2024-2025 BadgerCare Plus and Medicaid SSI HMO Contract

2025 Amendment

Substantive Changes effective January 1, 2025

Article I: Definitions and Acronyms

- Updating definitions of "individually identifiable health information" and "clean claim" to align with CFR (Article I.A)
- Deleting "members with special needs" (Article I.A) and adding new definition of "members with special healthcare needs" (Article III.A)
- Adding definition of complex rehabilitation technology (Article I.A)
- Updating definitions of "provider agreement" and "subcontractor" (Article I.A)
- Adding definitions of "deficiency or contractual performance deficiency," "remediation," and "sanction" and editing existing definitions of "quality reporting," "corrective action or corrective action plan" to align with updates to the quality strategy (Article I.A)

Article II: Enrollment and Disenrollment

- Clarifying that an HMO must report when HMOs are informed that a member is incarcerated but has not been disenrolled to comply with Social Security Act 1905(a)(30)(A) (Article II.B)
- Clarifying that HMOs are not liable for providing care to members who become incarcerated to comply with Social Security Act 1905(a)(30)(A) (Article II.B)

Article III: Care Management

- Deleting "members with special needs" (Article I.A) and adding new definition of "members with special healthcare needs" (Article III.A)
- Requiring HMOs to utilize and analyze their own claim/prior authorization systems in care management activities for members with special health care needs (Article III.A)
- Requiring HMOs to identify reports that HMO use for needs stratification or care plan development activities to ensure identification of members with needs (Article III.A)
- Applying care management staff training to both SSI and BadgerCare Plus (Article III.A)
- Adding requirement that HMOs regularly conduct utilization review of its data to identify members who could benefit from care management and ensure members are appropriately stratified (Article III.A)
- Modifying "best effort to contact the member for an initial screen" to be no less than 3 attempts to contact the member (Articles III.B and C)
- Clarifying the timeframe for when annual screens will be considered timely completed (Article III.C)
- Adding the ability for the Department to issue corrective actions or sanctions to HMOs that fail to meet screen completion benchmarks for more than one measurement year (Article III.B)

Article IV: Services

- Removing references to administrative codes because HMOs are generally responsible for all mental health services, unless explicitly carved out (Article IV.F)

- Adding requirement for HMOs to cover court-ordered services from out-of-network providers (Article IV.F)
- Removing peer services as an enhanced benefit (Article IV.F)
- Identifying ASAM as the prevailing guidelines for HMOs to use (Article IV.F)
- Adding language regarding sub acute psych ILOS to conform with CMS requirements regarding ILOS (Article IV.F)
- Removing requirement to submit MOUs to DHS and updating requirements for HMOs to cover court ordered services. HMOs will now have to cover services to out-of-network providers when court ordered (Article IV.F)
- Updating OB MH payment criteria and removing OB MH provider requirements from HMO contract (Article IV.H)
- Adding Medically Tailored Meals as an in lieu of service (Article IV.C)
- Removing 50-mile requirement from orthodontic and prosthodontic treatment coverage (Article IV.E)
- Adding Child Care Coordination as a covered service (Article IV.D)

Article V: Provider Network and Access Requirements

- Adding requirement that HMOs provide member impact assessments and geoaccess reports when HMOs are in conditional status for provider network adequacy (Article V.D)

Article VI: Marketing and Member Materials

- Updating requirements for member handbook requirements for distribution, including methods for HMOs to distribute and timeline for distribution to align with 42 CFR 438.10 (Article VI.A)
- Updating requirements for provider directory, including that for the HMO must make the directory available in searchable electronic form (42 CFR 438.10), and that the provider directory must include whether provider offers covered services via telehealth (42 CFR 438.10), and the provider's race and ethnicity if available and unless the provider has opted out of publication (Article VI.A)
- Adding requirement that HMOs post their services area on their website (Article VI.A)
- Continuing to allow HMOs to contact former members who have lost Medicaid eligibility in the last 90 days for purpose of providing enrollment and renewal information (Article VI.I)
- Clarifying how often marketing event spreadsheets must be sent in for review and approval (Article VI.C)

Article VII: Member Rights and Responsibilities

Article VIII: Provider Appeals

Article IX: Member Grievances and Appeals

Article X: Quality Assessment Performance Improvement (QAPI)

- Adding requirement that HMOs report certain provider credentialing data quarterly (Article X.E)
- Clarifying membership in member advisory councils are expected to be representative of the HMOs Wisconsin Medicaid population (Article X.F)

- Specifying clinical practice guidelines for HMOs and requiring HMOs to post clinical practice guidelines on their websites (Article X.C)
- Adding contract termination as a possible outcome for unsatisfactory QAPI program results (Article X.C)
- Adding in language for Consumer Assessment of Healthcare Providers and Systems (CAHPS) to maintain compliance with CMS reporting and NCQA accreditation reporting requirements, and prepare for Quality Rating System implementation, which includes CAHPS composites (Article X.F)

