**MCO Accreditation Crosswalk**

This Accreditation Crosswalk was prepared by the Department of Health Services and its External Quality Review Organization, MetaStar, in order to demonstrate to the Centers for Medicare & Medicaid Services (CMS) how the National Committee for Quality Assurance (NCQA) accredited organizations are deemed and therefore do not require a review of their compliance with Medicaid Managed Care rules. As instructed by CMS, this crosswalk was developed as the first step in the Managed Care Organization (MCO) Accreditation Deeming Plan to compare NCQA accreditation requirements with the federal Managed Care requirements for Medicaid MCOs (42 Code of Federal Regulations (CFR) section 438) in order to determine if there are any gaps between both requirements. The Accreditation Deeming Plan on pages 1-5 outlines Wisconsin’s plan to seek CMS’ approval for its Accreditation Deeming Policy and the next steps to cover any gaps identified in the crosswalk. This crosswalk was prepared using the *2021 Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2021.

The NCQA names and acronyms used in the following tables are: Quality Management and Improvement (QI), Population Health Management (PHM), Network Management (NET), Utilization Management (UM), Credentialing and Recredentialing (CR), and Member Experience (ME).

NCQA offers an optional Medicaid (MED) accreditation module. The MED module is in addition to the general NCQA accreditation and may address some of the remaining gaps between the federal Managed Care requirements and NCQA accreditation standards. MED standards meeting gap elements of the CFR are noted below in teal. NCQA also offers and optional distinction in multicultural health care (MHC). The MHC requirements did not meet any gaps between NCQA and the federal Managed Care regulations, but the distinction does align with the State’s overall Quality Strategy.

