<<PROGRAM>> CONTRACT

between

WISCONSIN DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAID SERVICES

and

<< NAME OF MCO >>

Issued January 1, 2020

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PREAMBLE

The Wisconsin Department of Health Services (the Department) contracts with the Managed Care Organization (MCO) to deliver the Family Care Program or the Family Care Partnership Program (Partnership) as defined in this contract. These programs provide supports and services in the individual benefit package through a managed care service delivery model to enrollees in need of long-term care.

It is the intent of the Department that the Family Care and Partnership programs be truly integrated models for the delivery of all aspects of the members' Medicaid services and that all of these programs employ the Family Care philosophy and basic methods. These programs differ primarily in the scope of services.

- **Family Care** is a capitated Medicaid managed care program for the delivery of all Medicaid long-term care services. Members enrolled in Family Care may be eligible at a Wisconsin Medicaid nursing home-certifiable level of care or at a non-nursing home level of care. One of these functional levels of care is required as a condition of eligibility.
- **Partnership** is a capitated integrated Medicaid and Medicare managed care program that, in addition to the Family Care long-term care benefits, provides managed health care benefits, and all applicable Medicare Advantage Special Needs Plan and Medicare Part D prescription drug benefits. All members enrolled in Partnership have a Wisconsin Medicaid nursing home-certifiable level of care, which is required as a condition of eligibility. As a fully integrated program, all supports and services – whether Medicare or Medicaid benefits – are delivered through the Partnership model design identified in this contract.

This contract and the MCO's Member Handbook/Evidence of Coverage (EOC) define the philosophy and basic methods for the programs above. It is the Department's expectation under this contract that benefits will be fully integrated and will afford options that foster opportunities for interaction and integration into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community while supporting each member's individual outcomes and recognizing each member's preferences. The Department further expects that each member will have the opportunity to make informed choices about where he or she will live, how he or she will make or maintain connections to the community and whether he or she will seek competitive employment.

All services and supports within the benefit package are delivered through the Family Care or Partnership program models of care including:

- Integration and support for Medicaid eligibility determination and enrollment procedures and, in the case of Partnership, for Medicare enrollment procedures;
- Maintenance of a network of providers with capacity to provide program benefits to members;
- Member-centered outcome-based care planning;
- Member-centered interdisciplinary care management;
- Member-centered service authorization and delivery;
- Support of member rights;
- Responsiveness to grievances and appeals;
- Quality management; and
- Cost effective and efficient contracting and service utilization.

Any MCO that delivers the Family Care or Partnership benefit under this contract must first be certified by the Department. The Department pays the MCO a fixed monthly capitation payment for each member. The MCO provides to each member the Medicaid long-term care and health care services and supports identified in this contract that are appropriate to that individual member's outcomes and needs.

As part of the Department's quality management strategy, this contract describes desired outcomes, how the Department will determine that member-identified outcomes have been supported, and the standards of operation the Department expects to be met by MCO contractors.

This contract is entered into between the State of Wisconsin represented by its Division of Medicaid Services, of the Department of Health Services, whose principal business address is One West Wilson Street, P.O. Box 309, Madison, Wisconsin, 53701-0309, and <<Generic>> Managed Care Organization, hereafter MCO, whose principal business address is <<Address>>.

An electronic version of this contract can be accessed at:
https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm.

I. Definitions

Refer to Addendum VII, Benefit Package Service Definitions for service definitions.

1. **Abuse:** as defined by Wis. Stats. s. 46.90(1)(a), means any of the following:
   a) Physical abuse: intentional or reckless infliction of physical pain or injury, illness, or any impairment of physical condition.
   b) Emotional abuse: language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.
   c) Sexual abuse: a violation of criminal assault law, Wis. Stats. §§ 940.225 (1), (2), (3), or (3m).
   d) Treatment without consent: the administration of medication to an individual who has not provided informed consent, or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.
   e) Unreasonable confinement or restraint: the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his/her living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint.

2. **Activities of Daily Living** or **ADLs:** bathing, dressing, eating, mobility, transferring from one surface to another such as bed to chair and using the toilet.

3. **Acute and Primary Care Benefit Package:** the services identified in Addendum VII, Benefit Package Service Definitions, Section C. that are not also identified in Addendum VII, Benefit Package Service Definitions, Section B.

4. **Acute Care:** treatment, including all supplies and services, for an abrupt onset as in reference to a disease. Acute connotes an illness that is of short duration, rapidly progressive, and in need of urgent care.

5. **Adult at Risk:** as defined in Wis. Stat. § 55.01(1e), means any adult who has a physical or mental condition that substantially impairs his/her ability to care for his/her needs and who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self–neglect, or financial exploitation.