Article XI: HMO Administration

- Disallowing HMOs from applying multiple procedure payment reduction logic for therapy payments for children ages 0-3 (Article XI.C)
- Adding in timeline for reporting discrepancies that resulted in an overpayment to the HMO (Article XII.M)
- Updating language so that HMO fraud, waste, and abuse compliance plans are reviewed and approved by the Department prior to the start of the calendar year (Article XII.M)
- Removing requirement of Child Enrollment Status Regarding Birth to 3 Program form (Article XI.C)

Article XII: Reports and Data

- Removing HMO Program Integrity Staff Assignment form requirement (Article XII.M)
- Adding information about the Data Program Integrity Log (Article XII.M)
- Adding recoveries of a provider overpayment from the HMOs stemming from a network provider audit completed by DHS OIG (Article XII.L)
- Updating program integrity contract language to align with CMS toolkit, including listing Compliance Officer's responsibilities and defining prompt as 2 days (Article XII.M)
- Adding language to clarify where HMOs must submit investigation summaries and complaints to OIG (Article XII.M)
- Adding language to allow OIG to request that HMOs review providers if issues of fraud, waste, and abuse are identified (Article XII.M)
- Adding language about OIG completing a preliminary review after receiving an allegation of substantiated fraud (Article XII.M)
- Adding language to describe OIG and HMO technical assistance meeting topics and frequency of meetings (Article XII.M)
- Adding additional documents—FWA Strategic Plans and Compliance Plans—that HMOs must keep for records retention (Article XII.M)
- Adding description of OIG Special Investigation Unit reviews (Article XII.M)
- Updating Article XII.N. non-disclosure of trade secrets and confidential competitive information for clarity and legal compliance (Article XII.N)
- Adding requirement that HMOs participate in annual compliance review (Article XII.T)
- Adding requirement that HMOs meet score threshold for annual compliance review (Article XII.T)
- Moving from Addendum IV to Article XII.S and updating the newborn reporting requirements to clarify requirements and mandate reporting (Article XII.S and Addendum IV)

Article XIII: Functions and Duties of the Department

Article XIV: Contractual Relationship

- Aligning SSI vent payment policy with BadgerCare Plus policy (Article XVI.H)
- Adding financial penalties for inadequate scores on the annual compliance review, member screening results below established benchmarks, and incomplete or inaccurate provider/facility data (Article XIV.D)
- Adding network adequacy deficiencies as a reason to impose enrollment reductions (Article XIV.D)
- Adding information reconsideration process for sanctions, financial penalties and remedial actions (Article XIV.D)
- Adding language allowing the Department to require HMOs to publicly post CAPs on their websites, and allowing the Department to post the information (Article XIV.D)
- Clarifying the timeline for when HMOs must notify a member of a provider termination (Article XIV.B)

Article XV: Fiscal Components/Provisions

- Updating language about billing members to conform with 42 CFR 438.106 (Article XV.A)
- Requiring same reimbursement for complex rehab technology wheelchair repair and accessories as FFS to comply with 2023 Wisconsin Act 23 (Article XV.D)
- Updating hospitalization liability language to clarify expectations and add language back in regarding calculation of a daily rate (Article XV.D)
- Removing exclusion for HMOs that are not NCQA accredited because as of 2024, all HMOs must be NCQA accredited (Article XV.D)
- Updating physician incentive plan language to align with 42 CFR 438.6 and 422.208 (Article XV.B)
- Establishing physician incentive plan contract, documentation and reporting requirements (Article XV.B)
- Adding requirements to follow the Stark Law (42 U.S.C. 1395nn) (Article XV.B)
- Moving due date for Performance Improvement Plan (PIP) proposals from the first business day of December to the first business day of November to support PIPs beginning in January (Article X.K)
- Deleting subsection XV.D to comply with Social Security Act 1905(a)(30)(A)

Article XVI: Payments to the HMO

- Removing timeframe for HMOs to review rate changes (Article XVI.B)

Article XVII: HMO Specific Contract Terms

- Aligning subsection about prohibited affiliations with MCO contract and 42 CFR 438.608 and 438.610 because HMO contract was more restrictive (Article XVII.B)

Addendum I: Memorandum of Understanding

Addendum II: HMO Standard Member Handbook

- Deleting this addendum, which only directs the reader to find the HMO Standard Member Handbook on ForwardHealth (Addendum II)

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

Addendum IV: Report Forms and Worksheets

- Automating required birth cost reporting in OnBase
- Removing Birth Cost Report requirement
- Moving from Addendum IV to Article XII.S and updating the newborn reporting requirements to clarify requirements and mandate reporting via the portal (Article XII.S and Addendum IV)

Addendum V: Benefits and Cost Sharing Information

Addendum VI: Intensive Care Coordination Pilot Program

Addendum VII: Fraud Waste and Abuse Strategic Plans

Addendum VIII: Grievance and Appeal Letters and Templates

- Deleting this Addendum and moving letters and templates to DHS Contracts (wi.gov) (Addendum VIII)

Addendum IX: Marketing and Member Materials checklists

Addendum X: HMO Service Area