**Attachment 2: 42 CFR 438 Managed Care - Subpart C**

**Enrollee Rights and Protections**

| **Federal Requirement** | **Elements Met with NCQA Accreditation/Total Elements** | **NCQA**  **Standard**  **Reference** | **Summarized NCQA Accreditation Standard** | **DHS Contract Requirements** | **Remaining Elements Met with DHS Certification** | **Gap Elements Remaining** |
| --- | --- | --- | --- | --- | --- | --- |
| **438.100 (a) (1) and (2)**  a) *General rule.* The State must ensure that:  (1) Each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in this section; and  (2) Each MCO, PIHP, PAHP, PCCM and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect those rights. | **2/2** | ME1  CR5  CR7 | **Met**  ME1evaluates if an organization has a written policy that states its commitment to treating members in a manner that respects their rights, and its expectations of members’ responsibilities.  ME1 also requires verification of the distribution of member rights policies and procedures to practitioners. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article VII – Member Rights and Responsibilities states the MCO must have written policies guaranteeing each member’s rights, and share those policies with staff and affiliated providers to be considered when providing services to members.  Article VI-Marketing and Member Materials requires MCOs to implement and enforce all requirements regarding member outreach and marketing processes as outlined in the *Communication, Outreach and Marketing Guide.*  Addendum II indicates the Standard Member Handbook is located in the guide.  ***Communication, Outreach, and Marketing Guide***  The MCO Standard Member Handbook requirements and required language are located in the *Communication, Outreach, and Marketing Guide*.  The guide requires MCOs to make members aware of their rights in the Member Handbook which shall be provided in hardcopy to new members within 10 days of final enrollment notification to the MCO. | **None** | **None** |
| **438.100 (b) (1) and (2)** *Specific rights*—(1) *Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (3) of this section.  (2) An enrollee of an MCO, PIHP, PAHP, PCCM, or PCCM entity has the following rights: The right to—  (i) Receive information in accordance with §438.10.  (ii) Be treated with respect and with due consideration for his or her dignity and privacy.  (iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(g)(2)(ii)(A) and (B).)  (iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.  (v) 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.  (vi) 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 his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526. | **1/2**  **Not Met:** 438.100(b)(2)(iv) and (v)  **MED: 1/2**  **Not Met:** 438.100(b)(2)(iv) and (v) | ME1  ME2  ME3  ME7  NET1  NET5  MED12 | **Not Met**  The NCQA standards do not fully address the following details found in 438.100:   * The right to refuse treatment; and * The right to be free of restraint or seclusion.   The MED standards affirm the rights of members to receive information in a manner appropriate to the enrollee's condition and ability to understand. However, the standards do not address a member’s right to be free from restraint/seclusion or the right to refuse treatment. The standards do meet the format and availability of requirements of 438.10 | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article VII – Member Rights and Responsibilities affirms enrollees of MCOs have specific rights including the right to refuse treatment and to 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.  Article V: Provider Network and Access Requirements states the MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: a. The enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the enrollee needs in order to decide among all relevant treatment options. c. The risks, benefits, and consequences of treatment or non-treatment. d. The enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.  Article V: Provider Network and Access Requirements, MCOs also send the provider directory to members when requested, which is available online. The provider directory has information on every provider in network, their specialty, address, hours of operation, languages spoken, etc.  ***Communication, Outreach, and Marketing Guide***  Includes Standard Member Handbook Language for the BadgerCare Plus and Medicaid SSI populations and includes family planning information.  The information about member rights is included in the Member Handbook which all MCOs are required to send to their membership upon enrollment. MCOs are required to make the Member Handbook available to members in different languages and formats. | **1/1**  **2020 Certification Application:**  Requires MCOs to submit policies and procedures to confirm member rights are disseminated to members, providers, etc.  **1/1** | **None**  **None** |
| **438.100 (b) (3)**  An enrollee of an MCO, PIHP, or PAHP, PCCM or PCCM entity has the right to be furnished health care services in accordance with §§438.206 through 438.210. | **1/1** | ME1  ME2  ME3  ME7  NET1  NET6 | **Met**  ME1-Member Rights  ME2-Benefits and services included in, and excluded from, coverage  ME3-Covered and Noncovered benefits | **2020-2021BadgerCare Plus and Medicaid SSI Contract:**  Article VII-Member Rights and Responsibilities affirms enrollees of MCOs have specific rights.  Article V-Provider Network and Access Requirements, states MCOs must send the provider directory to members when requested, which is available online. The provider directory has information on every provider in network, their specialty, address, languages spoken, etc.  ***Communication, Outreach, and Marketing Guide***  MCOs must make members aware of their rights in the Member Handbook which shall be provided in hardcopy to new members within 10 days of final enrollment notification to the HMO.  The MCO Standard Member Handbook requirements and required language are located in the *Communication, Outreach, and Marketing Guide* | **None** | **None** |
| **438.100 (c)**  The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, PCCM or PCCM entity and its network providers or the State agency treat the enrollee. | **0/1** | ME1  ME2  ME7  UM7  UM8  UM9 | **Not Met**  ME sections address the member’s rights and responsibilities and their ability to file appeals/complaints, but there is no mention of adverse treatment by the MCO due to the exercise of their rights. UM 7-9 also deal with member appeal rights. | **2020-2021BadgerCare Plus and Medicaid SSI Contract:**  Article VII – Member Rights and Responsibilities affirms that enrollees of MCOs have specific rights including freedom for the enrollee to exercise his or her rights, and that exercise of those rights does not adversely affect the way the MCO and its network providers treat the enrollee.  Addendum II indicates the Standard Member Handbook is located in the guide  ***Communication, Outreach, and Marketing Guide***  The information about Member Rights is included in the Member Handbook which all MCOs are required to send in hardcopy to new members within 10 days of final enrollment notification to the MCO. MCOs are required to make the Member Handbook available to members in different languages and formats.  If a member has an issue about rights not being respected, they can contact the MCO Member Advocate, the Enrollment Specialist, the BadgerCare Plus and Medicaid SSI Ombudsman, grieve to the Department, or contact the SSI External Advocate (if in SSI Managed Care). All of these resources and an explanation of the Member Grievances process are included in the Member Handbook. DHS monitors member grievance trends quarterly. | **1/1**  **2020 Certification Application:**  Requires MCOs to submit policies and procedures demonstrating members are free to exercise individual rights. | **None** |
| **438.102 (a)**  (a) *General rules.* (1) An MCO, PIHP, or PAHP may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:  (i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.  (ii) Any information the enrollee needs to decide among all relevant treatment options.  (iii) The risks, benefits, and consequences of treatment or non-treatment.  (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.  (2) Subject to the information requirements of paragraph (b) of this section, an MCO, PIHP, or PAHP that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section is not required to do so if the MCO, PIHP, or PAHP objects to the service on moral or religious grounds. | **2/5** | ME1 | **Not Met**  The NCQA guidance notes that the organization must not have any policies restricting dialogue between practitioner and patient and affirms that it does not direct practitioners to restrict information about treatment options.  It does not, however, specifically address the following elements of this requirement:   * The advocacy role of the practitioner; * The self-administered alternative treatment; and * The right of the enrollee to refuse treatment and express preferences. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article I, Definitions, Authorized Representative is an individual appointed by the member, including a power of attorney or estate representative, who may serve as an authorized representative 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.  Article V: Provider Network and Access Requirements states the MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: a. The enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the enrollee needs in order to decide among all relevant treatment options. c. The risks, benefits, and consequences of treatment or non-treatment. d. The enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.  ***Communication, Outreach, and Marketing Guide***  The Member Handbook includes language about an enrollee’s right to participate in decisions, including the right to refuse treatment. Also includes that enrollees have the right to receive information on available treatment options and alternatives. MCOs are required to send a Member Handbook in hardcopy to new members within 10 days of final enrollment notification to the MCO. | **3/3**  **Certification Application:**  The certification application does not address the member handbook.  **Other:**  The *Communication Outreach and Marketing Guide* requires all MCOs to receive DHS approval of written materials before dissemination. | **None** |
| **438.102 (b)**  (b) *Information requirements: MCO, PIHP, and PAHP responsibility.* (1)(i) An MCO, PIHP, or PAHP that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows:  (A) To the State—  (*1*) With its application for a Medicaid contract.  (*2*) Whenever it adopts the policy during the term of the contract.  (B) Consistent with the provisions of § 438.10, to enrollees, within 90 days after adopting the policy for any particular service.  (ii) Although this timeframe would be sufficient to entitle the MCO, PIHP, or PAHP to the option provided in paragraph (a)(2) of this section, the overriding rule in § 438.10(g)(4) requires the State, its contracted representative, or MCO, [PIHP](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=04b13365cdf0c37f21582e1c74c6bf02&term_occur=999&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:C:438.102), or PAHP to furnish the information at least 30 days before the effective date of the policy.  (2) As specified in § 438.10(g)(2)(ii)(A) and (B), the MCOs, PIHPs, and PAHPs must inform enrollees how they can obtain information from the State about how to access the service excluded under paragraph (a)(2) of this section. | **0/2**  **MED: 1/2**  **Not Met:** 538.102(b)(1) | ME1  MED8 | **Not Met**  No element in the NCQA standards addresses this elected option and related communication requirements.  The MED standards address the communication to members to access the service excluded by the MCO under moral or religious objection. | **2020-2021BadgerCare Plus and Medicaid SSI Contract:**  Article IV-Services, MCOs are required to furnish information about the services it does not cover as follows:   * To the Department and Enrollment Specialist so the Department can notify members of the MCO’s non-coverage of service; * With the MCO’s certification application for a BadgerCare Plus and/or Medicaid SSI contract; * Whenever the MCO adopts the policy during the term of the contract; * It must be consistent with the provisions of 42 CFR 438.10; * It must be provided to potential members before and during enrollment; * It must be provided to members within ninety (90) days after adopting the policy with respect to any particular service; and * In written and prominent manner, the MCO 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 MCO because of an objection on moral or religious grounds. The MCO must inform members about hot to access those services through the State.   Article II Enrollment and Disenrollment states a member may also request disenrollment 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.  All MCOs provide information to members about covered services through the Member Handbook | **2/2**  **2021 Certification Application:**  The application requires the MCO to provide policies and procedures regarding moral or religious objections to care  **1/2** | **None**  **None** |
| **438.102 (c)**  (c) *Information requirements: State responsibility.* For each service excluded by an MCO, PIHP, or PAHP under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in §438.10. | **0/0** | None | **Not Applicable, state responsibility** | **N/A** | **N/A** | **N/A** |
| **438.102 (d)**  (d) *Sanction.* An MCO that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part. | **0/0** | None | **Not Applicable, state responsibility** | **N/A** | **N/A** | **N/A** |
| **438.104**  (a) *Definitions.* As used in this section, the following terms have the indicated meanings:  *Cold-call marketing* means any unsolicited personal contact by the MCO, PIHP, PAHP, PCCM or PCCM entity with a potential enrollee for the purpose of marketing as defined in this paragraph (a).  *Marketing* means any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.  *Marketing materials* means materials that—  (i) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, PCCM, or PCCM entity; and  (ii) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM, or PCCM entity to potential enrollees.  *MCO, PIHP, PAHP, PCCM or PCCM entity* include any of the entity's employees, network providers, agents, or contractors.  *Private insurance* does not include a qualified health plan, as defined in 45 CFR 155.20.  (b) *Contract requirements.* Each contract with an MCO, PIHP, PAHP, PCCM, or PCCM entity must comply with the following requirements:  (1) Provide that the entity—  (i) Does not distribute any marketing materials without first obtaining State approval.  (ii) Distributes the materials to its entire service area as indicated in the contract.  (iii) Complies with the information requirements of §438.10 to ensure that, before enrolling, the beneficiary receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll.  (iv) Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.  (v) Does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.  (2) Specify the methods by which the entity ensures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the State agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that—  (i) The beneficiary must enroll in the MCO, PIHP, PAHP, PCCM or PCCM entity to obtain benefits or to not lose benefits; or  (ii) The MCO, PIHP, PAHP, PCCM or PCCM entity is endorsed by CMS, the Federal or State government, or similar entity.  (c) *State agency review.* In reviewing the marketing materials submitted by the entity, the State must consult with the Medical Care Advisory Committee established under §431.12 of this chapter or an advisory committee with similar membership. | **0/2**  **Not Met:** 438.104(b)(1) and (2) | None | **Not Met**  ME3 notes that NCQA does not review marketing materials if the MCO plan is government sponsored (Medicare/Medicaid). | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article VI-Marketing and Member Materials requires MCOs to implement and enforce all of the requirements regarding member outreach and marketing processes, including Title 42 Code as contained in the Communication Outreach and Marketing Guide  ***Communication, Outreach, and Marketing Guide***  The Health Plan agrees to engage only in member communication and outreach activities and distribute only those materials that are pre-approved in writing. The Health Plan that fails to abide by these requirements may be subject to sanctions. | **2/2**  **Certification Application:** The 2020 and 2021 Certification Applications do not monitor or review these requirements.  **Other:**  The *Communication Outreach and Marketing Guide* requires all MCOs to receive DHS approval of written materials before dissemination. This process confirms all elements are met. | **None**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application. |
| **438.106**  Each MCO, PIHP, and PAHP must provide that its Medicaid enrollees are not held liable for any of the following:  (a) The MCO's, PIHP's, or PAHP's debts, in the event of the entity's insolvency.  (b) Covered services provided to the enrollee, for which—  (1) The State does not pay the MCO, PIHP, or PAHP; or  (2) The State, or the MCO, PIHP, or PAHP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.  (c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or PAHP covered the services directly. | **0/5** | None | **Not Met**  While NCQA standard ME5 references information about financial responsibility for pharmaceutical benefits, the relevance to these requirements is limited. ME6 also contains language related to the organization’s responsibility for considering members’ financial responsibility, but as above, the specific details do not align with requirements. | **2020-2021BadgerCare Plus and Medicaid SSI Contract:**  Article XVII-MCO Specific Contract Terms, The MCO 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 MCO or any of its subcontractors to provide contract services.  b. The negligent provision of contract services by the MCO or any of its subcontractors.  c. Any failure, inability or refusal of the MCO to pay any of its subcontractors for contract services. | **5/5**  **2020 Certification Application:**  The MCOs must submit attestations confirming members are not held financially liable for the expenses outlined in this requirement. | **None** |
| **438.116**  (a) *Requirement for assurances.* (1) Each MCO, PIHP, and PAHP that is not a Federally qualified MCO (as defined in section 1310 of the Public Health Service Act) must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the MCO's, PIHP's, or PAHP's debts if the entity becomes insolvent.  (2) Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement.  (b) *Other requirements*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, an MCO or PIHP, must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.  (2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP that meets any of the following conditions:  (i) Does not provide both inpatient hospital services and physician services.  (ii) Is a public entity.  (iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers.  (iv) Has its solvency guaranteed by the State. | **0/1**  **Not Met:** 438.116 | None | **Not Met**  While NCQA standard, ME5, references information about financial responsibility for pharmaceutical benefits, the relevance to these requirements is limited. ME6 also contains language related to the organization’s responsibility for considering members’ financial responsibility, but as above, the specific details do not align with requirements. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article XVII-MCO Specific Contract Terms, The MCO 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 MCO or any of its subcontractors to provide contract services.  b. The negligent provision of contract services by the MCO or any of its subcontractors.  c. Any failure, inability or refusal of the MCO to pay any of its subcontractors for contract services.  Article XV- Fiscal Components/Provisions, states any provider who knowingly and willfully bills a BadgerCare Plus or Medicaid SSI member for a covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1) [42 U.S.C. 1320a-7b] of the Social Security Act and Wis. Stats. 49.49(3p). This provision shall continue to be in effect even if the MCO becomes insolvent.  The MCO and its providers and subcontractors must not bill a BadgerCare Plus or Medicaid SSI member for medically necessary covered services provided to the member, for which the State does not pay the MCO; or the State or the MCO does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member’s period of MCO enrollment, except for allowable copayments and premiums established by the Department for covered services provided during the member’s period of enrollment in BadgerCare Plus.  In addition, the MCO must ensure that its Medicaid members are not held liable for payments for medically necessary covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the MCO covered the services directly. | **1/1**  **2020 Certification Application:** The MCOs must submit attestations confirming solvency standards are met and Medicaid enrollees are not held liable for debts due to the MCO’s insolvency. | **None** |
| **438.108**  **Cost Sharing**  The contract must provide that any cost sharing imposed on Medicaid enrollees is in accordance with §§ [447.50](https://www.law.cornell.edu/cfr/text/42/447.50) through 447.82 of this chapter. | **0/1**  **Not Met:** 438.108 | None | **Not Met**  NCQA standards do not reflect the details included this requirement. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Addendum V-Benefits and Cost Sharing refers to the ForwardHealth Online Handbooks, Provider Updates, and interchange for the most recent information regarding covered services and allowable cost-sharing.  Addendum II- Standard Member Handbook Language for BadgerCare Plus and Medicaid SSI requires the MCO to notify members of any copays in the Member Handbook.  Article XV- Fiscal Components/Provisions, states the MCO and its providers and subcontractors must not bill a BadgerCare Plus or Medicaid SSI member for medically necessary covered services provided to the member, for which the State does not pay the MCO; or the State or the MCO does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member’s period of MCO enrollment, except for allowable copayments and premiums established by the Department for covered services provided during the member’s period of enrollment in BadgerCare Plus. | **0/1**  **2020 and 2021 Certification Application:** The 2020 and 2021 Certification Applications do not monitor or review these requirements. | **1**  All elements are addressed in the 2020-2021 contract, but are not included in the current certification process. |
| **438.114**  (a) *Definitions.* As used in this section—  *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:  (i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.  (ii) Serious impairment to bodily functions.  (iii) Serious dysfunction of any bodily organ or part.  *Emergency services* means covered inpatient and outpatient services that are as follows:  (i) Furnished by a provider that is qualified to furnish these services under this Title.  (ii) Needed to evaluate or stabilize an emergency medical condition.  *Poststabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.  (b) *Coverage and payment: General rule.* The following entities are responsible for coverage and payment of emergency services and poststabilization care services.  (1) The MCO, PIHP, or PAHP.  (2) The State, for managed care programs that contract with PCCMs or PCCM entities  (c) *Coverage and payment: Emergency services.* (1) The entities identified in paragraph (b) of this section—  (i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, PCCM or PCCM entity; and  (ii) May not deny payment for treatment obtained under either of the following circumstances:  (A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section.  (B) A representative of the MCO, PIHP, PAHP, PCCM, or PCCM entity instructs the enrollee to seek emergency services.  (2) A PCCM or PCCM entity must allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services.  (d) *Additional rules for emergency services.* (1) The entities specified in paragraph (b) of this section may not—  (i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and  (ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.  (2) An enrollee 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.  (3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.  (e) *Coverage and payment: Poststabilization care services.* Poststabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those provisions, reference to “MA organization” and “financially responsible” must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the States.  (f) *Applicability to PIHPs and PAHPs.* To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply. | **0/7**  **MED: 5/7**  **Not Met:**  438.114 (c),(d)(2) | None  MED9 | **Not Met**  NCQA standards do not reflect the details included this requirement.  The MED standards do not specifically note the limitation on holding the enrollee liable. Per NCQA, the organization will meet this element if its policies and procedures state that it covers all Emergency Department (ER) claims or does not deny any ER claims.  The standard addresses when a representative of the MCO entity instructs the enrollee to seek emergency services and screening enrollee for need for emergency services.  Post-stabilization services are addressed. | **2020-2021BadgerCare Plus and Medicaid SSI Contract:**  Article IV-Services establishes that the MCO is responsible for coverage and payment of emergency and post-stabilization care. It also defines emergency, post-stabilization, and it addresses all the elements outlined in 438.114. | **7/7**  **2021 Certification Application:** The application requires the MCO to provide policies and procedures regarding implementation of these requirements.  **2/2** | **None**  **NONE** |