6. **Adult Protective Services** or **APS:** as defined by Wis. Stat. § 55.01(6r), includes any of the following: (a) outreach, (b) identification of individuals in need of services, (c) counseling and referral for services, (d) coordination of services for individuals, (e) tracking and follow-up, (f) social services, (g) case management, (h) legal counseling or referral, (i) guardianship referral, (j) diagnostic evaluation, and (k) any services that, when provided to an individual with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other like incapacity, keep the individual safe from abuse, financial exploitation, neglect, or self-neglect or prevent the individual from experiencing deterioration or from inflicting harm on himself or herself or another person.

7. **Advance Directive:** a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated.

8. **Adverse Action Date:** by law, individuals must be given at least ten (10) calendar days advance notice before any adverse action (i.e., reduction or termination) can take effect relative to their Medicaid eligibility and benefits. The "Adverse Action Date" is the day during a given month by which an adverse action must be taken so as to assure that the member has the notice in hand at least ten (10) calendar days before the effective date of the adverse action. The effective date of most Medicaid benefit reductions or terminations is the first day of a given month. Therefore, the Adverse Action Date is generally mid-month in the month prior. In a thirty-one (31) day month, adverse action is on or around the 18th; in a thirty (30) day month, it's on or around the 17th.

9. **Aging and Disability Resource Center (ADRC)** or **Aging Resource Center** or **Disability Resource Center** or **Resource Center:** an entity that meets the standards for operation and is under contract with the Wisconsin Department of Health Services to provide services under Wis. Stat. § 46.283(3), or, if under contract to provide a portion of the services specified under Wis. Stat. § 46.283(3), meets the standards for operation with respect to those services. For the purposes of this contract, entity will be referred to as Resource Center.

10. **Assets:** any interest in real or personal property that can be used for support and maintenance. "Assets" includes motor vehicles, cash on hand, amounts in checking and savings accounts, certificates of deposit, money market accounts, marketable securities, other financial instruments and cash value of life insurance.

11. **Assistance:** cueing, supervision or partial or complete hands-on assistance from another person.

12. **Auxiliary Aids and Services:** includes qualified interpreters, screen readers, note takers, telephone headset amplifiers, telecommunications devices, qualified readers, audio recordings, large print or Braille materials, or other effective methods of making materials available to individuals with hearing or visual impairments.

13. **Balanced Work Force:** an equitable representation of handicapped persons, minorities and women in each level (job category) of a work force which approximates the percentage of individuals with disabilities, minorities, and women available for jobs at each level from the relevant labor market from which the contractors/vendor recruits job applicants.

14. **Behavior Modifying Medication**: a psychotropic medication (i.e., prescription medication within the classification of antipsychotic, mood stabilizer, anti-anxiety, antidepressant, or stimulant and/or medication outside of these classifications utilizing off-label use as a means to regulate behaviors).

15. **Benefit:** the package of services provided by the MCO under this contract to which a member has access if, within the benefit, a specific service is identified as a service necessary to support long term care outcomes. The benefit packages that may be contracted for under this contract are:

    a) The Family Care Benefit Package

        i. The home and community-based waiver services defined in Addendum VII.A;
        ii. The Medicaid State Plan Services identified in Addendum VII.B; and
        iii. Any cost-effective health care services the MCO substitutes for a Medicaid State Plan service.

    b) The Partnership Benefit Package

        i. The home and community-based waiver services defined in Addendum VII.A;
        ii. All Medicaid State Plan Services identified in Addendum VII.C; and
        iii. Any cost-effective health care services the MCO substitutes for a Medicaid State Plan service.

16. **Business Day:** Monday through Friday, except days which the office of the Managed Care Organization is closed.

17. **Care Management** (also known as Case Management or Service Coordination)**:** individualized assessment and care planning, authorizing, arranging and coordinating services in the member-centered plan (MCP) and periodic reassessments and updates of the MCP. Care management also includes assistance in filing grievances and appeals, maintaining eligibility, accessing community resources and obtaining advocacy services.

18. **Centers for Medicare and Medicaid Services** (CMS)**:** the federal agency responsible for oversight and federal administration of Medicare and Medicaid programs.

19. **Client Rights:** see Member Rights in this section.

20. **Cold Call Marketing:** any unsolicited personal contact by the MCO, including its employees, agents, subcontractors, and providers, with a potential enrollee for the purpose of marketing as defined in Article I.

21. **Community Supports:** supports and services that are not authorized or paid for by the MCO and that are readily available to the general population.

22. **Complex Medication Regime**: the member takes eight (8) or more scheduled prescription medications for three (3) or more chronic conditions. Chronic conditions include, but are not limited to, dementia or other cognitive impairment (including intellectual and/or developmental disability), heart failure, diabetes, end-stage renal disease, dyslipidemia, respiratory disease, arthritis or other bone disease, and mental health disorders such as schizophrenia, bipolar disorder, depression or other chronic and disabling mental health conditions. Medication classes of particular concern are: anticoagulants, antimicrobials, bronchodilators, cardiac medications, central nervous system (CNS) medications, and hormones.

