrees to forward to the Department all media contacts regarding BadgerCare Plus and/or Medicaid SSI programs or members.

D. HMO Specific Contract Terms

1. Initial Contract Period

The respective rights and obligations of the parties as set forth in this Contract shall commence on January 1, 2024, and unless earlier terminated, shall remain in full force effective through December 31, 2025. The specific terms for enrollment, rates, risk-sharing, dental and chiropractic coverage are as specified in the Contract.

2. Renewals

By mutual written agreement of the parties, there may be one one-year renewal of the term of the Contract. An agreement to renew must be effected at least 30 days prior to the expiration date of any contract term. The terms and conditions of the Contract shall remain in full force and effect throughout any renewal period, unless modified under the provision of the Contract.

3. Specific Terms of the Contract

a. The specific terms in the HMO's completed application for certification are incorporated into this Contract, including whether dental services and chiropractic services will be provided by the HMO.

b. For each rate period in this Contract, the HMO agrees, at minimum, to maintain the service area that was in effect at the time the HMO accepted the rates. This provision does not prevent the HMO from expanding to new service areas as approved by the Department.

c. The HMO's service area is specified in its certification application.

d. Rates are determined for county(ies) in which enrollment is accepted.

e. Adjusted rates - Rates may be changed to reflect legislative changes in BadgerCare Plus and/or Medicaid SSI reimbursement or changes in approved services. Rate changes may occur during the rate year or in rare instances, retroactively.

f. The Department shall calculate chronicity or risk adjustment scores as part of the rate development methodology depending on the availability of data. The risk adjustment scores will be applied prospectively to the rate schedule in the rate exhibits provided by the Department. The Department may adjust the HMO prospective risk score if a significant variance in chronicity occurs from the risk adjustment score that was used to adjust the base rates. Any such adjustment will take effect no sooner than 45 days after calculating the variance. Any risk score changes applied to a given HMO will also impact other HMO risk scores due to budget neutrality requirements.

g. An annual risk adjustment reconciliation will be calculated based on actual enrollment. This may result in additional payments to or recoupments from the HMO. The adjustments will be budget neutral to the Department.

E. Noncompliance

The Department shall have the right to audit any records of the HMO and to request any information to determine if the HMO has complied with the requirements in this section. If at any time the Department determines that the HMO has not complied with any requirement in this article, the Department will issue an order to the HMO to comply. The HMO shall comply within 15 calendar days after receipt of the order. If the HMO fails to comply after an order, the Department may pursue action against the HMO as provided under Article XIV.D. Additionally, the HMO may be required to forfeit the reimbursement.

F. Payment Disputes

The Department shall have the right to adjust the reimbursement outside the information provided by the HMO in the guide or template.

The HMO may dispute the reimbursement amount by sending a letter to the Department no later than 30 days after receipt of payment. After 30 days, the HMO waives the right to dispute the reimbursement amount.

G. Resolution of Reporting Errors

If the HMO discovers a reporting error, the Department's Bureau of Rate Setting in the Division of Medicaid Services must be contacted in writing within 15 days of the discovery.

Errors discovered after the retroactive capitation rate amendment is issued will be applied to the following year's reimbursement.

H. Signatures

In WITNESS WHEREOF, the State of Wisconsin and the MCO have executed this agreement:

Executed on behalf of Name of HMO	Executed on behalf of Department of Health Services
_____ Authorized Signer Chief Executive Officer	_____ William Hanna Medicaid Director
_____ Date	_____ Date

ADDENDUM

I. Memoranda of Understanding

A. MOU Submission Requirements

The HMO must submit to the Department copies of new MOUs, or changes in existing MOUs for review and approval before they take effect. This requirement will be considered met if the Department has not responded within 15 business days after receipt of the MOU.

The HMO shall submit MOUs referred to in this Contract and this Addendum to the Department upon the Department's request and during the certification process if required by the Department.

B. Emergency Services MOU or Contract

The HMO may have a contract or an MOU with hospitals or urgent care centers within the HMO's service area(s) to ensure prompt and appropriate payment for emergency services.