**42 CFR 438 Managed Care - Subpart D**

**Access Standards**

| **Federal Requirement** | **Elements Met with NCQA Accreditation/Total Elements** | **NCQA**  **Standard**  **Reference** | **Summarized NCQA Accreditation Standard** | **DHS Contract Requirements** | **Remaining Elements Met with DHS Certification** | **Gap Elements Remaining** |
| --- | --- | --- | --- | --- | --- | --- |
| **438.206 (a) (b) and 438.68**  438.206 (a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68.  (b) *Delivery network.* The State must ensure, through its contracts, that each MCO, PIHP and PAHP, consistent with the scope of its contracted services, meets the following requirements:  (1) Maintains and monitors 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 enrollees, including those with limited English proficiency or physical or mental disabilities.  438.68 (a) *General rule.* A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section.  (b) *Provider-specific network adequacy standard.*  (1) *Provider Types.* At a minimum, a State must develop a quantitative network adequacy standard for the following provider types, if covered under the contract:  (i) Primary care, adult and pediatric.  (ii) OB/GYN.  (iii) Behavioral health (mental health and substance use disorder), adult and pediatric.  (iv) Specialist (as designated by the State), adult and pediatric.  (v) Hospital.  (vi) Pharmacy.  (vii) Pediatric dental.  (2) *LTSS.* States with MCO, PIHP or PAHP contracts which cover LTSS must develop a quantitative network adequacy standard for LTSS provider types.  (i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and  (ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.  (3) *Scope of network adequacy standards.* Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.  (c) *Development of network adequacy standards.* (1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:  (i) The anticipated Medicaid enrollment.  (ii) The expected utilization of services.  (iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.  (iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.  (v) The numbers of network providers who are not accepting new Medicaid patients.  (vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees.  (vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language.  (viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.  (ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.  (2) States developing standards consistent with paragraph (b)(2) of this section must consider the following:  (i) All elements in paragraphs (c)(1)(i) through (ix) of this section.  (ii) Elements that would support an enrollee's choice of provider.  (iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.  (iv) Other considerations that are in the best interest of the enrollees that need LTSS.  (d) *Exceptions process.*  (1) To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:  (i) Specified in the MCO, PIHP or PAHP contract.  (ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area.  (2) States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under §438.66. | **2/4**  **Not Met:**  438.68 (b) (1) (vii)  438.68 (c) (1) (iii), (iv) and (viii)  438.68 (b) (2) and (c) (2) are N/A and were not included in the total elements.  **MED: 0/4**  **Not Met:**  438.68 (b) (1) (vii)  438.68 (c) (1) (iii), (iv) and (viii) | QI2  NET1  NET2  NET3  CR5  CR7  MED3 | **Not Met**  QI2 reviews the organization’s contracts to ensure providers foster open communication and cooperation with QI activities. The organization may use its provider manual or policies as evidence of contract requirements if the practitioner contract specifies that the manual or policy is an extension of the contract, and practitioners must abide by the conditions set forth in the contract and in the manual or policy. Some requirements may be met, but would require specific knowledge of what NCQA reviewed for a particular MCO.  NET1, CR5, CR7 address maintenance and monitoring of the provider network, though are not specific about confirming that the network is supported by written agreements.  Number and availability standards documented in NET1 do not align with DHS expectations, which are greater than NCQA.  NET2 also addresses accessibility and evaluates organizations based on the organizations’ self-declared standards for accessibility (i.e. time to secure appointment).  NCQA standards do not take into consideration the characteristics and health care needs of specific Medicaid populations.  MED3 addresses the physical accessibility of providers, but does not address reasonable accommodations for Medicaid enrollees with physical or mental disabilities. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article V. Provider Network and Access Requirements mandate that MCOs must provide medical care to its BadgerCare Plus and/or Medicaid SSI members that are accessible to them, in terms of timeliness, amount, duration, and scope, as those services to non-enrolled BadgerCare Plus and/or Medicaid SSI members within the area served by the MCO. | **1/2**  **2021 Certification Application:** Each MCO must provide copies of the policies and procedures in place describing the process to ensure the provider network meets distance and drive time requirements for primary care, mental health and substance abuse, dental care, hospitals, OB/GYN, and urgent care centers/walk-in clinics, and how the MCO monitors and addresses deficiencies.  Policies and procedures describing the process to ensure the provider network meets the standards for primary care, dental care, and access to psychiatry, including the plan to monitor compliance with these standards and how the MCO corrects for deficiencies if these ratios are not met must also be submitted.  DHS conducts network reviews whenever an MCO requests changes to their service area. At a minimum, DHS reviews networks of all MCOs as part of the annual certification application.  As part of the network review, DHS reviews access to primary care, mental health and substance abuse, dental care, hospitals, urgent care or walk-in clinics, and OB/GYN providers. DHS makes sure that MCOs are providing needed care for members within acceptable geographic distance standards.  **1/2** | **1**  438.68(c) (1) (viii)  This is included in the contract, but MCO policies and procedures related to physical access to providers and reasonable accommodations are not confirmed in the Certification Application  **1**  438.68(c) (1) (viii) |
| **438.206 (b) (2)**  (2) Provides female enrollees 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 enrollee’s designated source of primary care if that source is not a women’s health specialist. | **0/1**  **MED: 1/1** | None  MED1 | **Not Met**  NCQA does not review this element in its accreditation processes.  MED 1 reviews MCO policies and procedures to assure female enrollees have direct access to a women’s health specialist. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article V, Provider Network and Access Requirements requires each MCO to provide female members with direct access to a women’s health specialist within the network for covered women’s routine and preventive health care services. This is in addition to a primary care provider.  ***Communication Outreach and Marketing Guide***, Addendum I provides standard Member Handbook language to inform members of their right to see a women’s health specialist without referral, in addition to choosing from their primary care physician. | **1/1**  **2021 Certification Application:**  The applicationrequires MCOs to provide to the Department policies and procedures to make women’s health specialists available to members and the waiting times for care.    **NONE** | **None**  **NONE** |
| **438.206 (b) (3) (4) (5)**  (3) Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network at no cost to the enrollee.  (4) If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover the services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP’s provider network is unable to provide them.  (5) Requires out-of-network providers to coordinate with the MCO, PIHP or PAHP for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network. | **0/3**  **MED: 3/3**  **Not Met:**  438.68 (b) (1) (vii)  438.68 (c) (1) (iii), (iv) and (viii) | None  MED 1 | **Not Met**  NCQA does not review this element in its accreditation processes.  MED 1 reviews MCO policies and procedures to ensure all requirements for second opinions and out-of-network providers are met. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article V, Provider Network and Access Requirements requires that MCOs must have written policies and procedures for providing members the opportunity to have a second opinion. When a second opinion is outside of the network, it must be at no charge to the member, excluding allowable copayments.  The MCO must also provide adequate and timely coverage of services provided out-of- network, when the required medical service is not available within the MCO network.  ***Communication Outreach and Marketing Guide***, Addendum I provides standard Member Handbook language to inform members of their right to a second opinion. | **3/3**  **2021 Certification Application:**  The application requires MCOs to provide to the Department policies and procedures regarding provision of second medical opinions from a qualified provider in-network or out-of-network if needed.  MCOs must also provide policies and procedures for providing members with referrals to out-of-network providers for services if the service is not available within the MCO network, including information regarding coordination for payment and ensuring the cost to the member is no greater than it would be if the services were furnished within the network.  **NONE** | **None**  **NONE** |
| **438.206 (b) (6)**  (6) Demonstrates that its network providers are credentialed as required by §438.214. | **0/0** | None | **Not Applicable**  See 438.214 in the Structure and Operations standards section of this appendix. | **N/A** | **N/A** | **N/A** |
| **438.206 (b) (7)**  Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. | **0/1**  **Not Met:**  438.206 (b) (7) | NET1  NET2  NET3 | **Not Met**  NCQA standards reference the accessibility of services and network adequacy as a whole, but do not specifically address the sufficiency of family planning providers. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Art. V, Provider Network and Access Requirements states the MCO must ensure its network includes sufficient family planning providers to ensure timely access to covered services.  ***Communication Outreach and Marketing Guide***: The standard member handbook must include how members may obtain benefits, including family planning services and supplies from out-of-network providers, and include an explanation that the MCO cannot require a member to obtain a referral before choosing a family planning provider. | **0/1**  **2021 Certification Application:**  The 2021 Certification Application addresses adequacy of a network related to OB/GYN providers, and requires MCOs to provide policies and procedures to make women’s health specialists available to members and the waiting times for care, but does not cover timely access specific to family planning providers. | **1**  438.206(b) (7)  This element is addressed in the 2020-2021 contract, but is not included in the current certification process. |
| **438.206 (c) (1) (2) (3)**  (1) *Timely Access.* Each MCO, PIHP, AND PAHP must do the following:  (i) Meet and require its network providers to meet State standards for timely access tocare and services, taking into account the urgency of the need for services.  (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.  (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.  (iv) Establish mechanisms to ensure compliance by network providers.  (v) Monitor network providers regularly to determine compliance.  (vi) Take corrective action if there is a failure to comply by a network provider.  (2) *Access and cultural considerations.* Each MCO, PIHP, and PAHP participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.  (3) *Accessibility considerations*. Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. | **1/3**  **Not Met:**  438.206(c)(1)(i), (ii), (iii), and (vi)  406.206(c)(3)  **MED: 1/3**  **Not Met:**  438.206(c)(1)(i) and (3) | NET1  NET2  CR5  CR7  MED1  MED3 | **Not Met**  NCQA standards are not specific about the hours of operation and availability in the context of serving Medicaid enrollees. These standards also do not address the accessibility considerations required. NET 1 addresses assessment of network to ensure sufficient practitioners to meet language and cultural considerations.  CR5 and CR7 address monitoring and assessment of providers.  The MED standards cover hours of operation as well as accessibility considerations and monitoring of providers for compliance. The standards do not address reasonable accommodations. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article V. Provider Network and Access Requirements and Article VII. Member Rights and Responsibilities  The contract establishes that MCOs must have written standards for accessibility of care including specific waiting times for appointments. The contract also defines distance requirements for dental providers, primary care, mental health, substance abuse, OB/GYN providers, urgent care centers or walk-in clinics, and hospital access.  MCOs are required to provide access to appropriate prenatal care services for high-risk pregnant women, women’s health specialists, family planning services, medication-assisted treatment (MAT) services, access to Indian Health providers, and to monitor network adequacy regularly, including whether network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. | **1/2**  **2021 Certification Application:**  Sections 3. Service Area requires MCOs to submit policies and procedures to ensure the MCO’s provider network meets the access standards in the contract. It also requires MCOs to submit their plans to monitor compliance with the standards and how the MCO corrects for deficiencies, if required ratios are not met. The process additionally requires submission of the MCO’s plans for communicating standards to providers of primary, mental health, and dental care.  **1/3** | **1**  438.206(c) (3)  *Accessibility considerations*. The contract requires MCOs to meet this standard, but the certification application does not specifically address monitoring provider compliance with accessibility requirements.  **1** |