23. **Comprehensive Assessment:** an initial and ongoing part of the member-centered planning process employed by the interdisciplinary team (IDT) to identify the member's outcomes and the services and supports needed to help support those outcomes. It includes an ongoing process of using the knowledge and expertise of the member and caregivers to collect information about:

    a) The member's needs, strengths and outcomes;

    b) The member's resources, natural supports and community connections through significant others, family members and friends;

    c) Any ongoing conditions of the member or other risk factors that require a course of treatment or regular care monitoring; and

    d) The member's preferences for the way in which the services and supports identified in the member-centered planning process will be delivered or coordinated by IDT staff.

24. **Confidential Information:** all tangible and intangible information and materials accessed or disclosed in connection with this contract, transferred or maintained in any form or medium (and without regard to whether the information is owned by the Department or by a third party), that consist of:

    a) Personally Identifiable Information;

    b) Individually Identifiable Health Information;

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

    d) Information designated as confidential in writing by the Department.

25. **Conflict of Interest:** a situation where a person or entity other than the member is involved in planning or delivery of services to the member, and has an interest in, or the potential to benefit from, a particular decision, outcome or expenditure.

26. **Contract/this Contract/the Contract:** this contractual agreement between the Wisconsin Department of Health Services and the Managed Care Organization.

27. **Cost Share:** the contribution toward the cost of services required under 42 C.F.R. § 435.726 as a condition of eligibility for Medicaid for some members who do not otherwise meet Medicaid categorical or medically needy income limits.

28. **County Agency:** a county department of aging, social services or human services, an aging and disability resource center, a long-term care district or a tribal agency that has been designated by the Department of Health Services to determine financial eligibility and cost sharing requirements.

29. **Crime:** conduct which is prohibited by state or federal law and punishable by fine or imprisonment or both. Conduct punishable only by forfeiture is not a crime.

30. **Days:** calendar days unless otherwise noted.

31. **Department:** the Wisconsin Department of Health Services (DHS) or its designee.

32. **Developmental Disability:** a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome. This also includes an intellectual disability diagnosed before age 18 and characterized by below-average general intellectual function and a lack of skills necessary for daily living, or another neurological condition closely related to such intellectual disability or requiring treatment similar to that required for such intellectual disability, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. "Developmental disability" does not include senility that is primarily caused by the process of aging or the infirmities of aging.

33. **DHS:** the Wisconsin Department of Health Services.

34. **Donation:** something of value voluntarily transferred by or on behalf of a member to the MCO without compensation.

    a) Something of value means cash or some other existing identifiable items that has a fair market value of more than $100.00.

    b) Voluntarily transferred means any of the following:

        i. The member or another person on behalf of the member transferring the item of value has the intention to voluntarily give it without compensation;

        ii. The member or other person on behalf of the member transferring the gift is legally competent (in order to have intention);

iii. The MCO receiving the gift is an eligible recipient (e.g., some entities have prohibitions against employees accepting gifts);
iv. The item of value is an existing identifiable thing (e.g., a promise to give something in the future is not a gift); or
v. The item of value is actually transferred.

35. **Dual Eligible:** refers to an individual who meets the requirements to receive benefits from both the Federal Medicare Program and the Wisconsin Medicaid Program. "Dual eligibility" does not guarantee "dual coverage."

36. **Elder Adult at Risk:** as defined in Wis. Stat. § 46.90(br), means any person age 60 or older who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self–neglect, or financial exploitation.

37. **Emergency Medical Condition:** 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:

    a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

    b) Serious impairment to bodily functions; or

    c) Serious dysfunction of any bodily organ or part.

38. **Emergency Services:** covered inpatient and outpatient services that are:

    a) Furnished by a provider that is qualified to furnish these services under Title 19 of the Social Security Act; and

    b) Needed to evaluate or stabilize an emergency medical condition.

39. **Encounter Reporting:** the collection and reporting of encounter data to the Department of Health Services is submitted via the LTCare Information Exchange System (IES). Encounter data are detailed records of health care services or items that have been provided to MCO members. Encounter data are used for rate setting and program analysis.

40. **End Stage Renal Disease** or **ESRD:** the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

41. **Enrollee:** see Member in this section.

42. **Enrollment Consultant:** the individual who performs enrollment consulting activities to potential enrollees such as, answering questions and providing information in an unbiased manner on available delivery system options, including the option of enrolling in an MCO and advising on what factors to consider when choosing among these options.

43. **Experimental Surgery and Procedures:** "experimental" means a service, procedure, item or treatment that is "not proven and effective" for the conditions for which it is intended to be used.

44. **Fair Hearing:** a de novo proceeding under Wis. Admin. Code § HA 3, before an impartial administrative law judge in which the petitioner or the petitioner's representative presents the reasons why an action or inaction by the Department of Health Services, a county agency, a resource center or an MCO in the petitioner's case should be corrected.

