**CHECKLIST FOR HMOS COMPLETING THE CERTIFICATION APPLICATION PACKET**

**Note: New HMOs must complete all sections.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Application Section** | **Page Number** | **Special Instructions** | **Is it included? (check off)** |
| 1. General Information
 | 4 | All HMOs must complete. |  |
| 1. Ownership and Controlling Interest Information
 | 5 | All HMOs must complete. |  |
| C. HMO Data Sheets | 7 | New HMOs must complete. Current HMOs may submit if there are changes. All HMOs must update throughout contract period as needed. |  |
| 1. Service Area
 | 8 | All HMOs must complete. |  |
| 1. Optional Service Coverage
 | 16 | All HMOs must complete. |  |
| 1. Enrollment Limit
 | 17 | All HMOs must complete. |  |
| 1. Subcontracts
 | 18 | All HMOs must complete subsection #1. Subsection 2-4 must be completed by HMOs that have updated this information since the time of last submission. |  |
| 1. Memoranda of Understanding (MOUs)
 | 19 | All HMOs must complete. |  |
| 1. Access to Care
 | 20 | All HMOs must complete. |  |
| 1. Quality Improvement and Accreditation
 | 22 | All HMOs must complete subsection #1. HMOs with changes in subsection #2 since previous submission must submit those updates. |  |
| 1. Member Complaint and Grievance System
 | 24 | New HMOs must complete. HMOs with changes in these documents since previous certification must submit those updates. |  |
| 1. Provider Appeals System
 | 25 | New HMOs must complete. HMOs with changes in these documents since previous certification must submit those updates. |  |
| 1. HMO Member Advocate
 | 25 | All HMOs must complete. |  |
| 1. Reporting and Data Administration
 | 25 | New HMOs must complete. HMOs with changes in these documents since previous certification must complete subsection #1.  |  |
| 1. Encounter Data from Third Party Vendors
 | 26 | New HMOs must complete. HMOs with changes in these documents since previous certification must complete subsections #1and 2. All HMOs must submit #2. |  |
| 1. Computer and Data Processing System
 | 26 | New HMOs must complete. HMOs with changes in these documents since previous certification must complete subsections #1-3.All HMOs must complete subsection #4. |  |
| 1. Fraud and Abuse Policies and Procedures
 | 27 | New HMOs must complete. HMOs with changes in these documents since previous certification must submit those updates. |  |
| 1. Language Access Policies and Procedures
 | 27 | New HMOs must complete. HMOs with changes in these documents since previous certification must submit those updates. |  |
| 1. Care Management System and Continuity of Care
 | 28 | All SSI HMOs must complete. |  |
| 1. Signature
 | 29 | All HMOs must submit hard-copy. |  |

**HMO APPLICATION FOR CERTIFICATION**

**Instructions**

Enclosed are the materials, formats, and additional instructions necessary to apply for certification to provide services to BadgerCare Plus and/or Medicaid SSI members under the HMO program. Every item is required unless indicated otherwise by the checklist. Improperly completed forms, or outdated or incomplete information may result in delayed certification. The application may be typed or printed and submitted to the HMO’s file on the SFTP server, emailed or mailed to the contract monitor. Electronic submissions must not contain the HMO’s ID (6900xxxx) in the file name. HMOs may mail a hard copy or the documentation to the Department.

For any member materials (brochures, handbooks, or letters) or revised/new subcontract language that the HMO is requesting Department approval for, please submit those in a Microsoft Word format electronically to allow for review, and note that the HMO is requesting initial approval.

The signature page must be signed and dated in ink by the HMO’s authorized agent responsible for applying for certification, and mailed to the Department.

1. **General Information**

**Applicant HMO Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Applicant HMO Name* – The name indicated on this line must be the name used on all other documents for the Wisconsin BadgerCare Plus and Medicaid SSI program. BadgerCare Plus and Medicaid SSI require a Wisconsin HMO license for HMO certification so the applicant name must match the name on the license. The Wisconsin HMO license should be sent to the Wisconsin Office of the Commissioner of Insurance (OCI) at:

<http://oci.wi.gov/company/app-pack.htm>

**Contract Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical Address: (Street): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The address for corporate entities must include a primary business address, every business location and P.O. box address.**

**(City): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (State): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Contact Person): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Telephone Number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Physical address* – Indicate the address where the HMO’s primary office is located. **Do not use a billing service address.** This address is used for mailing BadgerCare Plus and Medicaid SSI correspondence. Please indicate the complete nine digit zip code.

**Payee’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Payee Name* – Enter the name to whom checks are payable. HMOs reporting income to the IRS under an employer identification number (EIN) must indicate the name associated with the EIN and enter the name exactly as it is recorded with the IRS.

**Group Name or Attention to (Optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Group Name or Attention To* – Enter an additional name (e.g., business, group, and agency) that should be printed on checks and Remittance and Status Reports (payment/denial report).

**Payee’s Address: (Street): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(City): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (State): \_\_\_\_\_\_\_\_ (Zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Payee’s Address* – Indicate where Remittance and Status Reports (payment/denial report), and other financial information should be mailed.

**Taxpayer Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Taxpayer Identification Number (TIN)* – Enter the TIN that should be used to report income to the IRS. The number must be the TIN of the payee name and match what is recorded with the IRS.

**Contact name for questions on this application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The “Contact Name” should be the person most knowledgeable about the certification. The address and phone number will be used if there are any questions about the application.