| **438.207**  (a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at §438.68 and §438.206(c)(1).  (b) *Nature of supporting documentation.* Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:  (1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees 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 enrollees in the service area.  (c) *Timing of documentation.* Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:  (1) At the time it enters into a contract with the State.  (2) On an annual basis.  (3) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including—  (i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; or  (ii) Enrollment of a new population in the MCO, PIHP, or PAHP.  (d) *State review and certification to CMS.* After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the State's requirements for availability of services, as set forth in §438.68 and §438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP or PAHP related to its provider network.  (e) *CMS' right to inspect documentation.* The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP. | **0/3**  **Not Met:**  438.207(a) (b) and (c)  438.207 (d) and (e) are NA and were not included in the total elements. | None | **Not Met**  NCQA standards address network adequacy, but do not include provisions specific to the CFR requirements. Additionally, standards associated with network capacity/ accessibility do not align with DHS standards. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article V. Provider Network and Access Requirements state MCOs must provide assurances to the State that demonstrates the MCO has the capacity to serve the expected enrollment in its service area per the State standards for access to care. All MCO network reviews are based on the number of providers accepting new patients.  The MCO must ensure its delivery network is sufficient to provide adequate access to all services covered under the contract. It also includes all considerations for the MCO in establishing the network.  The MCO must provide documentation and assurance of the network adequacy criteria as required by the Department for pre-contract certification, annual provider network recertification, or upon request of the Department. The MCO must submit its provider network and facility file electronically in the format designed by the Department in the MCO Provider Network File Submission Specification Guide.  The MCO must also notify the Department of changes related to network adequacy. Changes that could affect network adequacy have been defined by the Department as changes in the MCO’s operations that would affect adequate capacity and services, including modifications to MCO benefits, geographic service areas, provider networks, payments, or enrollment of a new population into the MCO. | **3/3**  **2021 Certification Application:** The application monitors network adequacy and collects the required documentation. | **None** |
| **438.208**  a) *Basic requirement*—  (1) *General rule.* Except as specified in paragraphs (a)(2) and (3) of this section, the State must ensure through its contracts, that each MCO, PIHP, and PAHP complies with the requirements of this section.  (2) *PIHP and PAHP exception.* For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section.  (3) *Exception for MCOs that serve dually eligible enrollees.* (i) For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare Advantage Organization (as defined in §422.2 of this chapter), the State determines to what extent the MCO must meet the identification, assessment, and treatment planning provisions of paragraph (c) of this section for dually eligible individuals.  (ii) The State bases its determination on the needs of the population it requires the MCO to serve.  (b) *Care and coordination of services for all MCO, PIHP, and PAHP enrollees.* Each MCO, PIHP, and PAHP must implement procedures to deliver care to and coordinate services for all MCO, PIHP, and PAHP enrollees. These procedures must meet State requirements and must do the following:  (1) Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity;  (2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee:  (i) Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;  (ii) With the services the enrollee receives from any other MCO, PIHP, or PAHP;  (iii) With the services the enrollee receives in FFS Medicaid; and  (iv) With the services the enrollee receives from community and social support providers.  (3) Provide that the MCO, PIHP or PAHP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful;  (4) Share with the State or other MCOs, PIHPs, and PAHPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities;  (5) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and  (6) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. | **2/6**  **Not Met:**  438.208(b)(1), (b)(2)(iii), (b)(3), and (b)(4)  **MED: 5/6**  **Not Met:**  438.208(b)(2)(iii), | NET5  QI3  QI4  MED5  MED6 | **Not Met**  These standards address coordination and continuity of care; however, assurances for designating an entity with primary responsibility for coordination, except for those with complex conditions are not included in the guideline. They also do not address the need to share assessment results to prevent duplication of activities. Privacy protections are addressed in 438.224 below.  NET5 element B addresses continued access to a provider for active treatment/or for up to 90 days whichever is less if member has a chronic or acute condition.  QI3 and QI4 address collecting information and identifying opportunities for improvement in coordination of care.  MED standards address the requirement for an ongoing source of care, but does not address coordination of care with services the enrollee receives in FFS Medicaid. The MED standards also address the completion and sharing of an initial screening. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article III. Care Management requires MCOs to coordinate care between settings of care, with services provided by another MCO, with services a member receives through Medicaid Fee-for-Service, and with services a member receives through community and social support providers.  Article VII. Member Rights and Responsibilities states MCOs must ensure that every member has a primary care provider or primary care clinic responsible for coordinating the services accessed by the member. The MCO 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.  MCOs are required to have a system in place that ensures well-managed patient care, meeting all Federal requirements. | **4/4**  **2021 Certification Application:**  The application requires MCOs to provide their primary care assignment policies and procedures to the Department for review which include a description of each requirement is met.  **1/1** | **None**  **None** |
| **438.208 (c) (1)**  (c) *Additional services for enrollees with special health care needs or who need LTSS*—  (1) *Identification.* The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms—  (i) Must be specified in the State's quality strategy under §438.340.  (ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs. | **0/0** | None | **Not applicable; State responsibility** | **N/A** | **N/A** | **N/A** |
| **438.208 (c) (2) (3) (4)**  (2) *Assessment.* Each MCO, PIHP, and PAHP must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO, PIHP, or PAHP as appropriate.  (3) *Treatment/ service plans.* MCOs, PIHPs, or PAHPs must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be:  (i) Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee;  (ii) Developed by a person trained in person-centered planning using a person-centered process and plan as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans;  (iii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP;  (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 enrollee's circumstances or needs change significantly, or at the request of the enrollee per §441.301(c)(3) of this chapter.  (4) *Direct access to specialists.* For enrollees with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this section) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs. | **2/2**  (c)(3) is N/A and was not included in the total elements. | PHM4  QI3  QI4 | **Met**  The NCQA guidance notes the look back period for this requirement is at least once during the prior year for first surveys and 24 months for renewals. The Medicaid product line is exempted if the state conducts its own assessment or mandates a tool for the MCO to conduct the assessment, but the MCO must provide proof of such a requirement.  QI3 and QI4 focus on continuity and coordination of medical care and medical/behavioral health care. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X – Quality Assessment Performance Improvement states the MCO must identify at-risk populations for preventive services and develop strategies for reaching BadgerCare Plus and/or Medicaid SSI members included in this population. MCOs are encouraged 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. The MCO agrees to implement systems to independently identify members with special health care needs and 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.  Article III, requires MCOs to develop care management guidelines to operationalize their care management model, which must receive Department approval prior to implementation.  The MCO must have policies and procedures in place to allow members with special health care needs to directly access a specialist as appropriate for the member’s condition and identified needs.  The contract also outlines the care management requirements for MCOs serving Medicaid SSI enrollees including timeframes and an evidence-based care plan.  MCOs must conduct an initial screen for all BadgerCare Plus members to gather necessary information for care management. | **None** | **None** |
| **438.210 (a)**  (a) *Coverage.* Each contract between a State and an MCO, PIHP, or PAHP must do the following:  (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.  (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter.  (3) Provide that the MCO, PIHP, or PAHP—  (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.  (ii) 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 beneficiary.  (4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service—  (i) On the basis of criteria applied under the State plan, such as medical necessity; or  (ii) For the purpose of utilization control, provided that—  (A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;  (B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and  (C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter.  (5) Specify what constitutes “medically necessary services” in a manner that—  (i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and  (ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that address:  (A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.  (B) The ability for an enrollee to achieve age-appropriate growth and development.  (C) The ability for an enrollee to attain, maintain, or regain functional capacity.  (D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice. | **1/4**  **Not Met:**  438.210 (a) (1), (2), (4) and (5) | UM1  UM2  UM3  UM4  UM5 | **Not Met**  NCQA UM standards address requirements in general, but NCQA does not specifically address this element.  The NCQA guidance includes several standards related to UM that are similar to DHS standards or protocols, but may not meet DHS’ responsibilities to ensure that the MCO is not limiting services required in the benefit package described in DHS MCO contract. For example, the NCQA criteria describes that it “takes into account the local delivery system.” If NCQA considers the Medicaid contract as part of the “local delivery system” in making its evaluation of the MCO, then the element may be comparable. UM 5 is focused on timeliness of decisions and those timelines may not align exactly with DHS contract standards  Another example relates to timeframe differences between DHS and NCQA standards: 14 days (DHS) vs 15 days (NCQA) for non-urgent decisions. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  The contract defines the services that MCOs will cover in Article IV, Services. Medical necessity is defined in the contract as well as the standards of access to care that MCOs are accountable for. | **3/3**  **2021 Certification Application:**  The application requires submission of policies and procedures along with data files that address the MCO’s ability to provide an adequate, appropriate network of providers.  DHS also reviews care management policies, procedures, and guidelines related to the MCO care management system and continuity of care to ensure member-specific care and coordination is provided. | **None** |
| **438.210 (b)**  (b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—  (1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.  (2) That the MCO, PIHP, or PAHP—  (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.  (ii) Consult with the requesting provider for medical services when appropriate.  (iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.  (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs. | **3/3** | UM1  UM2  UM4  UM6 | **Met**  NCQA utilization management (UM) standards require each organization to have a UM program with a clearly defined structure and processes, with responsibility assigned to appropriate individuals. This includes participation of a senior-level physician and behavioral healthcare practitioner. UM decision making criteria are objective and based on medical evidence. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X- Quality Assessment Performance Improvement requires that the MCO 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. The MCO 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.  Documentation of denial of services must be available to the Department upon request.  The MCO must also have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and 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 MCO 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. | **None** | **None** |
| **438.210 (c) (d)**  (c) *Notice of adverse benefit determination.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404.  (d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:  (1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—  (i) The enrollee, or the provider, requests extension; or  (ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.  (2) *Expedited authorization decisions.*  (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.  (ii) The MCO, PIHP, or PAHP may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.  (3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act. | **1/2**  **Not Met:**  438.210 (d)  438.210 (d)(3) is NA as covered outpatient drug coverage is carved out of the DHS-MCO contract. | UM2  UM5  UM7 | **Not Met**  While timeframes for decision-making are addressed in these NCQA references, the details do not align with all timeframes associated with this requirement. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X- Quality Assessment Performance Improvement states the MCO’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. The contract also specifies written notice requirements and allowable timeframes for authorization decisions. | **1/1**  **2021 Certification Application:**  The application requires submission of policies and procedures related to notification of adverse actions and timeliness of decisions including policies for processing expedited and urgent authorization requests. | **None** |
| **438.210 (e)**  (e) *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §§438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. | **1/1** | UM2  UM4 | **Met**  Standard UM2 requires MCOs to have written utilization management decision-making criteria that is objective and based on medical evidence. UM4 focuses on service denials being based upon medical necessity and no other criteria (other than the existence of coverage). It also includes an element that determines utilization management decisions are based on appropriateness of care and financial incentives do not encourage decisions that result in under-utilization or reward practitioners for denials of service. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X- Quality Assessment Performance Improvement states the MCO 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 result in the under-utilization of services.  Article XV. Fiscal Components/ Provisions, states MCOs may operate a physician incentive plan only if no specific payment can be made directly or indirectly under such a plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. | **None** | **None** |