1. The MOU Shall Provide For
   a. The process for determining whether an emergency exists.
   b. The requirements and procedures for contacting the HMO before the provision of urgent or routine care.
   c. Agreements, if any, between the HMO and the provider regarding indemnification, hold harmless or any other deviation from malpractice or other legal liability which would attach to the HMO or provider in the absence of such an agreement.
   d. Payments for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.
   e. Assurance of timely and appropriate provision of and payment for emergency services.
2. The HMO's Liability for Emergency Situations

   Unless a contract or MOU specifies otherwise, the HMO is liable to the extent that FFS would have been liable for the emergency situation. The Department reserves the right to resolve disputes between the HMO, hospitals and urgent care centers regarding emergency situations based on FFS criteria.

C. County and Other Human Service Agencies MOU or Contract Requirements for Services Ordered by the Courts

The HMO must make a good faith attempt to negotiate either an MOU or a contract with the county(ies) in their service area. The MOU, contract, or written documentation of a good faith attempt must be available when requested by the

Department. Failure of the HMO to have an MOU, contract or a demonstrated good faith effort, may result in the the Department pursuing contractual remedies.

1. MOU Requirement with Boards Created Under Wis. Stats., §. 51.42, 51.437 or 46.23.

   At a minimum the MOU must specify the conditions under which the HMO will either reimburse the Board(s) or another contract provider, or directly cover medical services, including, but not limited to, examinations ordered by a court, specified by the Board's designated assessment agency in a member's driver safety plan as provided under DHS 62. It is the responsibility of both the HMO and the Board to ensure that courts order the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full BadgerCare Plus and/or Medicaid SSI rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own provider arrangements, the HMO is not liable. Reasonable arrangements, in this situation, are Medicaid-enrolled providers with facilities and services to safely meet the medical and psychiatric needs of the member within a prompt and reasonable time frame. The MOU shall further specify reimbursement arrangements between the HMO and the Board's provider for assessments performed by the Board's designated assessment agency under DHS 62, Intoxicated Driver Program rules. The MOU shall also specify other reporting and referral relationships if required by the Board or the HMO.

2. MOU Requirement with the Department of Social Services (DSS) Created Under Wis. Stats., s. 46.21 or 46.22, or the Human Service Department Created Under Wis. Stats., s. 46.23.

   At a minimum the MOU must specify that the HMO will reimburse the DSS or its provider if the HMO cannot provide the treatment, or will directly cover medical services including examinations and treatment which are ordered by a court. It is the responsibility of both the HMO and the DSS to ensure that courts order the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full BadgerCare Plus and/or Medicaid SSI rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own provider arrangements, the HMO is not liable. The MOU will also specify the reporting and referral relationships for suspected cases of child abuse or neglect pursuant to Wis. Stats., s. 48.981. The MOU shall also specify a referral agreement for HMO members who are physically disabled and who may be in need of supportive home care or other programming provided or purchased by the county agency. The MOU may specify that evaluations for substitute care will be provided by a provider acceptable to both parties; the DSS may require in the MOU that the HMO specify expert providers acceptable to the DSS and the HMO in dealing

with court-related children's services, victims of child abuse and neglect, and domestic abuse.

The HMO and the counties may develop alternative MOU language, if both parties agree. However, all elements defined above must be addressed in the MOU. As an alternative to an MOU, the HMO may enter into contracts with the counties. Any contracts the HMO enters into with the counties must be in compliance with Part A of this Addendum and would supersede any MOU requirements.

ADDENDUM

II. Guidelines for the Coordination of Services Between the HMO, Targeted Case Management (TCM) Agencies and Child Welfare Agencies

A. HMO Rights and Responsibilities

1. The HMO must designate at least one individual to serve as a contact person for case management providers. If the HMO chooses to designate more than one contact person, the HMO should identify the target populations for which each contact person is responsible.
2. The HMO may make referrals to case management agencies when they identify a member from an eligible target population who could benefit from case management services.
3. If the member or case manager requests the HMO to conduct an assessment, the HMO will determine whether there are signs and symptoms indicating the need for an assessment. In the mental health/substance abuse benefit area, a request for an assessment must be accepted in all situations. If the HMO finds that assessment is needed, the HMO will determine the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the HMO determines that no assessment is needed, the HMO will document the rationale for this decision.
4. The HMO must determine the need for medical treatment of those services covered under the HMO Contract based on the results of the assessment and the medical necessity of the treatment recommended.
5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required.
    a. The case planning may be done through telephone contact or means of communication other than attending a formal case planning meeting. If the member requests the HMO case management liaison to attend a case planning meeting, the HMO needs to make every effort to honor this request.
    b. The HMO must informally discuss differences in opinion regarding the HMO's determination of treatment needs if requested by the member or case manager.
    c. The HMO case management liaison and the case manager must discuss who will be responsible for ensuring that the member receives the services authorized by and provided through the HMO.
    d. The HMO's role in the case planning may be limited to a confirmation of the services the HMO will authorize if the member and case manager find these acceptable.