1. **Ownership and Controlling Interest Information**

The Department requires the Ownership and Controlling interest information by Federal law and for administrative purposes. The information must be supplied in the given format. Additional pages should be attached if needed, with the same information in the same format.

Has the HMO (including any employee, vendors, or providers) in whom the HMO has a controlling interest, or any person having a controlling interest in the HMO, since the inception of the Medicare, Medicaid, or Title XX services program, been convicted of a crime related to, or been terminated from, a federal-assisted or state-assisted medical program?

[ ]  Yes [ ]  No

Per PPACA Section 455.104(b): If yes, please include the individual’s name, date of birth, and social security number or Tax ID number for corporations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As defined by CMS, “Controlling Interest” includes, but is not limited to, all owners, creditors, controlling officers, administrators, mortgage interest holders, employees or stockholders with holdings of 5 percent or greater or outstanding stock, or holders with such position or relationship who may have a bearing on the operation or administration of a medical service-related business.

*Specifically: “Controlling interest or ownership” means that a person:*

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

List the names and addresses of all persons (individual and/or corporate) who have a controlling interest in the HMO.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type and percent of controlling interest:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the names and addresses of all vendors of drugs or medical supplies, laboratories, pharmacies, transportation providers, or other providers in which the HMO has a controlling interest or ownership.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Provider #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number or Federal Tax ID Number (FEIN):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_

County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type and percent of controlling interest:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Include a statement as to whether any of the persons with ownership or controlling interest is related as a spouse, parent, child or sibling to any other of the persons with ownership or controlling interest.

Disclosures are due upon submission of the provider application, upon execution of the Medicaid contract, upon recertification of the HMO and within 35 days of any change in ownership.

1. **HMO Data Sheets**

HMOs are required to completely and accurately fill out the HMO Data Sheet. A name and telephone number is needed for each item. Incomplete forms will be returned. This form is used for administrative purposes. If, during the contract period, any changes are made, the Bureau of Benefits Management Contract Monitor must be notified in writing of the changes and the effective dates. Changes may be submitted via e-mail.

Please complete if you have any changes to your current HMO data sheet.

**HMO Data Sheet**

**HMO Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical Address (Street):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(City)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (State) \_\_\_\_\_\_\_\_\_\_\_\_\_ (Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Numbers:**

**Corporate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Member Services:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**24 Hour Nurse Line/Member Services:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**24 Hour Provider Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental Health:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TTY/TDD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Website:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Contact People** | **Name** | **Phone Number** | **E-Mail Address** |
| Chief Executive Officer: |  |  |  |
| Medical Director: |  |  |  |
| Contract Administrator: |  |  |  |
| BadgerCare Plus HMO AdvocatePrimary:Backup: |  |  |  |
| Birth to Three Contact: |  |  |  |
| Birth Cost Report Contact: |  |  |  |
| Claims Processing: |  |  |  |
| Coordination of Benefits: |  |  |  |
| Electronic Funds Transfer: |  |  |  |
| Encounter Data ReportingPrimary:Backup: |  |  |  |
| Enrollment: |  |  |  |
| Finance: |  |  |  |
| Fraud and Abuse Compliance Officer: |  |  |  |
| Grievance: |  |  |  |
| HealthCheck: |  |  |  |
| HMO Pharmacy Lock-in Coordinator: |  |  |  |
| Hospital/ASC Assessment: |  |  |  |
| Medicaid SSI HMO AdvocatePrimary:Backup: |  |  |  |
| Member Outreach/Marketing: |  |  |  |
| MetaStar: |  |  |  |
| Privacy Officer: |  |  |  |
| Provider Appeals: |  |  |  |
| Provider Relations: |  |  |  |
| Quality Improvement: |  |  |  |
| Reporting (utilization/survey): |  |  |  |
| Systems: |  |  |  |

1. **Service Area**

HMOs must indicate their service area. Include the geographic parts of the State in which the HMO will provide services to BadgerCare Plus and/or Medicaid SSI members.

HMOs are required to comply with the network adequacy requirements defined in Article III.H of the 2014-2015 BadgerCare Plus and Medicaid SSI HMO Contract. HMOs are required to submit a provider network file to DHS by **October 9, 2013**, the specifications for the file are defined in D.3 below. Please contact your DHS Contract Monitor if you have any questions regarding your network review.

1. **Certified Service Area**

[ ]  HMO is applying for recertification in the same service area(s) as their current BadgerCare Plus and/or Medicaid SSI certification. The county/zip code chart does not need to be completed.

[ ]  HMO is applying for recertification in the same service area(s) as their current BadgerCare Plus and/or Medicaid SSI certification **AND** is applying to expand their service area. Please complete county/zip code chart listing only the new expansion zip codes and/or counties.

[ ]  HMO is applying for recertification and is decreasing their service area(s). Please submit a list of all zip codes and/or counties in which the HMO plans to decrease.

[ ]  HMO is applying for initial certification. Please complete the county/zip code chart.