**Structure and Operations Standards**

| **Federal Requirement** | **Elements Met with NCQA Accreditation/Total Elements** | **NCQA**  **Standard**  **Reference** | **Summarized NCQA Accreditation Standard** | **DHS Contract Requirements** | **Remaining Elements Met with DHS Certification** | **Gap Elements Remaining** |
| --- | --- | --- | --- | --- | --- | --- |
| **438.214 (a) and (b)**  (a) The state must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers and that those policies and procedures, at a minimum, meet the requirements of this section.  (b) *Credentialing and recredentialing requirements.*  (1) Each State must establish a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate, and requires each MCO, PIHP and PAHP to follow those policies.  (2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of network providers. | **0/2**  **Not Met:**  438.214 (a) and (b) | CR1 | **Not Met**  CR1 requires MCOs to have well-defined credentialing and recredentialing processes, though they do not specify adhering to a state’s uniform credentialing and recredentialing policy. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X. Quality Assessment Performance Improvement outlines the process MCOs must follow to credential and recredential providers. | **2/2**  **2020 Certification Application:** The Application requires MCOs to submit policies and procedures related to the credentialing process for new and recertifying providers, including a description of all related process steps including the required database searches. | **None** |
| **438.214 (c)**  **Nondiscrimination**  (c) *Nondiscrimination.* MCO, PIHP, and PAHP network provider selection policies and procedures, consistent with §438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. | **0/1**  **Not Met:**  438.214 (c) | CR1 | **Not Met**  CR1 includes language related to nondiscrimination but is not specific about providers serving high risk/high cost consumers. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X- Quality Assessment Performance Improvement states the selection process must not discriminate against providers such as those serving high-risk populations, or specialize in conditions that require costly treatment. The MCO must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners in the MCO’s network. | **0/1**  **2020 Certification Application:** The Application requires MCOs to submit policies and procedures related to the credentialing process for new and recertifying providers, including a description of all related process steps including the required database searches. The Certification Application does not address nondiscrimination in credentialing or recredentialing providers. | **1**  This element is addressed in the 2020-2021 contract, but not included in the current certification process. |
| **438.214 (d)**  (d) Excluded providers.  (1) MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. | **0/1** | CR3  CR5  CR7 | **Not Met**  MCOs are required to confirm credentialed providers are in good standing with state and federal regulatory bodies. Collecting and reviewing information from the *List of Excluded Individuals and Entities* (maintained by OIG) is included as an option to identify any sanctions against providers. However, the standards do not review to confirm the MCO has a process that clearly prohibits excluded providers or employees. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X- Quality Assessment Performance Improvement prohibits an MCO from employing or contracting with providers debarred or excluded in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. | **1/1**  **2020 Certification Application:** The Application requires MCOs to submit policies and procedures related to the credentialing process for new and recertifying providers, including a description of the verification that federally excluded providers are not part of the MCO’s provider network. | **None** |
| **438.214 (e)**  (e) Each MCO, PIHP, and PAHP must comply with any additional requirements established by the State. | **0/1** | None | **Not Met**  NCQA standards do not address this requirement. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article XI., MCO Administration addresses compliance with all federal and state statutes. The contract also requires memoranda of understanding (MOU) to coordinate services with Prenatal Care Coordination (PNCC) agencies, school-based services, local law enforcement agencies for transfer to emergency detention or commitment, human service agencies in the counties within the MCO service area to coordinate Fee-for-Service services, hub and spoke pilot sites to coordinate AIDS services, and home health agencies to prevent duplication of services. In addition, the MCO must work with the, Targeted Case Management Services, as indicated in Addendum III. | **1/1**  **2020 Certification Application:** The Application requires MCOs to submit a list of all subcontractors and organizations with which there is a MOU/ agreement/ contract currently in effect. | **None** |
| **438.224**  **Confidentiality**  The State must ensure, through its contracts, that (consistent with subpart F of part 431 of this chapter), for medical records and any other health and enrollment information that identifies a particular enrollee, each MCO, PIHP, and PAHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. | **0/1**  **Not Met:**  438.224  **MED: 1/1** | None  MED4 | NCQA does not review this element in its accreditation processes.  The MED standards address the confidentiality of member information and records. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article XI MCO Administration defines appropriate disclosure of individually identifiable health information. It also describes inappropriate disclosures of individually identifiable health information and sets liquidated damages in case of breaches. | **0/1**  **2020 and 2021 Certification Application:**  The Certification process does not address or monitor confidentiality requirements.  **NONE** | **1**  This element is addressed in the 2020-2021 contract, but not included in the current certification process.  **NONE** |
| **438.228**  **Grievance and appeal systems**  (a) The State must ensure, through its contracts that each MCO, PIHP, and PAHP has in effect a grievance and appeal system that meets the requirements of subpart F of this part.  (b) If the State delegates to the MCO, PIHP, or PAHP responsibility for notice of action under subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCO, PIHP, or PAHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner. | **0/0** | None | **See Subpart F, Grievance Systems for details related to this requirement.** | **N/A** | **N/A** | **N/A** |
| **438.230**  **Subcontractual relationships and delegation agreement**  (a) *Applicability.* The requirements of this section apply to any contract or written arrangement that an MCO, PIHP, PAHP, or PCCM entity has with any subcontractor.  (b) *General rule.* The State must ensure, through its contracts with MCOs, PIHPs, PAHPs, and PCCM entities that—  (1) Notwithstanding any relationship(s) that the MCO, PIHP, PAHP, or PCCM entity may have with any subcontractor, the MCO, PIHP, PAHP, or PCCM entity maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and  (2) All contracts or written arrangements between the MCO, PIHP, PAHP, or PCCM entity and any subcontractor must meet the requirements of paragraph (c) of this section.  (c) Each contract or written arrangement described in paragraph (b)(2) of this section must specify that:  (1) If any of the MCO's, PIHP's, PAHP's, or PCCM entity's activities or obligations under its contract with the State are delegated to a subcontractor—  (i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.  (ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, PAHP's, or PCCM entity's contract obligations.  (iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, PAHP, or PCCM entity determine that the subcontractor has not performed satisfactorily.  (2) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions;  (3) The subcontractor agrees that—  (i) The State, 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 MCO's, PIHP's, or PAHP's contract with the State.  (ii) The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees.  (iii) The right to audit under paragraph (c)(3)(i) of this section 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.  (iv) If the State, 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. | **0/3**  **Not Met:** 438.230 (a), (b), and (c)  **MED: 2/3**  **Not Met:** 438.230 (c) | QI5  PHM7  NET6  UM13  CR8  ME8  MED15 | **Not Met**  Each section of the NCQA standards includes delegation of all or part of the section. Up to four delegation agreements in effect during the look-back period are reviewed. However, the NCQA requirements for delegation agreements do not align with the requirements of the CFR.  The NCQA MED standard requirements for delegation agreements aligns with most requirements of the CFR. The MED standards do not specifically address subcontractor compliance with Medicaid laws, or regulations such as State or CMS having the right to audit. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article XI. MCO Administration requires all MCO subcontractors to be in compliance with federal and state statutes, including the specific requirements of this section. | **2/3**  **2020 Certification Application:**  The Application requires MCOs to submit a list of all subcontractors and organizations in which there is a MOU/ agreement/ contract currently in effect, and a copy of the subcontractor contract template. The MCO must also submit policies and procedures for delegation that includes the requirements listed under 438.230(c) (1) and (2), but does not address 438.230(c)(3).  **0/1** | **1**  All elements are addressed in the 2020-2021 contract, but 438.230(c)(3) is not included in the current certification process.  **1** |