ADDENDUM

III. Report Forms and Worksheets

A. Coordination of Benefits Quarterly Report Form and Instructions for Completing the Form

In order to comply with CMS reporting requirements, the HMO must submit a Coordination of Benefits (COB) report regarding their BadgerCare Plus and/or Medicaid SSI members. For the purposes of this report, the HMO member is any BadgerCare Plus and Medicaid SSI member listed as an ADD or CONTINUE on the monthly HMO enrollment report(s) that are generated by the Department's Fiscal Agent.

THIRD PARTY LIABILITY (TPL)

Third Party Liability (TPL) – The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the "payer of last resort," the identification of other payer obligations is a major requirement in the adjudication of claims.

Coordination of Benefits (COB) – Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.

1. In Medicaid, there are two primary functions related to detecting TPL obligations:
    a. Cost-avoidance – Determining the presence of TPL obligations before the claim is paid.
    b. Pay-and-chase – Identifying TPL obligations after the claim is paid.
2. The following definitions apply to TPL:
    a. Coinsurance – A portion or percentage of the cost for a specific service or item for which the individual is responsible when the service or item is delivered.
    b. Cost Avoidance – A method of preventing inappropriate payments under Medicaid and reducing improper Medicaid expenditures. Whenever the Medicaid agency is billed first and a potentially liable third party exists, the Medicaid agency rejects the claim and returns it to the provider to be billed to the primary payer to determine the third party's liability (42 CFR 433.139(b)).
    c. Deductible – A fixed dollar amount that an individual must pay before the costs of services are covered by an insurance plan.
    d. Estate – Property (real or personal) in which one has a right or interest at time of death.
    e. Health Insurer – Includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service

benefit plan, and a Managed Care Organization (MCO). (The inclusions are explanatory and not mutually exclusive.)

f. Insurer – Any private insurer or public insurer

g. Post Payment Recovery (Pay and Chase) – A method used where Medicaid pays the member's medical bills and then attempts to recover from liable third parties. Pay and Chase waivers are based on specific services as determined by procedure code or type of service.

h. Third Party – Any individual, entity, insurer, or program that is, or may be, liable to furnish health care services or to pay for all or part of the costs of medical assistance covered under a Medicaid State plan. Medicaid is generally the payer of last resort. Examples of a third party are employment-related health insurance, medical child support from non-custodial parents, and Medicare. Every Medicaid jurisdiction is required by §1902(a)(25) of the Act to take reasonable measures to determine the legal liability of third party payers.

Birth costs or delivery costs (e.g., routine delivery and associated hospital charges) are not to be included in the report.

The report is to be for the HMO's entire service area, aggregating separate service areas if the HMO has more than one service area. HMOs are not required to report BadgerCare Plus and SSI COB separately. The report must be completed on a calendar quarterly basis and submitted to your DHS managed care analyst and the Department's fiscal agent within 45 calendar days of the end of the quarter being reported.

FAX To:

(608) 266-1096

STATE OF WISCONSIN
BADGERCARE PLUS AND MEDICAID SSI
HMO REPORT ON COORDINATION OF BENEFITS

Name of HMO Mailing Address
Office Telephone
Provider Number

Please designate below the quarter period for which information is given in this report.
_____, 20____ through _____, 20

A. Cost Avoidance – The amount reported should be the amount paid by TPL for "Dates of Payment" in the quarter covered by this report. Coinsurance and deductible amounts associated with the BadgerCare Plus and/or SSI program should not be reported.

Amount Cost Avoided:_____

B. Recoveries (Post-Pay Billing/Pay and Chase) – The amount reported should be the amount paid by TPL for "Dates of Recovery" in the quarter covered by this report. Coinsurance and deductible amounts associated with the BadgerCare Plus and/or SSI program should not be reported.

Subrogation/Workers' Compensation Amount:_____
(e.g., a recovery associated with physical injury).

Other Recoveries Amount:_____
(e.g., All other Third Party Liability (TPL) not specifically noted above.)

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the HMO, except as noted on the report.