1. **County Service Area Chart**

For each county, please indicate in one column if the HMO is applying for BadgerCare Plus, Medicaid SSI, or both. Then indicate for each county if the application is for all zip codes or a select list. If applying for partial certification in select zip codes, please list the zip codes, and denote with an asterisk (\*) any new expansion zip codes/counties.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **County Name** | **BC+** | **SSI** | **Both** | **All zip codes** | **Partial** | **SSI: If partial, list requested zip codes** | **BC+: If partial, list requested zip codes** |
| Adams |   |   |   |   |   |   |   |
| Ashland |   |   |   |   |   |   |   |
| Barron |   |   |   |   |   |   |   |
| Bayfield |   |   |   |   |   |   |   |
| Brown |   |   |   |   |   |   |   |
| Buffalo |   |   |   |   |   |   |   |
| Burnett |   |   |   |   |   |   |   |
| Calumet |   |   |   |   |   |   |   |
| Chippewa |   |   |   |   |   |   |   |
| Clark |   |   |   |   |   |   |   |
| Columbia |   |   |   |   |   |   |   |
| Crawford |   |   |   |   |   |   |   |
| Dane |   |   |   |   |   |   |   |
| Dodge |   |   |   |   |   |   |   |
| Door |   |   |   |   |   |   |   |
| Douglas |   |   |   |   |   |   |   |
| Dunn |   |   |   |   |   |   |   |
| Eau Claire |   |   |   |   |   |   |   |
| Florence |   |   |   |   |   |   |   |
| Fond du Lac |   |   |   |   |   |   |   |
| Forest |   |   |   |   |   |   |   |
| Grant |   |   |   |   |   |   |   |
| Green |   |   |   |   |   |   |   |
| Green Lake |   |   |   |   |   |   |   |
| Iowa |   |   |   |   |   |   |   |
| Iron |   |   |   |   |   |   |   |
| Jackson |   |   |   |   |   |   |   |
| Jefferson |   |   |   |   |   |   |   |
| Juneau |   |   |   |   |   |   |   |
| Kenosha |   |   |   |   |   |   |   |
| Kewaunee |   |   |   |   |   |   |   |
| La Crosse |   |   |   |   |   |   |   |
| Lafayette |   |   |   |   |   |   |   |
| Langlade |   |   |   |   |   |   |   |
| Lincoln |   |   |   |   |   |   |   |
| Manitowoc |   |   |   |   |   |   |   |
| Marathon |   |   |   |   |   |   |   |
| Marinette |   |   |   |   |   |   |   |
| Marquette |   |   |   |   |   |   |   |
| Menominee |   |   |   |   |   |   |   |
| Milwaukee |   |   |   |   |   |   |   |
| Monroe |   |   |   |   |   |   |   |
| Oconto |   |   |   |   |   |   |   |
| Oneida |   |   |   |   |   |   |   |
| Outagamie |   |   |   |   |   |   |   |
| Ozaukee |   |   |   |   |   |   |   |
| Pepin |   |   |   |   |   |   |   |
| Pierce |   |   |   |   |   |   |   |
| Polk |   |   |   |   |   |   |   |
| Portage |   |   |   |   |   |   |   |
| Price |   |   |   |   |   |   |   |
| Racine |   |   |   |   |   |   |   |
| Richland |   |   |   |   |   |   |   |
| Rock |   |   |   |   |   |   |   |
| Rusk |   |   |   |   |   |   |   |
| St. Croix |   |   |   |   |   |   |   |
| Sauk |   |   |   |   |   |   |   |
| Sawyer |   |   |   |   |   |   |   |
| Shawano |   |   |   |   |   |   |   |
| Sheboygan |   |   |   |   |   |   |   |
| Taylor |   |   |   |   |   |   |   |
| Trempealeau |   |   |   |   |   |   |   |
| Vernon |   |   |   |   |   |   |   |
| Vilas |   |   |   |   |   |   |   |
| Walworth |   |   |   |   |   |   |   |
| Washburn |   |   |   |   |   |   |   |
| Washington |   |   |   |   |   |   |   |
| Waukesha |   |   |   |   |   |   |   |
| Waupaca |   |   |   |   |   |   |   |
| Waushara |  |  |  |  |  |  |  |
| Winnebago |   |   |   |   |   |   |   |
| Wood |   |   |   |   |   |   |   |

1. **Provider Network File Submission**

Each HMO shall submit a provider network and facility file to DHS on **October 9, 2013**; the format for the file should be an Excel 2010 file following the naming convention below:

HMO Name MM-DD-YY.xls

All files should be sent electronically to your HMO Contract Monitor. Please notify your HMO Contract Monitor of any providers included in the provider or facility files for which your HMO does not have a signed contract with at the time of the file submission.

**Provider Network**

The HMO provider network file should include the following fields:

1. Provider NPI
2. Provider Last Name
3. Provider First Name
4. Provider Middle Initial
5. Line Address 1
6. Line Address 2
7. City
8. County
9. State
10. Zip Code
11. Clinic Name
12. Clinic NPI
13. Clinic Type – values limited to “C” – Clinic and “H” – Hospital
14. Specialty Description – please see the list of values defined in D.5 below
15. Provider Accepting New Patients? – limited to “Y” or “N”
16. Primary Care Indicator – limited to “Y” or “N”

**Facility File**

The HMO facility file should include the following fields:

1. Facility Medicaid ID
2. Facility NPI
3. Facility Name
4. Facility Type – “C” – Clinic, “H” – Hospital, “U” – Urgent Care
5. Line Address 1
6. Line Address 2
7. City
8. County
9. State
10. Zip Code
11. Facility Accepting New Patients? – “Y” or “N”

If HMOs would like a copy of the provider network template, please send an email to Amy Trostel at Amy.Trostel@wi.gov.