**Measurement and Improvement Standards**

| **Federal Requirement** | **Elements Met with NCQA Accreditation/Total Elements** | **NCQA**  **Standard**  **Reference** | **Summarized NCQA Accreditation Standard** | **DHS Contract Requirements** | **Remaining Elements Met with DHS Certification** | **Gap Elements Remaining** |
| --- | --- | --- | --- | --- | --- | --- |
| **438.236 (a) (b)**  (a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP meets the requirements of this section.  (b) *Adoption of practice guidelines.* Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:  (1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.  (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.  (3) Are adopted in consultation with contracting health care professionals.  (4) Are reviewed and updated periodically as appropriate. | **0/4**  **Not Met:** 438.236 (b)  **MED: 4/4** | None  MED2 | **Not Met**  Practice guidelines were eliminated as a NCQA standard beginning July 1, 2018.Population health management focuses on the whole person and each member’s needs. This is too broad to cover the specific CFR requirements.  The MED standards require adopting and updating clinical practice guidelines that are reviewed and updated at least every two years. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X- Quality Assessment Performance Improvement requires MCOs to develop or adopt best practice guidelines in accordance with the requirements. | **4/4**  **2021 Certification Application:**  The Application requires submission of a description of the clinical guidelines used for utilization management, member education on health and disease management, coverage of services and other areas to which the guidelines may apply. Related policies and procedures used by MCOs are also required specific to adoption and review/update of guidelines.  **None** | **None**  **None** |
| **438.236 (c)**  (c) *Dissemination of guidelines.* Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. | **0/2**  **Not Met:** 438.236 (c)  **MED: 2/2** | None  MED2 | **Not Met**  NCQA eliminated practice guidelines as a standard beginning July 1, 2018.  The MED standards require dissemination of practice guidelines as required in CFR. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X- Quality Assessment Performance Improvement requires MCOs to disseminate established practice guidelines to providers and, upon request, to members and potential members. | **2/2**  **2021 Certification Application:** The 2021 Certification Application includes the dissemination of guidelines to providers and members (upon request).  **None** | **None**  **None** |
| **438.236 (d)**  (d) *Application of guidelines.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. | **0/1**  **Not Met:** 438.236 (d)  **MED: 0/1**  **Not Met:** 438.236 (d) | UM2  MED2 | **Not Met**  While the UM standards reflect the need to adhere to evidence-based criteria and local delivery system practice, NCQA eliminated practice guidelines as a standard beginning July 1, 2018.  The MED standard only references the use of practice guidelines in member education, not for utilization, coverage or other areas. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X- Quality Assessment Performance Improvement states that decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines. | **1/1**  **2021 Certification Application:**  The Application reviews a description of the practice guidelines as well as the related policies and procedures used by MCOs.  **1/1** | **None**  **None** |
| **438.242 (a)**  (a) *General rule.* The State must ensure, through its contracts that each MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. | **0/1**  **Not Met:**  438.242 (a) | PHM2  UM2 | **Not Met**  NCQA standards for both PHM and UM focus on data collection from claims, encounters, electronic health records, or other data sources. However, there is no NCQA standard regarding an MCO maintaining a health information system that can collect, analyze, integrate, and report data. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article XII- Reports and Data describes the requirements for MCOs to maintain their health information systems. | **1/1**  **2021 Certification Application:** The Application requires MCOs to provide documentation confirming the organization has the security, data, claims and encounter processing, computer system and reporting standards as outlined in the contract and in compliance with this standard.  **Other:**  DHS conducts encounter data testing with MCOs. | **None** |
| **438.242 (b)**  (b) *Basic elements of a health information system.* The State must require, at a minimum, that each MCO, PIHP, and PAHP comply with the following:  (1) Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.  (2) Collect data on enrollee and provider characteristics as specified by the State, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by the State.  (3) Ensure that data received from providers is accurate and complete by—  (i) Verifying the accuracy and timeliness of reported data, including data from network providers the MCO, PIHP, or PAHP is compensating on the basis of capitation payments.  (ii) Screening the data for completeness, logic, and consistency.  (iii) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.  (4) Make all collected data available to the State and upon request to CMS.(5) Implement an Application Programming Interface (API) as specified in 431.60 of this chapter as if such requirements applied directly to the MCO, PIHP, or PAHP and include—  (i) All encounter data, including encounter data from any network providers the MCO, PIHP, or PAHP is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractor.  (ii) [Reserved]  (6) Implement, by January 1, 2021, and maintain a publicly accessible standards-based API described in 431.70, which must include all information specified in 438.10(h)(1) and (2) of this chapter. | **0/1**  **Not Met:**  438.242 (b) | None | **Not Met**  NCQA standards do not specify the basic elements needed for health information systems. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article XII Reports and Data  Describes the requirements for MCOs to maintain their health information systems and submit compliant encounter data files. | **0/1**  **2021 Certification Application:**  The Application requires the MCOs to meet security, data, claims and encounter processing, computer system, and reporting standards outlined in the 2020-2021 BadgerCare Plus and Medicaid SSI Contract. It also requires submission of policies and procedures in place to meet the outlined requirements. | **1**  438.242(b)(5) and (6)  This is a new requirement, effective 1/1/21 and was not included in the 2021 certification application. Recommend adding to the 2022 Certification Application to address this gap. |
| **438.242 (c) (d)**  (c) *Enrollee encounter data.* Contracts between a State and a MCO, PIHP, or PAHP must provide for:  (1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.  (2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.  (3) Submission of all enrollee encounter data, including allowed amount and paid amount, that the State is required to report to CMS under §438.818.  (4) Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.  (d) *State review and validation of encounter data.* The State must review and validate that the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP, meets the requirements of this section. The State must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted under paragraph (c) of this section is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP. | **0/1**  **Not Met:**  438.242 (c)  438.242 (d) is N/A and was not included in the total elements. | None | **Not Met**  NCQA standards focus on data collection and analytics in general, but do not address external reporting, submission, review, or validation of the data collected. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article XII Reports and Data describes the requirements for MCOs to maintain their health information systems. | **1/1**  **2021 Certification Application:**  requires the MCOs to meet security, data, claims and encounter processing, computer system, and reporting standards outlined in the 2020-2021 BadgerCare Plus and Medicaid SSI Contract. It also requires submission of policies and procedures in place to meet the outlined requirements. | **None** |

**42 CFR 438 Managed Care - Subpart E**

**Quality Measurement and Improvement Standards**

The majority of Subpart E is applicable to states and EQROs. Those sections of CFR not applicable to MCOs, PHIPs or PAHPs were excluded.