Signed:

Original Signature of CEO or CFO

Printed Name: _____

Title:

Date Signed:

ADDENDUM

IV. Benefits and Cost Sharing Information

A. Benefits and Cost Sharing Information

For current information about Wisconsin Medicaid covered services and allowable cost-sharing, please refer to ForwardHealth Online Handbooks, Provider Updates, and interchange. A summary of covered services for member audiences is available in Appendix B of the ForwardHealth Enrollment and Benefits Handbook (available at https://www.dhs.wisconsin.gov/library/p-00079.htm).

ADDENDUM

V. Intensive Care Coordination Pilot Program (also known as Emergency Department Care Coordination)

A. Intensive Care Coordination Pilot Program

HMOs shall coordinate with participating hospital systems by sharing member information, collaborating on care coordination and case management efforts, and passing payments to the hospital systems no later than 30 calendar days after receiving the payments from the Department.

The Intensive Care Coordination Pilot Program is authorized by the following Wisconsin Statutes: 49.45 (26g), 946.91 (3) (c) 3 and 946.93 (5) (c) 3. The Department is funding selected hospital systems to provide care coordination services to Medical Assistance recipients that use the emergency department frequently, in an effort to reduce their emergency department utilization. This initiative is funded with state general purpose revenue (GPR) and the Department will not be claiming federal financial participation for payments related to this initiative.

HMOs shall pass the payments to the participating hospital systems no later than 30 calendar days after receiving the payment from the Department. These payments include $250 per enrollee for each six month enrollment period. Additional payments include shared savings and $250 per enrollee at the end of each six month enrollment period that are dependent on hospital performance outcomes. An HMO that fails to comply with the terms of this addendum shall be required to reimburse the Department in an amount equal to the payments not properly passed through to participating hospital systems.

HMO shall coordinate care coordination and case management efforts with participating hospital systems as identified in Article III.

ADDENDUM

VI. Fraud, Waste and Abuse Strategic Plans

A. Fraud, Waste, and Abuse (FWA) Strategic Plans General Guidelines

1. HMOs must submit their annual FWA strategic plans to the DHS Office of Inspector General (OIG) for review by November 15 using the DHS OIG SharePoint site.
    a. HMOs may consult with their DHS OIG representative throughout the calendar year while developing their annual FWA strategic plan to ensure a successful approval process.
2. The DHS OIG auditor will review the FWA strategic plan according to the rubric located on the DHS OIG SharePoint site and provide feedback to the HMO regarding any necessary changes.
    a. The HMO must make the necessary edits and submit the plan to the DHS OIG SharePoint site for additional review. This cycle will continue until a compliant FWA strategic plan is submitted.
    b. HMOs must ensure that DHS OIG's feedback, including any requested corrections or revisions, are incorporated into their strategic plans.
3. HMOs are required to have approval of their annual FWA strategic plan prior to December 31.

B. FWA Strategic Plan Components

1. Data Analysis - Provide an overview of the data analysis that will be conducted to determine which fraud, waste or abuse issues the HMO will prioritize in their FWA strategic plan. The HMO is responsible for conducting the data analysis and determining risk.
2. Program Integrity Initiatives - Identify a minimum of three program integrity initiatives that will be implemented during the calendar year to address the identified fraud, waste or abuse issues identified in the data analysis. A program integrity initiative is the plan or action that will be implemented during the calendar year to address the identified fraud, waste, or abuse issue

    Each program integrity initiative must:

    a. Identify the program integrity issue or risk the HMO is attempting to address with each initiative
    b. Identify the goal of each initiative
    c. Identify the expected results of the initiative
    d. Identify the objectives or strategies that will be used to achieve the goal of each initiative

e. Describe the planned tasks for each quarter that are intended to achieve the identified goal.

f. Identify the anticipated completion date of the initiative

g. Identify the personnel responsible for the completion of the initiative

h. Identify the method by which the HMO will measure compliance or return on investment on the initiative.

3. Additional Required Components

The following list can be used as an individual initiative or as a strategy within another initiative. All the additional required components must be included in the strategic plan.

a. Prepayment activities.

b. Post-payment activities. These post-payment activities must include audits of medical records, including reviewing for appropriate coding and medical necessity. Post-payment audits are only one example of post-payment activities, and the HMO must consider all post-payment activities when developing their plan.

c. Verification of the provision of services to members:

i. Includes the planned number of verifications. Must be equal to or greater than 100 verifications per quarter;

ii. Includes methodology for verifying services – explanation of benefits, phone calls, etc.

iii. Includes methodology for tracking related reports of fraud and subsequent overpayment recoveries.

d. Plan to increase the quantity of credible allegations of fraud identified.

e. Planned provider education related to fraud, waste, and abuse.