1. **Distance Requirements**

Per Article III, H.5 of the 2014-2015 BadgerCare Plus and Medicaid SSI HMO Contract, HMOs are required to meet the following distance requirements for selected services:

* Primary Care Access: The HMO must have a certified primary care provider within a 10-mile distance from any member residing in the cities of Milwaukee, Kenosha, Racine and Madison and a 20-mile distance from any member residing in other cities and counties in the state.
* Mental Health and Substance Abuse Access to Care: The HMO must have a mental health or substance abuse provider within a 35-mile distance from any member residing in the HMO service area.
* Dental Care Access: The HMO that covers dental services must have a dental provider within a 35-mile distance from every member residing in regions 1-4 and a 25-mile distance from any member residing in counties in regions 5 and 6.
* Hospitals: the HMO must include a non-specialized hospital within a 20-mile distance from any member residing in regions 5 and 6 and in the counties of Brown and Dane and a 35-mile distance from any member residing in other counties of regions 1-4.
1. **Provider Specialty Description**

|  |  |
| --- | --- |
| 010 | Inpatient/Outpatient Hospital |
| 020 | Ambulatory Surgical Center (ASC) |
| 035 | Skilled Nursing Facility |
| 040 | Rehabilitation Facility |
| 050 | Home Health Agency |
| 052 | Personal Care Agency |
| 053 | Home Health/Personal Care Dually Certified Provider |
| 061 | Hospital |
| 063 | Free Standing |
| 064 | Nursing Home |
| 080 | Federally Qualified Health Clinic (FQHC) |
| 083 | Family Planning Clinic |
| 090 | Pediatric Nurse Practitioner |
| 092 | Family Nurse Practitioner |
| 093 | Nurse Practitioner (Other) |
| 094 | Certified Registered Nurse Anesthetist (CRNA) |
| 095 | Certified Nurse Midwife |
| 100 | Physician Assistant |
| 101 | Anesthesiology Assistant |
| 112 | Psychologist |
| 117 | Psychiatric Nurse |
| 122 | Alcohol and Other Drug Abuse Counselor (non-billing) |
| 123 | Psychotherapist (MS, MSW) with AODA Certificate (non-billing) |
| 124 | Psychotherapist (MS, MSW) (non-billing) |
| 125 | Advanced Practice Nurse Practitioner |
| 140 | Podiatrist |
| 150 | Chiropractor |
| 160 | Registered Nurse (RN) |
| 161 | Licensed Practical Nurse (LPN) |
| 170 | Physical Therapist |
| 171 | Occupational Therapist |
| 173 | Speech/Hearing Therapist |
| 174 | Occupational Therapy Assistant |
| 175 | Physical Therapy Assistant |
| 176 | Speech Therapy (BA) (non-billing) |
| 180 | Optometrist |
| 182 | Speech/Hearing Clinic |
| 184 | Hospital Based Rural Health Clinic |
| 185 | Free Standing Rural Health Clinic |
| 190 | Optician |
| 191 | SPEC Contractor |
| 192 | Therapeutic Pharmaceutical Agents |
| 200 | Audiologist |
| 208 | LPN/RCS |
| 209 | RN/RCS |
| 212 | Nurse Midwife |
| 220 | Hearing Aid Dealer |
| 240 | Pharmacy |
| 250 | DME/Medical Supply Dealer |
| 261 | Air Ambulance |
| 268 | Water Ambulance |
| 270 | Endodontist |
| 271 | General Dentistry Practitioner |
| 272 | Oral Surgeon |
| 273 | Orthodontist |
| 274 | Pediatric Dentist |
| 275 | Periodontist |
| 276 | Oral Pathologist |
| 277 | Prothesis |
| 280 | Independent Lab |
| 283 | Blood Bank |
| 289 | Dental Hygienist |
| 291 | Mobile X-Ray Clinic |
| 300 | Free-standing Renal Dialysis Clinic |
| 301 | Hospital Affiliated |
| 310 | Allergist |
| 311 | Anesthesiologist |
| 312 | Cardiologist |
| 314 | Dermatologist |
| 315 | Emergency Medicine Practitioner |
| 316 | Family Practitioner |
| 317 | Gastroenterologist |
| 318 | General Practitioner |
| 319 | General Surgeon |
| 320 | Geriatric Practitioner |
| 322 | Internist |
| 324 | Nephrologist |
| 325 | Neurological Surgery |
| 326 | Neurologist |
| 327 | Nuclear Medicine Practitioner |
| 328 | Obstetrician/Gynecologist |
| 329 | Oncologist |
| 330 | Opthamologist |
| 331 | Orthopedic Surgeon |
| 332 | Otologist, Laryngologist, Rhinologist |
| 333 | Pathologist |
| 336 | Physical Medicine and Rehabilitation Practitioner |
| 337 | Plastic Surgeon |
| 338 | Proctologist |
| 339 | Psychiatrist |
| 340 | Pulmonary Disease Specialist |
| 341 | Radiologist |
| 342 | Thoracic Surgeon |
| 343 | Urologist |
| 345 | Pediatrician |
| 354 | Preventive Medicine |
| 510 | Basic Life Support Statewide |
| 511 | Advanced Life Support Statewide |
| 512 | Basic Life Support Metro |
| 513 | Advanced Life Support Metro |
| 514 | Basic Life Support Milwaukee County |
| 515 | Advanced Life Support Milwaukee County |
| 520 | Specialized Medical Vehicle |
| 532 | Registered Alcohol and Drug Counselor (RADC)/NTS (non-biller) |
| 540 | Individual Orthotist |
| 541 | Prothesis |
| 542 | Individual Orthotist/Prosthetist |
| 543 | Other Individual Medical Supply |
| 650 | Crisis |
| 651 | CSP |
| 652 | CCS |
| 700 | SNF/ICF/MR |
| 702 | Centers |
| 712 | AODA General Hospital |
| 713 | Psychiatric Hospital |
| 733 | Case Management Only |
| 734 | Screener |
| 735 | Screener Case Management |
| 740 | Mental Health |
| 741 | Residential Care Centers for Children or Group Home |
| 742 | HealthCheck Other Services |
| 743 | Pediatric Community Care |
| 751 | Public Sector |
| 752 | Private Sector |
| 765 | High Cost Case Management |
| 770 | CESA Statewide Rate |
| 771 | School District, Statewide Rate |
| 780 | Managed Care Payee Provider |
| 781 | Managed Care Assigned Provider |
| 802 | AODA Only (Suffix 21) |
| 803 | Both Mental Health and AODA |
| 831 | Barron Co. |
| 832 | Lacrosse Co. |
| 833 | Milwaukee Co. |
| 900 | Group/Clinic |