| **Federal Requirement** | **Elements Met with NCQA Accreditation/Total Elements** | **NCQA**  **Standard**  **Reference** | **Summarized NCQA Accreditation Standard** | **DHS Contract Requirements** | **Remaining Elements Met with DHS Certification** | **Gap Elements Remaining** |
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| **438.330 (a) (b)**  (a) *General rules.*  (1) The State must require, through its contracts, that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that includes the elements identified in paragraph (b) of this section.  (2) After consulting with States and other stakeholders and providing public notice and opportunity to comment, CMS may specify performance measures and PIPs, which must be included in the standard measures identified and PIPs required by the State in accordance with paragraphs (c) and (d) of this section. A State may request an exemption from including the performance measures or PIPs established under paragraph (a)(2) of this section, by submitting a written request to CMS explaining the basis for such request.  (3) The State must require, through its contracts, that each PCCM entity described in §438.310(c)(2) establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees which incorporates, at a minimum, paragraphs (b)(2) and (3) of this section and the performance measures identified by the State per paragraph (c) of this section.  (b) *Basic elements of quality assessment and performance improvement programs.* The comprehensive quality assessment and performance improvement program described in paragraph (a) of this section must include at least the following elements:  (1) Performance improvement projects in accordance with paragraph (d) of this section.  (2) Collection and submission of performance measurement data in accordance with paragraph (c) of this section.  (3) Mechanisms to detect both underutilization and overutilization of services.  (4) Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under §438.340.  (5) For MCOs, PIHPs, or PAHPs providing long-term services and supports:  (i) Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable; and  (ii) Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§441.302 and 441.730(a) of this chapter) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per §441.302(h) of this chapter. | **2/4**  **Not Met:**  438.330 (b)(1) and (3)  438.330 (b)(5)(ii) is N/A and was not included in the total elements.  **MED: 3/4**  **Not Met:**  438.330 (b)(1) | QI1  QI3  QI4  PHM1  PHM6  MED7 | **Not Met**  The NCQA standards require a quality improvement infrastructure which includes an annual work plan and annual evaluation. The standards do not specifically require improvement projects and do not address monitoring for under- and over-utilization.  QI3 and QI4 include coordination and continuity of care for both medical and behavioral health, but do not specifically address the CFR requirements. PHM1 and PHM6 require a strategy (with annual evaluation) to address member needs across the continuum, but do not specifically reference those with special health care needs.  The MED standards address monitoring for over- and under-utilization, as well as mechanisms to assess the quality and appropriateness of care provided to members with special health care needs. However, the standards do not address or require performance improvement projects. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X. Quality Assessment and Performance Improvement specifically addresses the requirements of the CFR elements. The QAPI is not monitored annually, but must be made available to the Department upon request. | **2/2**  **2021 Certification Application:**  The Application requires all MCOs to submit its accreditation status including lines of business or specific population for which accreditation was obtained, and the year of accreditation.  The 2021 Certification Application does request the MCO’s most recent Quality Assessment/Performance Improvement (QAPI) work plan and QAPI annual report.  **Other:** PIPs are reviewed and validated by the EQRO annually.  DHS also monitors under- and over-utilization of services regularly through analysis of encounter data. As part of the pay for performance (P4P) requirements, DHS evaluates quality of care at least on an annual basis through specific performance indicators. See P4P requirements in the 2020 MCO P4P Guide.  **1/1** | **None**  DHS analysis of encounter data could address element (b)(3).  **None** |
| **438.330 (c)**  (c) *Performance measurement.* The State must—  (1)(i) Identify standard performance measures, including those performance measures that may be specified by CMS under paragraph (a)(2) of this section, relating to the performance of MCOs, PIHPs, and PAHPs; and  (ii) In addition to the measures specified in paragraph (c)(1)(i) of this section, in the case of an MCO, PIHP, or PAHP providing long-term services and supports, identify standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports.  (2) Require that each MCO, PIHP, and PAHP annually—  (i) Measure and report to the State on its performance, using the standard measures required by the State in paragraph (c)(1) of this section;  (ii) Submit to the State data, specified by the State, which enables the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State under paragraph (c)(1) of this section; or  (iii) Perform a combination of the activities described in paragraphs (c)(2)(i) and (ii) of this section. | **0/1**  **Not Met:**  438.330 (c) Performance measurement  438.330 (c)(1)(ii) is N/A and was not included in the total elements. | None | **Not Met**  No reference for reporting obligations to outside entities is found in the standards. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X. Quality Assessment and Performance Improvement. | **1/1**  **2021 Certification Application:**  The Application requires the MCO to describe its system’s ability to provide data necessary to monitor program performance relative to P4P.  **Other:** TheMCO *Quality Guide* lists the performance measures used in the P4P program. As part of the P4P requirements, DHS evaluates quality of care at least on an annual basis through specific performance indicators. See P4P requirements in the 2021 MCO *Quality Guide*. The P4P measures are validated by the EQRO annually. | **None** |
| **438.330 (d)**  (d) *Performance improvement projects.*  (1) The State must require that MCOs, PIHPs, and PAHPs conduct performance improvement projects, including any performance improvement projects required by CMS in accordance with paragraph (a)(2) of this section, that focus on both clinical and nonclinical areas.  (2) Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements:  (i) Measurement of performance using objective quality indicators.  (ii) Implementation of interventions to achieve improvement in the access to and quality of care.  (iii) Evaluation of the effectiveness of the interventions based on the performance measures in paragraph (d)(2)(i) of this section.  (iv) Planning and initiation of activities for increasing or sustaining improvement.  (3) The State must require each MCO, PIHP, and PAHP to report the status and results of each project conducted per paragraph (d)(1) of this section to the State as requested, but not less than once per year.  (4) The State may permit an MCO, PIHP, or PAHP exclusively serving dual eligibles to substitute an MA Organization quality improvement project conducted under §422.152(d) of this chapter for one or more of the performance improvement projects otherwise required under this section. | **1/5**  **Not Met:**  438.330 (d)(2)  (d)(2)(i)  (d)(2) (iii)  (d)(2) (iv) | QI1  QI3  QI4 | **Not Met**  While NCQA standards address the need to complete QI activities that address quality and safety of care and quality of service, it is not specific in verifying that the plan has implemented specific performance improvement projects, meeting specific requirements, to impact care every year. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X Quality Assessment and Performance Improvement (QAPI), defines the process for MCOs to submit Performance Improvement Projects (PIPs) to DHS, the timeframe, and all the requirements they need to include in the PIP. | **4/4**  **2020 and 2021 Certification Applications:**  The Certification process does not address  PIP requirements.  **Other:** DHS, along with the EQRO, reviews PIP topics for all MCOs annually. DHS approves the topics, based on input from the EQRO.  Final PIP reports are submitted annually by each MCO. The EQRO validates the final reports and provides written feedback to each MCO. | **None** |
| **438.330 (e)**  (e) *Program review by the State.*  (1) The State must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP, and PCCM entity described in §438.310(c)(2). The review must include—  (i) The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report.  (ii) The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects.  (iii) The results of any efforts by the MCO, PIHP, or PAHP to support community integration for enrollees using long-term services and supports.  (2) The State may require that an MCO, PIHP, PAHP, or PCCM entity described in §438.310(c)(2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program. | **0/1**  **Not Met:** 438.330 (e)  438.330(e)(1)(iii) is N/A. | None | **Not Met**  No reference is found in the NCQA standards for external reporting obligations beyond making the QAPI program information available to members annually. NCQA does not address any regulatory oversight for the QAPI program. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article X. Quality Assessment and Performance Improvement (QAPI) The QAPI is not monitored or reviewed annually, but must be made available to the Department upon request. | **0/1**  **2021 Certification Application:**  The 2021 Certification Application does request the MCO’s most recent Quality Assessment/Performance Improvement (QAPI) work plan and QAPI annual report.  **Other:** TheMCO *Quality Guide* lists the performance measures used in the pay-for-performance program. DHS, along with the EQRO, reviews PIP topics for all MCOs annually and DHS approves the topics, based on input from the EQRO.  Once the final PIP reports are submitted, the EQRO validates the final report and provides feedback to each MCO.  The EQRO validates the required performance measures annually. | **1**  (e)(1)  The element is addressed in the 2020-2021 contract, but is not included in the current certification process. |