C. FWA Strategic Plan Approval Process

DHS OIG and the HMOs will engage in the following process to review and approve the annual FWA strategic plans:

1. HMOs will draft their annual FWA strategic plans in accordance with the requirements of this addendum.

2. HMOs must submit their annual FWA strategic plan through the DHS OIG SharePoint site no later than November 15.

3. DHS OIG will use the rubric below to evaluate compliance with the requirements of this addendum.

4. DHS OIG will either approve the FWA strategic plan or return the plan to the HMO for changes based on DHS OIG feedback from the rubric assessment.

5. DHS OIG will upload the FWA Strategic Plan Feedback Form to the HMO SharePoint site indicating whether the plan has been approved or needs additional work completed.
6. If the FWA Strategic Plan needs correction, the HMOs will incorporate DHS OIG's feedback and resubmit the FWA strategic plan. DHS OIG will provide the due date for returning the draft for the next review as part of the feedback to ensure the plan receives approval by December 31.
7. Steps 4-6 are to be repeated until DHS OIG approves the FWA strategic plan.
8. Each HMO must have an FWA strategic plan approved by DHS OIG by December 31.

D. FWA Strategic Plan Implementation Process

HMOs will implement their approved FWA strategic plan each year on January 1. DHS OIG will monitor the Quarterly Program Integrity Report and other methods the HMOs indicate that they will be measuring their compliance with their FWA strategic plan. DHS OIG representative will contact HMOs periodically during the year to offer support and technical assistance, and to ensure the HMO is on track with their FWA strategic plan. If an updated FWA strategic plan is needed, DHS OIG can assist the HMO in making the needed updates.

ADDENDUM

VII. Member Communications/Outreach Checklist

	Member Communication/Outreach Checklist	
1.	Intent of Material for Review If other, please describe	Choose an item.
2.	Delivery Method Check all that apply	Choose an item. If Other, Please Describe: Click or tap here to enter text.
3.	Type of Material If other, please describe	Choose an item. If Other:Click or tap here to enter text.
4.	Target audience	Choose an item.
5.	Intended distribution schedule	Click or tap here to enter text.
6.	All materials have been spelling and grammar checked.	☐
7.	All materials are at a 6th grade or lower reading level. Exclude physical addresses, email addresses, phone numbers, TTY from the review. If materials are above a 6th grade reading level, please explain.	☐ Click here to enter text.
8.	All materials include the required language translation text.	☐
9.	All materials use a font size no smaller than 12 point.	☐
10.	All materials include conspicuously visible taglines in at least the top three prevalent non-English languages in the region.	☐
11.	All materials include conspicuously visible taglines and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.	☐

12.	All materials include a toll-free phone number for the HMO/PIHP program.	☐
13.	All materials have been reviewed and approved by the appropriate HMO staff and its contract representative, or their designee, and meet all additional requirements in DHS's marketing policy and the Medicaid Program Contract.	☐
14.	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. • 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.	☐ ☐ Yes ☐ No Click here to enter text. Click here to enter text.
15.	Send all materials as Microsoft Word with red-line track changes. DHS will not accept PDFs until DHS final approval.	☐
16.	If an incentive or raffle will be provided, please provide the following: • Description • Declared amount • Number to be disbursed	N/A Click here to enter text. Click here to enter text.
17.	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: • 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,	Click here to enter text.

	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.	

ADDENDUM

VIII. HMO Service Area

The HMO is authorized to provide services in the following counties. The Department may amend the list of authorized counties at any time during the contract year.

The Department may remove authorization for any counties due to contract non-compliance, including determinations that the HMO does not meet provider network adequacy standards.

The Department may add to the list of authorized counties based approved expansion requests.

County	BadgerCare Plus	Medicaid SSI

ADDENDUM

IX. CY 2025 Rates

A. SSI Medicaid Only Rate Exhibits

B. SSI Dual Eligible Rate Exhibits

C. BadgerCare Plus Standard Rate Exhibits

D. BadgerCare Plus Childless Adult (CLA) Rate Exhibits