45. **Family Care:** a capitated Medicaid managed care program for the delivery of all Medicaid long-term care services. Members enrolled in Family Care may be eligible at a Wisconsin Medicaid nursing home-certifiable level of care or at a non-nursing home level of care. One of these functional levels of care is required as a condition of eligibility.

46. **Family Care Benefit:** see Benefit in this section.

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

48. **Financial Abuse:** a practice that is inconsistent with sound fiscal, business, or medical practices and results in unnecessary program costs or any act that constitutes financial abuse under applicable Federal and State law. Financial abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Managed Care Organization, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Financial abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

49. **Financial Eligibility** and **Cost-Sharing Screen:** a uniform screening tool prescribed by DHS that is used to determine financial eligibility and cost-sharing under Wis. Stat. §§ 46.286(1) (b) and (2) and Wis. Admin. Code §§ DHS 10.32 and 10.34.

50. **Financial Exploitation:** includes any of the following acts:

    a) Fraud, enticement or coercion;

    b) Theft;

    c) Misconduct by a fiscal agent;

    d) Identity theft;

    e) Unauthorized use of the identity of a company or agency;

f) Forgery; or

g) Unauthorized use of financial transaction cards including credit, debit, ATM and similar cards.

51. **Frail Elder:** an individual who is 65 years of age or older and has a physical disability or irreversible dementia that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.

52. **Fraud:** any intentional deception made for personal gain or to damage another individual, group, or entity. It includes any act that constitutes fraud under applicable federal or state law. Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. 1347).

53. **Functional Capacity:** the skill to perform activities in an acceptable manner.

54. **Gift:** something of value voluntarily transferred by one person or entity to another person or entity without compensation.

a) Something of value means cash or some other existing identifiable thing that has a fair market value of more than $100.00.

b) Voluntarily transferred means:

i. The person or entity transferring the thing of value has the intention to voluntarily give it without compensation; and
ii. The person transferring the gift is competent (in order to have intention); and
iii. The person or entity receiving the gift is an eligible recipient (e.g., some entities have prohibitions against employees accepting gifts); and
iv. The thing of value is an existing identifiable thing (e.g., a promise to give something in the future is not a gift); and
v. The thing of value is actually transferred.

55. **Group A:** persons age 18 and over who are financially eligible for full-benefit Medicaid on a basis separate from qualifying to receive home-and-community-based waiver services.

56. **Group B:** persons age 18 and over who are not in Group A, meet the non-financial requirements to receive home and community-based waiver services and have a gross monthly income no greater than a special income limit equal to 300% of the SSI federal benefit rate for an individual.

57. **Group B+:** persons age 18 or over not in Group A, meeting all requirements for Group B except for income, whose monthly income after subtracting the cost of institutional care is at or below the medically needy income limit.

58. **Harassment:** any unwanted offensive or threatening behavior, which is linked to one or more of the below characteristics when:

    a) Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or eligibility for services;

    b) Submission to or rejection of such conduct by an individual is used as the basis for employment or service decisions affecting such individual; or

    c) Such conduct has the purpose or effect of substantially interfering with an individual's work performance, or of creating an intimidating, hostile or offensive work or service delivery environment, which adversely affects an individual's opportunities.

    Harassing behavior may include, but is not limited to, demeaning or stereotypical comments or slurs, ridicule, jokes, pranks, name calling, physical or verbal aggression, gestures, display or possession of sexually graphic materials, cartoons, physical contacts, explicit or implicit threats separate from supervisory expressions of intention to use the disciplinary process as a consequence of continued inappropriate behavior, malicious gossip or any other activity that contributes to an intimidating or hostile work environment.

    Sexually harassing behavior is unwelcome behavior of a sexual nature toward males or females which may include, but, is not limited to, physical contact, sexual advances or solicitation of favors, comments or slurs, jokes, pranks, name calling, gestures, the display or possession of sexually graphic materials which are not necessary for business purposes, malicious gossip and verbal or physical behaviors which explicitly or implicitly have a sexual connotation.

    Harassment is illegal when it is a form of discrimination based upon age, disability, association with a person with a disability, national origin, race, ancestry or ethnic background, color, record of arrest or conviction which is not job-related, religious belief or affiliation, sex or sexual orientation, marital status, military participation, political belief or affiliation, and use of a legal substance outside of work hours.

59. **Home:** a place of abode and lands used or operated in connection with the place of abode.

60. **Hospital:** has the meaning specified in Wis. Stat. § 50.33(2).

61. **Incident Management System**: a System which manages incidents occurring at the member and provider levels and includes the activities of incident discovery, report, response, investigation, remediation, and data collection and analysis in order to a) assure

member health and safety; b) reduce member incident risk(s), and; c) enable development of strategies to prevent future incident occurrence(s).

62. **Income Maintenance Agency or IM Agency:** a subunit of a county, consortia, or tribal government responsible for administering IM Programs including Wisconsin Medicaid; formerly known as the Economic Support Agency.