**42 CFR 438 Managed Care - Subpart F**

**Grievance Systems**

| **Federal Requirement** | **Elements Met with NCQA Accreditation/Total Elements** | **NCQA**  **Standard**  **Reference** | **Summarized NCQA Accreditation Standard** | **DHS Contract Requirements** | **Remaining Elements Met with DHS Certification** | **Gap Elements Remaining** |
| --- | --- | --- | --- | --- | --- | --- |
| **438.400 Statutory basis, definitions, and applicability.**  (a) Statutory basis. This subpart is based on the following statutory sections:  (1) Section 1902(a)(3) of the Act requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.  (2) Section 1902(a)(4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.  (3) Section 1932(b)(4) of the Act requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.  (4) Section 1859(f)(8)(B) of the Act requires that the Secretary, to the extent feasible, establish procedures unifying grievances and appeals procedures under sections 1852(f), 1852(g), 1902(a)(3), 1902(a)(5), and 1932(b)(4) of the Act for items and services provided, by specialized Medicare Advantage plans for special needs individuals described in section 1859(b)(6)(B)(ii), under Titles XVIII and XIX of the Act.  (b) Definitions. As used in this subpart, the following terms have the indicated meanings:  Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:  (1) 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.  (2) The reduction, suspension, or termination of a previously authorized service.  (3) The denial, in whole or in part, of payment for a service.  (4) The failure to provide services in a timely manner, as defined by the State.  (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.  (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.  (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.  Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.  Grievance means 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 enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.  Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.  State fair hearing means the process set forth in subpart E of part 431 of this chapter.  (c) Applicability. This subpart applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states, MCOs, PIHPs, and PAHPs are required to continue to comply with subpart F contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. | **0/1** | ME7 | **Not Met**  The standards that address appeals and grievances do not include specific references to providers acting on behalf of an enrollee, except for expedited appeals and relative to an appeal involving an independent review entity.  While a reference to access to an independent review entity is noted, the standards do not reference the fair hearing process. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 1 requires all Wisconsin Medicaid Health Plans to implement and enforce all of the requirements regarding member grievance and appeals processes, adhering to the requirements of the Guide. | **0/1**  **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements. | **1**  All elements are addressed in the 20-21contract, but none are included in the 2020 and 2021 Certification Application. |
| **438.402 General requirements**  (a) The grievance and appeal system. Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in §438.9, are not subject to this subpart F. For grievances and appeals at the plan level, an applicable integrated plan as defined in §422.561 of this chapter is not subject to this subpart F, and is instead subject to the requirements of §§422.629 through 422.634 of this chapter. For appeals of integrated reconsiderations, applicable integrated plans are subject to §438.408(f).  (b) Level of appeals. Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.  (c) Filing requirements—(1) Authority to file. (i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld.  (A) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.  (B) External medical review. The State may offer and arrange for an external medical review if the following conditions are met.  (1) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.  (2) The review must be independent of both the State and MCO, PIHP, or PAHP.  (3) The review must be offered without any cost to the enrollee.  (4) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.  \* (ii) If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term “enrollee” is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in §438.420(b)(5).  (2) Timing—(i) Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.  (ii) Appeal. Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.  (3) Procedures—(i) Grievance. The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO, PIHP, or PAHP.  (ii) Appeal. The enrollee may request an appeal either orally or in writing. | **3/8**  **Not Met:** 438.402 (b), (c) (2)(i) and (ii) and (3)(i) and (ii)  438.402 (c)(i)(A) and (B) are NA and were not included in the total elements.  **MED: 3/8**  **Not Met:** 438.402 (b), (c) (2)(i) and (ii) and (3)(i) and (ii) | ME7  UM8  MED10 | **Not Met**  See notes above about the absence of references to providers acting on behalf of an enrollee.  For grievances, no timeframes are specifically identified, but rather are noted in a general manner.  The MED standards provide general requirements for a grievance and appeal process, but do not meet the specific CFR requirements. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 4 states each MCO must have a grievance and appeal system in place for its members. The MCO’s policies and procedures must detail what the grievance and appeal system is and how it operates. The section also states the levels of appeals permitted, filing requirements, member filing timeframes and the procedures for filing. | **0/5**  **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.  **0/5** | **5**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.  **5** |
| **438.404 Timely and adequate notice of adverse benefit determination**  (a) *Notice.* The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10.  (b) *Content of notice.* The notice must explain the following:  (1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make.  (2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.  (3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at §438.402(b) and the right to request a State fair hearing consistent with §438.402(c).  (4) The procedures for exercising the rights specified in this paragraph (b).  (5) The circumstances under which an appeal process can be expedited and how to request it.  (6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.  (c) *Timing of notice.* The MCO, PIHP, or PAHP must mail the notice within the following timeframes:  (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.  (2) For denial of payment, at the time of any action affecting the claim.  (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).  (4) If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must—  (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and  (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.  (5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.  (6) For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2). | **0/3**  **Not Met:** 438.404 (a), (b) and (c)  **0/3**  **Not Met:** 438.404 (a), (b) and (c) | ME7  MED8  MED9  MED10  MED12 | **Not Met**  Notices are not required if the denial is either concurrent or post-service and the member is not at financial risk.  While the standards include references to details such as the timeframe for appeal, how to submit information, and the timeframe within which the plan must make a decision, the standards do not include sufficient detail to fully meet federal requirements.  The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 5 outlines the MCO requirements for providing notice of adverse benefit determinations to member, including the content and timing of the notice. Appendix B: *Member Letter Templates and Mandatory Language for Member Letters* provides the standard language required for all member letters | **0/3**  **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.  **0/3** | **3**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.  **3** |
| **438.406 Handling of grievances and appeals**  (a) *General requirements.* In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees 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.  (b) *Special requirements.* An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:  (1) Acknowledge receipt of each grievance and appeal.  (2) Ensure that 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, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.  (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.  (3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals.  (4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution.  (5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c).  (6) Include, as parties to the appeal—  (i) The enrollee and his or her representative; or  (ii) The legal representative of a deceased enrollee's estate. | **4/7**  **Not Met:** 438.406(a), (b)(4) and (6)  **MED: 4/7**  **Not Met:** 438.406(a), (b)(4) and (6) | ME7  UM8  MED8  MED10 | **Not Met**  The standards do not address the following elements:   * Require provision of assistance to the enrollees to access grievance and appeal systems, except to provide interpretation assistance; * The option to allow deceased enrollee’s legal representative to appeal; * In-person presentation of information.   NCQA standards related to expertise of those hearing an appeal are limited to medical necessity appeals only.  The option to examine case files and medical records is noted, but more in the past tense as part of the interaction following a utilization management decision.  The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 6 outlines the requirement for MCOs to provide reasonable assistance to members when filing a grievance or appeal. The section further outlines the requirements for handling member grievances and appeals for adverse benefit determinations. | **0/3**  **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.  **0/3** | **3**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.  **3** |
| **438.408 Resolution and notification: Grievances and appeals**  (a) *Basic rule.* Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.  (b) *Specific timeframes*—(1) *Standard resolution of grievances.* For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.  (2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.  (3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.  (c) *Extension of timeframes.* (1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—  (i) The enrollee requests the extension; or  (ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.  (2) *Requirements following extension.* If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:  (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.  (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.  (iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.  (3) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.  (d) *Format of notice*—(1) *Grievances.* The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10.  (2) *Appeals.* (i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10.  (ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.  (e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:  (1) The results of the resolution process and the date it was completed.  (2) For appeals not resolved wholly in favor of the enrollees—  (i) The right to request a State fair hearing, and how to do so.  (ii) The right to request and receive benefits while the hearing is pending, and how to make the request.  (iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.  (f) *Requirements for State fair hearings*—(1) *Availability.* An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.  (i) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.  (ii) *External medical review.* The State may offer and arrange for an external medical review if the following conditions are met.  (A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.  (B) The review must be independent of both the State and MCO, PIHP, or PAHP.  (C) The review must be offered without any cost to the enrollee.  (D) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.  (2)*State fair hearing.* The enrollee must have no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution to request a State fair hearing.  (3) *Parties.* The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate. | **3/13**  **Not Met:** 438.408 (a), b(1) and (2), (c) (2)(ii), d(1), e(1) and (2), and f(1), (2) and (3)  438.408(f)(1)(i) and (ii) are NA. | ME7  UM8  UM9 | **Not Met**  In general, policies for complaints and appeals are evaluated against the MCO’s standards for timeliness, not specific timeframes associated with federal requirements.  The timeframe for internal appeal resolution in the guidelines is 30 days from receipt of appeal for pre-service, 60 days for post-service and 72 hours for expedited appeals.  NCQA guidelines state the organization records the time and date of the notification and identifies the staff member that spoke with the member or practitioner.  The notification process evaluation does not address communication of the potential for financial responsibility for services received under a continuation of benefits. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 7 outlines the requirements for resolution and notification for all appeals and grievances including timeframes, extensions, format of notices, and content of notices to members. | **0/10**  **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements. | **10**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application. |
| **438.410 Expedited resolution of appeals**  (a) *General rule.* Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee'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.  (b) *Punitive action.* The MCO, PIHP, or PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.  (c) *Action following denial of a request for expedited resolution.* If the MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it must—  (1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2).  (2) Follow the requirements in §438.408(c)(2). | **1/3**  **Not Met:** 438.410 **(**b) and (c)  **MED: 2/3**  **Not Met:** 438.410 **(**b) | ME7  MED10 | **Not Met**  NCQA standards do not include references to assurances that providers do not suffer punitive action through their involvement in appeals and does address transfer to the standard process for appeals.  The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 8 requires MCOs to establish a process for expedited appeals, including prohibiting punitive action and steps that must be taken when the request for an expedited appeal is denied. | **0/2**  **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.  **0/1** | **2**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.  **1** |
| **438.414 Information about the grievance and appeal system to providers and subcontractors**  The MCO, PIHP or PAHP must provide information specified in §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. | **0/1**  **Not Met:** 438.414  **MED: 1/1** | None  MED10 | **Not Met**  NCQA standards do not address this requirement.  The MED standards require MCOs to distribute information about the grievance and appeal system to all providers at the time of contracting. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 13 requires MCOs to distribute the member grievance and appeals informational flyer to its gatekeepers, providers, subcontractors and Independent Practice Associations along with the *Member Grievances and Appeals Guide* at the time of contracting and within three weeks of updates thereafter. The MCOs must also ensure these entities have written procedures addressing how members are informed of a denied service. | **0/1**  **2020 & 2021 Certification Applications:** The Certification Applications do not monitor or review these requirements.  **0/1** | **1**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.  **1** |
| **438.416 Recordkeeping requirements**  (a) The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.  (b) The record of each grievance or appeal must contain, at a minimum, all of the following information:  (1) A general description of the reason for the appeal or grievance.  (2) The date received.  (3) The date of each review or, if applicable, review meeting.  (4) Resolution at each level of the appeal or grievance, if applicable.  (5) Date of resolution at each level, if applicable.  (6) Name of the covered person for whom the appeal or grievance was filed.  \* (c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. | **2/3**  **Not Met:** 438.416(c)  **MED: 2/3**  **Not Met:** 438.416(c) | UM9  UM9  MED10 | **Not Met**  This standard includes requirements for documentation of complaints and appeals but without regard for the need for state oversight.  The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 11 specifies the MCO recordkeeping requirements and grievance report quarterly submissions to DHS. Section 12 specifies the information and formatting of the quarterly submissions. The reports address all requirements except (b)(3) | **1/1**  **2020 & 2021 Certification Applications:** The Certification Applications do not monitor or review these requirements.  **Other:**  The *Member Grievances and Appeals Guide*  requires all MCOs to submit quarterly reports to DHS of all grievances and appeals. DHS conducts random reviews to ensure the requirements are met. | **None** |
| **438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending**  (a) *Definition.* As used in this section—  *Timely files* means files for continuation of benefits on or before the later of the following:  (i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination.  (ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination.  (b) *Continuation of benefits.* The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur:  (1) The enrollee files the request for an appeal timely in accordance with §438.402(c)(1)(ii) and (c)(2)(ii);  (2) The appeal involves the termination, suspension, or reduction of previously authorized services;  (3) The services were ordered by an authorized provider;  (4) The period covered by the original authorization has not expired; and  (5) The enrollee timely files for continuation of benefits.  (c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO, PIHP, or PAHP 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:  (1) The enrollee withdraws the appeal or request for state fair hearing.  (2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2).  (3) A State fair hearing office issues a hearing decision adverse to the enrollee.  (d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under §431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section. | **2/4**  **Not Met:** 438.420 (a) and (c)  **MED: 2/4**  **Not Met:** 438.420 (a) and (c) | UM8  MED11 | **Not Met**  While the general concepts of these federal requirements are addressed in NCQA standards, specific details, especially those related to criteria for continuation of benefits are not included.  The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide*** Section 9 outlines the requirements for continuation of benefits during the appeal and State Fair Hearing process, including timely filing, continuation of benefits, duration of benefits and the member’s financial responsibility. | **0/2**  **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.  **Other:**  The *Member Grievances and Appeals Guide*  requires all MCOs to submit quarterly reports to DHS of all grievances and appeals. DHS conducts random reviews to ensure most requirements are met, but does not fully address the continuation of benefits.  **0/2** | **2**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application. The quarterly grievance and appeals report required in the *Member Grievances and Appeals Guide* does not include all requirements for the continuation of benefits.  **2** |
| **438.424 Effectuation of reversed appeal resolutions**  *(a) Services not furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP 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.  (b) *Services furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations. | **0/2**  **Not Met:** 438.424(a) and (b)  **MED: 2/2** | None  MED10 | **Not Met**  NCQA standards do not reflect the details included this requirement.  The MED standards address the effectuation of reversed appeal decisions. | **2020-2021 BadgerCare Plus and Medicaid SSI Contract:**  Article IX Member Grievances and Appeals requires MCO’s to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*  ***Member Grievances and Appeals Guide***  Section 10 requires MCOs to authorize or provide disputed services no later than 72 hours from the date it receives notice reversing the determination. The MCO must also pay for any disputed services the member received while the appeal was pending. | **0/2**  **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.  **None** | **2**  All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.  **None** |