1. **Optional Service Coverage**

**Chiropractic Coverage (please check one)**

[ ]  HMO elects to cover chiropractic services.

[ ]  HMO elects not to cover chiropractic services.

[ ]  Mix of the above depending on county. The counties where the HMO provides chiropractic services are as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Coverage (please check one or all that apply)**

[ ]  HMO elects to cover dental services for BadgerCare Plus members in Regions 1-4. Counties:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  HMO elects to cover dental services for Medicaid SSI members in Regions 1-4. Counties:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  HMO elects to cover dental services for Medicaid SSI members in Regions 5 & 6. Counties:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the HMO subcontracts with a dental benefits administrator (DBA), please identify it:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

**Additional Services**

[ ]  This HMO does not charge co-pays for:

 \_\_\_\_\_BadgerCare Plus \_\_\_\_\_\_ Medicaid SSI

[ ]  This HMO offers free cooking and nutrition classes.

|  |
| --- |
| [ ]  This HMO offers free weight loss or exercise classes. |
| [ ]  This HMO offers discounts on massage therapy and acupuncture. |

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Enrollment Limit**

Please indicate your requested maximum enrollment limit. The Department reserves the right to revise this limit, with notification to the HMO, as needed.

NOTE: If you have more than one service area/provider number, please indicate an enrollment limit for each area/provider number:

**BadgerCare Plus:**

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BadgerCare Plus – Childless Adults:**

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SSI:**

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you choose to increase or reduce the enrollment limit, please notify the Department in writing via e-mail to the Contract Monitor.

1. **Subcontracts**
2. **Provider Contracts**

New HMOs must submit contract templates. HMOs are reminded to submit any changes in subcontract language to the Department for approval prior to obtaining signatures.

1. **Group Contracts [Independent Practice Association (IPA) Contract]**

An IPA is an intermediate entity with which the HMO contracts. The HMO subcontracts with the IPA and the IPA, in turn, subcontracts with individual providers. Providers continue in their existing individual or group practices. The following entities with which the HMO subcontracts are considered to be IPAs: chiropractic networks, physician services, group physician practices, and mental health benefits managers.

For each contracted group (IPA), please submit the following information:

* Name of IPA
* Complete address of IPA
* Type of services provided (chiropractic, mental health, physician, etc.)
1. **Administrative Services Agreement (ASA)**

ASAs are entities with which HMOs contracts to provide administrative support. Following is a list of types of ASAs (however this list is not meant to be all-inclusive):

* Claims processing
* Utilization reporting
* Quality improvement
* Computer support
* HealthCheck screening and/or outreach
* Third party liability

For each contracted ASA, please submit the following:

* Name of subcontractor
* Complete address of subcontractor
* Type of services provided
1. **Delegation**

Please submit policy and procedure governing delegation, including sample written agreement. Include policies on:

* Pre-delegation evaluation of prospective subcontractor’s ability to perform;
* Monitoring activities and reporting requirements;
* Corrective actions when problems are identified;
* Provisions for termination of delegation; and
* Provisions for retention by the HMO of the right to make final selection decisions about practitioners and providers credentialed or recredentialed by a delegate.
1. **Memoranda of Understanding (MOUs)**

Per Article III, sections C and F of the 2014-2015 BadgerCare Plus and Medicaid SSI Contract, the HMO must provide a listing of all organizations with which there are MOUs, including but not limited to:

* Prenatal Care Coordination (PNCC) agencies
* School Based Services
* 51.42 Boards (Mental Health and Substance Abuse Services)
* Targeted Case Management agencies
* Milwaukee Child Welfare
* Public Health
* Birth to Three agencies
1. **Access to Care**
2. Primary Care Assignment

Per Article III, I.3 of the 2014-2015 BadgerCare Plus and Medicaid SSI Contract, HMOs must have policies and procedures in place to assign members to a primary care provider, a primary care clinic, or a specialist when appropriate based on the health care needs of the member.