63. **Indian:** an individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. 136.12. This means the individual:

    a) Is a member of a Federally recognized Indian tribe; or

    b) Resides in an urban center and meets one or more of these four criteria:

        i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
        ii. Is an Eskimo or Aleut or other Alaska Native;
        iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;
        iv. Is determined to be an Indian under regulations issued by the Secretary; or

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

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

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

65. **Individual at Risk:** an elder adult at risk (age 60 and over) or an adult at risk (age 18-59).

66. **Individually Identifiable Health Information:** member demographic information, claims data, insurance information, diagnosis information, and any other information that relates to an individual's past, present or future physical or mental health or condition, provision of health care, or payment for health care that identifies the individual or could reasonably be expected to lead to the identification of the individual.

67. **Ineligible Person**: a person is ineligible for membership in the MCO if the person fails to meet the eligibility requirements specified in Article III, as determined by the Department, the resource center or income maintenance agency prior to enrollment in the MCO, or if the person determined to be eligible prior to enrollment no longer meets

eligibility requirements as determined by DHS, the resource center or income maintenance agency.

68. **Institution for Mental Disease:** a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

69. **Instrumental Activities of Daily Living** or **IADLs:** management of medications and treatments, meal preparation and nutrition, money management, using the telephone, arranging and using transportation and the ability to function at a job site.

70. **Interdisciplinary Team** or **IDT:** the member and individuals identified by the MCO to provide care management services to members.

71. **Interdisciplinary Team Staff:** individual employees assigned to an IDT that shall have specialized knowledge of the conditions of the target populations served by the MCO, the full-range of long-term care resources and community alternatives.

72. **Interdisciplinary Team for County Elder Adults/Adults at Risk** or **I-Team:** a group of selected professionals from a variety of disciplines who meet regularly to discuss and provide consultation on specific cases of elder abuse, neglect or exploitation. An I-Team uses the varied backgrounds, training and philosophies of the different professions to explore the best service plan for the cases involved.

73. **Legal Decision Maker:** a member's or potential member's legal decision maker is a person who has the legal authority to make certain decisions on behalf of a member or potential member. A legal decision maker may be a guardian of the person or estate (or both) registered under Chapter 53 of the Wisconsin Statutes, a guardian of the person or estate (or both) appointed under Chapter 54 of the Wisconsin Statutes, a conservator appointed under Chapter 54 of the Wisconsin Statutes, a person designated power of attorney for health care under Chapter 155 of the Wisconsin Statutes or a person designated durable power of attorney under Chapter 244 of the Wisconsin Statutes. A legal decision maker may have legal authority to make certain kinds of decisions, but not other kinds of decisions. A member may have more than one legal decision maker authorized to make different kinds of decisions. In any provision of this Contract in which the term "legal decision maker" is used, it applies only to a person who possesses the legal authority relevant to that provision. A person designated by the member or potential member as an "authorized representative" under 42 C.F.R. § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker.

74. **Limited English Proficient (LEP):** potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

75. **Long-Term Care Benefit Package/LTC Benefit Package:** the services identified in Addendum VII, Benefit Package Service Definitions, sections A and B.

76. **Long-Term Care District:** a special purpose district created under Wis. Stat. § 46.2895(1).

77. **Long-Term Care Facility:** a nursing home, adult family home, community-based residential facility or residential care apartment complex.

78. **Long-Term Care Functional Screen** or **LTC FS:** a uniform screening tool prescribed by DHS that is used to determine functional eligibility under Wis. Stat. §§ 46.286(1) (a) and (1m) and Wis. Admin. Code §§ DHS 10.32 and 10.33.

79. **Managed Care Organization** or **MCO:** an entity that the Department has certified as having capacity for financial solvency and stability as defined in Article XVII, Fiscal Components/Provisions, and which has agreed under this contract to make the services in the benefit package defined in Article VII, Services, available to members for payment as defined in Article XVIII, Payment to the Managed Care Organization.

80. **Marketing/Outreach:** any communication, sponsorship of community events, or the production and dissemination of marketing/outreach materials from an MCO, including its employees, agents, subcontractors, and providers, to an individual who is not enrolled in that entity that can reasonably be interpreted as intended to influence the individual to enroll in or not to enroll in that particular managed care organization's Medicaid product, or to disenroll from another managed care organization's Medicaid product. Communications from a Qualified Health Plan to Medicaid beneficiaries are excluded from the definition of marketing, even if the issuer of the Qualified Health Plan is also an entity providing Medicaid managed care.

81. **Marketing/Outreach Materials:** materials in all mediums, including but not limited to, internet, brochures and leaflets, newspaper, magazine, radio, television, billboards, yellow pages, advertisements, other print media and presentation materials, used by or on behalf of the MCO to communicate with individuals who are not members, and that can be reasonably interpreted as intended to influence the individuals to enroll or reenroll in the MCO.