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

* The processes and procedures to allow members to have choice of providers before assignment;
* The communication plan to inform members about their primary care provider options, the primary care assignment process, and their rights to change primary care providers after assignment;
* Describe the process to assist members in getting a primary care visit as part of the primary care assignment process.
* How the primary care assignment process takes into account members’ health care needs and how members with chronic conditions (including, but not limited to diabetes, asthma, COPD, congestive heart failure, and behavioral health) are identified (including clinical guidelines and other tools used);
* How the HMO ensures that PCPs provide culturally sensitive care for members;
* The HMO policies and procedures for members that want to change their assigned primary care provider;
* The HMO processes and procedures to ensure coordination of care and information sharing between the primary care provider and the specialists, including pharmacy data;
* The HMO processes and procedures for ensuring patient-centered care and that a comprehensive treatment plan is developed between members and their primary care provider;
* The processes and procedures HMOs use to evaluate the effectiveness of their primary care assignment strategies.
1. Provider-to-Member Ratios
2. Per Article III, H.7 of the 2014-2015 BadgerCare Plus and Medicaid SSI HMO ContractHMOs in regions 5 and 6 are required to meet the following provider-to-member ratios for selected provider types:

|  |  |
| --- | --- |
| Provider Type | Provider to Member Ratio |
| Primary Care Provider | 1:100 |
| Dentist | 1:1,600 |
| Psychiatry | 1:900 |

HMOs in regions 5 and 6 must submit their policies and procedures to ensure their provider network meets the aforementioned standards for primary care, dental care, and access to psychiatry. HMOs in these regions also have to submit to the Department their plan to monitor compliance with these standards and how the HMO corrects for deficiencies if these ratios are not met.

1. All HMOs must submit to the Department any provider-to-member ratio standards used to ensure adequate access to care. If applicable, the HMO must submit the provider-to-member ratio by specialty, the frequency the standards are monitored, as well as plan to correct any deficiencies if the ratios are not being met at a particular time.
2. Waiting Times

Per Article III, H.3 of the 2014-2015 BadgerCare Plus and Medicaid SSI HMO Contract, the HMO must have written standards for access to care which must include the following:

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

The HMO’s standards for waiting times for appointments must be as follows for the indicated provider types:

* BadgerCare Plus and Medicaid SSI (regions1-6)
	+ To be no longer than 30 days for an appointment with a PCP;
	+ To be no longer than 30 days for an appointment with a Mental Health provider for members who are discharged from an inpatient psychiatric hospital stay;
	+ To be no longer than 90 days for an appointment with a dental provider for a routine dental appointment.
* BadgerCare Plus and Medicaid SSI (regions 5 & 6)
	+ To be no longer than 90 days for an appointment with a dental provider for a routine dental appointment.

HMOs are required to submit to the Department for review:

* If different from the waiting times defined above, submit waiting times for care at facilities and appointments for the following provider specialties:
	+ Primary Care
	+ Mental Health
	+ Dental
* Communication plan for educating primary care, mental health, and dental providers on these waiting times.
* Processes and procedures to monitor provider compliance with the waiting times and processes to correct for deficiencies if the waiting standards are not being met.
1. Urgent Care Access

Per Article III, H.5 of the 2014-2015 BadgerCare Plus and Medicaid SSI HMO Contract, the HMO must include in its network urgent care centers, walk-in clinics, or other medical facilities. A hospital emergency department may not serve to meet this requirement. All urgent care centers, walk-in clinics, or physician offices (open during extended office hours) must accept and advertise that walk-in appointments are accepted.

HMOs are required to provide to the Department:

* Policies and procedures to make urgent care available to members during extended office hours (such as from 5 pm to 7 pm during week days and open during weekends).
* Communication plan to educate members on adequate use of urgent care vs. Emergency Department and the availability of urgent care.

In addition to the aforementioned requirements, HMOs in regions 5 and 6 must submit policies and procedures to ensure urgent care is available to members within a 20-mile distance of every member in the counties located in both regions.

1. **Quality Improvement and Accreditation**
2. **All HMOs must submit the following:**
* If accredited by a nationally recognized accrediting body (i.e. AAAHC, NCQA, URAC), the HMO must submit letter from accrediting body, year of accreditation, and line of business for which it obtained accreditation.
* Most recent annual Quality Assessment/Performance Improvement (QAPI) work plan. If the HMO received Pay for Performance (P4P) goals for targeted Performance Improvement Projects, the work plan must include those goals.
* Most recent QAPI program annual report.
1. **HMOs applying for initial certification, or existing HMOs with changes in the following items, must submit the following:**
* QAPI program description, including description of program monitoring and oversight, committees, position descriptions and FTE staffing data.
* Quality program and/or overall HMO organization chart.
* Policy on clinical practice guidelines, including development, adoption, dissemination, and monitoring. Copies of clinical practice guidelines need not be submitted, though a sample of one that has been circulated to providers would be helpful.
* Sample documentation of a performance improvement project.
* Standards and policies on access to care, availability of providers and monitoring procedures. Include the HMO’s access standards for in-office wait time, appointment wait time, emergency, routine sick care and preventive or non-illness appointment wait times. Include policy on monitoring clinical site conformance with the HMO’s access standards, if it is not described in the standards policy.
* Documentation on policy and strategy for preventive health services.
* Policies and procedures on continuity and coordination of care, particularly for pregnant and post-partum women (i.e. interconception care), those with chronic conditions, and high-cost members.
* Policies and procedures for identification of enrollees with special health care needs, assessment and linkage to appropriate services.
* Documentation of policy and procedure for practitioner and institutional provider (hospital, nursing home, home health agency, hospices and free-standing ambulatory surgical centers) credentialing and recredentialing. Must include: 1) initial credentialing policy and procedure; 2) recredentialing policy and procedure; 3) policy and procedure governing practitioner and institutional provider termination for quality issues, appeal procedures and reporting to entities as required by law (DHS, NPDB, DRL).
* Policies governing confidentiality, including HIPAA compliance, security, transfer, organization, disclosure, completeness and monitoring of medical records.
* Policies governing utilization management (UM), notification of adverse actions, timeliness of decisions, persons authorized to make denial decisions based on medical necessity, UM criteria conformity with applicable HMO clinical proactive guidelines, and inter-rater reliability. Also, clinical information requirements, consultation guidelines, policies for processing expedited and urgent authorization requests. **Do not submit UM criteria, but identify which criteria are used, ie: InterQual, Milliman, HMO-developed, etc.**
* Policy and procedure governing telephone triage, clinical protocols in use, clinical credentials required for staff (not credentials documentation – only a description of the minimum credentials required, for example, “RN with three years of acute experience” etc., and copy of annual evaluation of the clinical appropriateness of decisions made through the system). **(Applies only to HMOs using “nurse lines” or other telephone triage demand management systems where clinical advice is provided by telephone. If no such system is in operation, please provide written indication of that).**
1. **Member Complaint and Grievance System**