82. **Master Client Index** or **MCI:** this index is a way to identify the same person between different computer systems. Client Assistance for Reemployment and Economic Support (CARES), the LTC Functional Screen and the ForwardHealth interChange system all use MCI. The member ID used in the ForwardHealth interChange system is also that member's MCI.

83. **Medicaid:** the Wisconsin Medical Assistance program operated by the Wisconsin Department of Health Services under Title XIX of the Federal Social Security Act, Wis. Stats. ch. 49 and related state and federal rules and regulations. The term "Medicaid" will

be used consistently in this contract. However, "Medicaid" is also known as "MA," "Medical Assistance," and "Wisconsin Medical Assistance Program" or "WMAP."

84. **Medicaid Deductible:** a way of attaining full-benefit Medicaid financial eligibility in which an applicant is given a six-month deductible period in which incurred medical and remedial costs can be used to lower excess income to medically needy limits. The applicant's deductible amount is equal to six times the difference between net monthly income and the monthly medical needy limit. Once the applicant has met the deductible, the person becomes eligible for Medicaid for the remainder of the six-month period and may enroll in Family Care. A person can also pre-pay a deductible instead of incurring medical and remedial expenses.

85. **Medicaid Recipient:** any individual receiving benefits under Title XIX of the Social Security Act and the Medicaid State Plan as defined in Wis. Stats. ch. 49.

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

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

88. **Medically Necessary Services:** for the State plan services in Addendum VII.B and C medically necessary has the meaning in Wis. Admin. Code DHS §101.03(96m): Medicaid services (as defined under Wis. Stat. § 49.46 and Wis. Admin. Code § DHS 107) that are required to prevent, identify or treat a member's illness, injury or disability; and that meet the following standards:

    a) Are consistent with the member's symptoms or with prevention, diagnoses or treatment of the member's illness, injury or disability;

    b) Are provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

    c) Are appropriate with regard to generally accepted standards of medical practice;

    d) Are not medically contraindicated with regard to the member's diagnoses, symptoms, or other medically necessary services being provided to the member;

    e) Are of proven medical value or usefulness and, consistent with Wis. Admin. Code § DHS 107.035 are not experimental in nature;

    f) Are not duplicative with respect to other services being provided to the member;

    g) Are not solely for the convenience of the member, the member's family or a provider;

h) With respect to prior authorization of a service and other prospective coverage determinations made by DHS, are cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and

i) Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

For the home and community-based waiver services in Addendum VII.A medically necessary means that the service is reasonable, appropriate and cost-effectively addresses a member's assessed long-term care need or outcome related to any of the following purposes:

a) The prevention, diagnosis, and treatment of a disease, condition, and/or disorder that results in health impairments and/or disability;

b) The ability to achieve age-appropriate growth and development;

c) The ability to attain, maintain, or regain functional capacity; and

d) The opportunity to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

89. **Medication Review and Intervention:** a comparison of medications prescribed by health care providers and medications taken by the member.

90. **Member:** a person who is currently enrolled in a Managed Care Organization (MCO).

91. **Member-Centered Plan** or **MCP:** a record that documents a process by which the member and the interdisciplinary team staff further identify, define and prioritize the member's outcomes initially identified in the comprehensive assessment. The MCP also identifies the services and supports, paid or unpaid, provided or arranged by the MCO including the frequency and duration of each service (e.g., start and stop date), and the provider(s) that will furnish each service. The MCP identifies long-term care outcomes, personal experience outcomes, and any risks.

92. **Member Handbook/Evidence of Coverage:** a document describing the program benefits and policies that is approved by the Department and distributed to members. The handbook must meet all the handbook requirements identified in Article IX, Marketing and Member Materials. For the Partnership programs, the member handbook is known in the Medicare program as the Evidence of Coverage (EOC).

93. **Member Materials:** materials in all mediums to inform members of benefits, procedures, formularies and provider networks, including but not limited to, handbooks and brochures used by or on behalf of the MCO to communicate with enrolled members.

94. **Member Rights:** the rights outlined in applicant information materials and the Member Handbook/Evidence of Coverage as approved by DHS consistent with Wis. Admin. Code § DHS 10.51.

95. **Member's Home:** living quarters in which a member resides that is owned or leased by the member or member's family.

96. **Memorandum of Understanding** or **MOU:** an agreement detailing the actions of two parties under circumstances specified in the agreement.

97. **Natural Supports:** individuals who are available to provide unpaid, voluntary assistance to the member in lieu of 1915(c) waiver and/or State Plan home and community-based services (HCBS). They are typically individuals from the member's social network (family, friends, neighbors, etc.).