Please submit written documentation detailing the member complaint and grievance process. The documentation must include and will be evaluated based on the following criteria:

* A definition of a grievance.
* A definition of an appeal.
* A definition of an emergency grievance.
* A description of the formal grievance process including a timeline for handling formal grievances and emergency grievances.
* A description of the process for handling HIPAA privacy complaints.
* The name and phone number of the person(s) responsible for receiving, routing, and processing grievances.
* A description of the process and format used for logging informal grievances.
* A description of the recordkeeping system for formal grievances.
* A description of how members are informed about the grievance process.
* IPA policies and procedures for enrollee grievances and a description of how IPAs notify HMO enrollees of the complaint/grievance process.
* A sample of informal grievance logs.
* A description of how the HMO assures compliance with the time frames for adjudicating grievances as required in the HMO Contract.
* A description of how the HMO assures that grievances filed by BadgerCare Plus and Medicaid SSI members are adjudicated based on Medicaid rules.
* A description of how the HMO assures that individuals with authority to require the HMO to implement a corrective action are involved in the grievance process.
* Provide sample copies of template letters (for a denial of a service, reduction of a service, or a termination of a service) including any attached information sheet on the grievance process:
1. Initial denial letters sent to members
2. Initial response letters to a grievance request
3. Final response letters to a grievance request.
* A description of how members are informed about access to interpreter services during the grievance process.
1. **Provider Appeals System**

HMOs are required to submit written documentation of the provider appeals process, consisting of:

* The name, phone number and email of the person(s) responsible for receiving, routing and processing appeals.
* Samples of all remittance advice notices with provider appeal language included.
* Documentation of how providers are advised of their right to appeal to the Department if the HMO fails to respond to their appeal within 45 days.
* Samples of **all** template notification letters sent to providers as a result of an appeal submitted for claim reconsideration based on technical issues, medical record review, DRG change or any other appeal action, with appeal language included.
* Policies and procedures for adjudicating provider appeals, showing time lines for adjudication, including information on handling appeals when a claim is submitted outside of timely filing based on a payment recoupment by a third party.
* A description of how the HMO assures that provider appeals pertaining to BadgerCare plus and Medicaid SSI services are adjudicated using Medicaid (not commercial) policies and procedures.
1. **HMO Member Advocate**

The HMO must submit to the Department:

* Job description(s) of the HMO Member Advocate position(s).
* Number of FTE’s allocated to the advocate position (s).
* Other duties or responsibilities of the advocate position(s) other than those required in the HMO Contract.
* Organizational chart showing reporting relationship of the advocate position(s) to the Contract Administrator.
* The work plan of the Advocate(s) covering the next two years.
* Policies and procedures for evaluating the advocate position to determine when additional FTE’s may be necessary.
1. **Reporting and Data Administration**
2. **Provider ID Numbers**

The Department must ensure that HMOs are using Wisconsin Medicaid enrolled providers when providing services to BadgerCare Plus and Medicaid SSI members. The contract between the Department and HMOs requires that HMOs use only providers enrolled in the WI Medicaid program when rendering services to members, except in emergency situations.

The encounter data submitted by the HMOs will be used to assist in monitoring this requirement. This means that data submitted by the HMO will be edited and reviewed to ensure that a valid Medicaid provider ID or Medicaid-certified NPI is present, except when the service is identified as an emergency service and the provider of emergency services does not have a Medicaid-certified NPI.

* Describe how the HMO currently updates its provider file with Wisconsin Medicaid provider IDs and NPI numbers.
* Describe the steps the HMO takes to ensure that when new providers are added to the network, they are appropriately enrolled in the Wisconsin BadgerCare Plus and Medicaid SSI program and have a valid NPI or Medicaid assigned non-NPI.
1. **Encounter Data from Third Party Vendors**

Some of the encounter data you submit to the Department may come from third party vendors who pay and process claims on your behalf (e.g., behavioral health benefits manager).

* Please identify any third party vendors, the service provided, and the type of encounters (e.g., inpatient, behavioral health, etc.).
* Please describe how you will obtain the required data from them, how often (e.g., monthly), and the timeliness of the data (i.e., how soon after the date of service will the data be transmitted to you, and subsequently to the Department).
* Please describe how the HMO will ensure accuracy of data (through audit or other means).
1. **Computer and Data Processing System**
2. The HMO must prepare a written description that addresses the system hardware and software, the technical resources that will be used and the name of the agency or organization (e.g., HMO, outside vendor, etc.) responsible for the following:
* Claims Processing
* Monitoring Enrollment and Disenrollment
* Non-Encounter Data Reporting (e.g., Neonatal ICU patient care data)
* Encounter Data Reporting
1. Describe how the HMO will comply with Wisconsin Medicaid standards for HIPAA compliant transactions as specified in the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products and the 834 Benefit Enrollment and Maintenance Implementation Guides.
2. Quality Control of HMO Information System:
* How and how often (daily, etc.) is system performance monitored?
* What processes are in place to identify and inform staff of any system performance problems?
* Please, briefly describe your system’s disaster recovery program.
1. Describe the HMO’s system’s ability to provide data necessary to monitor program performance relative to Pay-for-Performance (P4P).
2. **Fraud and Abuse Policies and Procedures**

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

* Submit a compliance plan that includes written procedures, a description and designation of a compliance officer and compliance committee.
* Describe the training requirements for the compliance officer and employees.
* Describe the enforcement standards and disciplinary guidelines developed by the plan.
* Describe the plan’s internal monitoring and auditing procedures.
* Describe how the plan will provide a prompt response to detected problems.
* Describe how the plan will evaluate the compliance program.
1. **Language Access Policies and Procedures**

HMOs are required to provide oral and written language access to non-English speaking or limited English proficiency members. HMOs must submit the following documentation to the Department:

* Provide a description or policy statement regarding the provision of language access services including the effective date of the policy, next review date of the policy, and who the policy affects.
* Describe the criteria for selection of interpreters including evaluation of competency in both English and other languages; and include information about sign language interpreter services for members with hearing impairments.
* Describe how emergency interpretation services will be provided.
* Describe the HMO’s monitoring mechanism for member satisfaction, and provider compliance.
* Provide a list of all materials produced by the HMO that must be translated.
* Describe how the HMO will identify Limited English Proficiency (LEP) or hearing impaired members.
* Describe how the hearing-impaired members preference for the type of auxiliary aid(s) is addressed.
* Provide a list of all interpreters, including sign language interpreters, used by the HMO and the procedures for updating the list and evaluating the need for additional interpreters.
* Describe how members are notified of the availability of free interpretation services including the frequency of the notification, and the manner in which members are notified.
1. **Care Management System and Continuity of Care**

**All SSI HMOs must submit the below information to DHS by December 2, 2013.**

HMOs that contract with the Department to provide covered services to the SSI population must describe how they will identify and manage their acute or chronic complex illness, injury or other special health care needs. Your submission must include:

* Copies of policies, procedures, position descriptions, and subcontracts that describe who is responsible within the HMO to coordinate care for enrolled persons with special needs. By definition, SSI members have special needs.
* **Initial Assessment**: Copies of policies and procedures to conduct an initial assessment of every SSI Managed Care member within 60 days of enrollment in the HMO.
	+ A description of the qualifications of the staff conducting the initial assessment.
	+ A description of the outreach process to engage members and/or legal guardians in completing the assessment. Include number of telephonic contacts, in-person visits, or mail attempts.
	+ Copies of the assessment questionnaire for new members.
	+ A description of how staff captures member responses to the assessment and documents member life goals and supports.
* **Reassessment:** A description of when the HMO conducts a reassessment based on a member’s change in medical condition.
	+ A description of how the HMO identifies changes in member’s medical condition. Include data sources or define the medical conditions that would trigger a reassessment.
	+ A description of the process for conducting reassessments and the staff involved in re-assessing members.
	+ A description of how members’ re-assessment responses are then integrated into the Care Plan and service delivery.
* **Care Plan:** Copies of policies and procedures to develop a Care Plan within 30 days of completion of the initial assessment or within 90 days of HMO enrollment.
	+ A description of the process for timely completion of the Care Plan; include:
		- A flowchart explaining the steps to complete the Care Plan in relation to the completion of the initial assessment.
		- The questions included in the Care Plan.
	+ A description of the qualifications of the staff developing the Care Plan.
	+ The process for addressing issues and needs identified in the initial assessment in the Care Plan.
	+ A description of how staff captures member preferences and documents member’s consent with the Care Plan.
	+ A description of how the Care Plan information is shared with the member and/or legal guardian.
	+ A description of how the HMO shares the Care Plan with the member’s primary care provider and/or specialist as appropriate.
* **Risk Stratification:** A description of how the HMO stratifies members by risk level and determine the level of care needed including:
	+ A description of the process to integrate utilization data (ER admissions and inpatient stays), data from the initial assessment, the Medicaid claim history reports (provided by DHS) and other tools used by the HMO to determine member’s risk level.
* **Service Delivery:** A description of how the HMO coordinates delivery of Medicaid covered medically needed services to members as identified in the Care Plan and assessments.
	+ A description of how the HMO ensures continuity of care for new members who were receiving services under fee-for-service.
	+ A description of how the HMO ensures that services delivered addressed the needs identified in the initial assessment and Care Plan.
	+ A description of how the care coordinator follows-up with the member to determine if the services delivered addressed their needs.
1. **Signature**

Applications must have the signature of an authorized representative for the organization. ALL signatures and signature dates must be in pen. Photocopied or stamped signatures and dates are not acceptable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(HMO Name) wishes to provide services and agrees to abide by rules and regulations governing Wisconsin’s BadgerCare Plus and Medicaid SSI Programs. As the Authorized Agent, I hereby certify that the information contained herein is accurate and complete, or, in the case of a currently certified HMO applying for renewal of certification, that the information contained in the original application, as revised by any changes in such information contained in this and previous applications for certification renewal, is accurate and complete.

I further understand and acknowledge that, should information provided to the Department or its fiscal agent as part of the certification process prove to be false or incomplete, any certification granted as a result of that information could be subject to sanctions indicated in HFS 106, Wis. Adm. Code.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of HMO’s Authorized Agent

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Printed Name of HMO’s Authorized Agent