98. **Necessary Long-Term Care Services and Supports:** any service or support that is provided to assist a member to complete daily living activities, learn new skills, maintain a general sense of safety and well-being, or otherwise pursue a normal daily life rhythm, and that meets the following standards:

    a) Is consistent with the member's comprehensive assessment and member-centered plan;

    b) Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

    c) Is appropriate with regard to the Department's and MCO's generally accepted standards of long-term care and support;

    d) Is not duplicative with respect to other services being provided to the member;

    e) With respect to prior authorization of a service and other prospective coverage determinations made by the MCO, is cost-effective compared to an alternative necessary long-term care service which is reasonably accessible to the member; and,

    f) Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

99. **Neglect:** the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. "Neglect" does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual's previously executed declaration or do−not−resuscitate order under ch. 154, Wis. Stats., a power of attorney for health care under ch. 155, Wis. Stats., or as otherwise authorized by law. *See*, Wis. Stat. s.46.90(1)(f).

100. **Non-Nursing Home Level of Care:** a level of care in the Family Care program only, which is defined in s. 46.286(1)(a)2m., Wis. Stats.

101. **Nursing Home:** has the meaning specified in s. 50.01(3), Wis. Stats.

102. **Nursing Home Level of Care:** a level of care provided in a nursing facility and reimbursable under the Medicaid program.

103. **Office of the Commissioner of Insurance** or **OCI:** for Family Care, the OCI issues the annual permits to operate the program, monitors the MCO's financial solvency (i.e. financial position), and performs financial examinations of the MCOs. For Partnership the OCI issues the HMO license, monitors the HMO's solvency, and performs financial examinations of the HMO in accordance with prescribed insurance laws and regulations.

104. **Outcome:** a desirable situation, condition, or circumstance in a member's life that can be a result of the support provided by effective care management. Outcomes defined include:

    a) **Clinical outcome** is an identified need, condition or circumstance that relates to a member's individual physical, mental, or emotional health, safety, or well-being. Clinical outcomes are objectively measurable by someone other than the member, and their presence or absence can be determined without knowing the member's preferences regarding the condition or circumstance. Clinical outcomes, along with functional outcomes, are referred to as "long term care" outcomes on the Member Care Plan (MCP).

    b) **Functional outcome** is an identified need, condition or circumstance that results in limitations on the member's ability to perform certain functions, tasks, or activities and require additional support to help the member maintain or achieve their highest level of independence. This includes, but is not limited to, assistance with Activities of Daily Living and Instrumental Activities of Daily Living. The presence, absence, or degree of functional outcomes can be objectively measurable by someone other than the member, and their presence or absence can be determined without knowing the member's preferences regarding the functional ability. Functional outcomes, along with clinical outcomes, are referred to as "long term care" outcomes in the member's MCP.

    c) **Personal-experience outcome** is a desirable situation, condition, or circumstance that a member identifies as important to him/her. A personal experience outcome is measurable primarily by the member.

    d) **Long term care outcome** is a situation, condition, or circumstance that a member, or IDT staff, identifies that maximizes a member's highest level of independence. This outcome is based on the members identified clinical and functional outcomes.

    Throughout this contract the use of the term "outcomes" refers to both long term care outcomes (comprised of clinical and functional outcome identification) as well as personal experience outcomes, unless otherwise specified (e.g., health and safety outcomes, quality outcomes).

105. **Participant:** see Member in this section.

106. **Partnership:** means the Wisconsin Family Care Partnership program. A capitated integrated Medicaid and Medicare managed care program that, in addition to the Family Care long-term care benefits, provides managed health care benefits, and all applicable Medicare Advantage Special Needs Plan and Medicare Part D prescription drug benefits. All members enrolled in Partnership have a Wisconsin Medicaid nursing home-certifiable level of care, which is required as a condition of eligibility. As a fully integrated program, all supports and services – whether Medicare or Medicaid benefits – are delivered through the Partnership model design identified in this contract

107. **Partnership Benefit:** see Benefit in this section.

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

    a) The individual's Social Security number;

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

    c) The individual's date of birth;

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

    e) The individual's DNA profile; or

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

109. **Physical Abuse:** the willful or reckless infliction of bodily harm. Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

110. **Physical Disability:** a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, “major life activity” means self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking and capacity for independent living.

111. **Post-Eligibility Treatment of Income:** see Cost Share in this section.

112. **Post Stabilization Services:** services related to an emergency medical condition that are either provided:

   a) After a member is stabilized in order to maintain the stabilized condition; or

   b) To improve or resolve the member's condition.

   Coverage of Post Stabilization Services is defined under Article VII, Services, Section C.2.d., of this contract.

113. **Potential Enrollee** or **Potential Member:** a person who is or may be eligible to enroll in a managed care organization but is not yet a member.

114. **Primary Care:** health care provided by a medical professional with whom a patient has initial contact and by whom the patient may be referred to a specialist for further treatment. Services are provided to the patient with a goal of providing a broad spectrum of care, both preventive and curative, over a period of time. Activities include coordinating all of the care the patient receives and, ideally, the provision of continuity and integration of health care. Family practice and general practice physicians and most pediatricians, internists, and obstetricians/gynecologists are considered as primary care physicians.

115. **Private Pay Individual:** a person who:

   a) Would like to pay privately for services and supports, including but not limited to care management and long-term care; and

   b) Meets the requirements of one of the following:

      i. Wis. Admin. Code § DHS 10.37(1)(b)(1); or

      ii. Wis. Admin. Code § DHS 10.37(1)(b)(2); or

      iii. Wis. Admin. Code § DHS 10.37(1)(b)(3).

116. **Provider:** any individual or entity that has a provider agreement with the MCO or a subcontractor and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Department's contract with an MCO.

117. **Provider Agreement:** a written agreement between a provider as defined under 116 of this Article and the MCO or a subcontractor to provide services to the MCO's members.

118. **Provider Preventable Condition:** means a condition that meets either of the following criteria:

   a) Is a Healthcare Acquired Condition. A Healthcare Acquired Condition is a condition listed below occurring in any inpatient hospital setting:

      i. Foreign object retained after surgery;

      ii. Air embolism;

iii. Blood incompatibility;

iv. Stage III and IV pressure ulcers;

v. Falls and trauma; including fractures, dislocations, intracranial injuries, crushing injuries, burns, other injuries;

vi. Catheter-associated urinary tract infection (UTI);

vii. Vascular catheter-associated infection;

viii. Manifestations of poor glycemic control including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity;

ix. Surgical site infection following coronary artery bypass graft (CABG)-Mediastinitis;

x. Surgical site infection following bariatric surgery for obesity, including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery;

xi. Surgical site infection following certain orthopedic procedures including spine, neck, shoulder, and elbow;

xii. Surgical site infection following cardiac implantable electronic device (CIED);

xiii. Deep vein thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions; or

xiv. Latrogenic pneumothorax with venous catheterization.

b) Is an Other Provider-Preventable Condition. An Other Provider-Preventable Condition is a condition occurring in any health care setting that meets the following criteria:

i. Is identified in the State plan;
ii. Has been found by the State, based upon a review of the medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
iii. Has a negative consequence for the beneficiary;
iv. Is auditable; and
v. At a minimum includes:

- Wrong surgical or other invasive procedure performed on a patient;
- Surgical or other invasive procedure performed on the wrong body part;
- Surgical or other invasive procedure performed on the wrong patient.

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

120. **Re-enrollee:** an individual who is disenrolled from Family Care and then re-enrolled in the same MCO within 30 calendar days.

121. **Regional Long-Term Care Committee:** has the meaning specified in Wis. Stat. § 46.2825.

122. **Residential Care Apartment Complex** or **RCAC:** a place where 5 or more adults reside that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, including a stove, and individual bathroom, sleeping and living areas, and that provides, to a person who resides in the place, not more than 28 hours per week of services that are supportive, personal and nursing services. "Residential care apartment complex" does not include a nursing home or a community-based residential facility, but may be physically part of a structure that is a nursing home or community-based residential facility.

123. **Resource Allocation Decision (RAD) Method:** the Department's approved method of authorizing services.

124. **Resource Center:** see Aging and Disability Resource Center in this section.

125. **Restrictive Measure:** any type of restraint, isolation, seclusion, protective equipment, or medical restraint.

126. **Secretary:** means the secretary of the Wisconsin Department of Health Services.

127. **Self-neglect:** means a significant danger to an individual's physical or mental health because the individual is responsible for his/her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care. *See*, Wis. Stat. s. 46.90(1)(g).

128. Service Area: the geographic area within which potential members must reside in order to enroll and remain enrolled in the MCO under this contract. To be eligible to enroll in an MCO, a potential member must be a resident of the county (or one of the counties) listed in Article XIX, MCO Specific Contract Terms.

129. **Services Necessary to Support Outcomes:** services necessary to support outcomes are identified in the member's Member-Centered Plan and include both necessary long-term care services and medically necessary services. The MCO can offer reasonable alternative services that meet a member's needs and support desired outcomes at less expense. Reasonable alternatives are those which:

    a) Have been effective for persons with similar needs;

b) Would not have a negative impact on desired outcomes; and.

c) Are likely to support the desired outcomes.

130. **Sexual Abuse:** sexual conduct in the first through fourth degrees as defined in Wis. Stat. § 940.225.

131. **Subcontract:** a written agreement between the MCO and a subcontractor as defined under 132 of this Article to fulfill the administrative requirements of this contract.

132. **Subcontractor:** any individual or entity that has a contract with the MCO that relates directly or indirectly to the performance of the MCO's obligations under its contract with the Department except for the provision of services to the MCO's members.

133. **Target Population:** any of the following groups that a managed care organization has contracted with DHS to serve:

a) Frail elderly.

b) Adults with a physical disability.

c) Adults with a developmental disability.

134. **Third Party Administrator** or **TPA:** a service business that provides health and other service claims processing services, as an independent agent under contract with the MCO. In addition to the control, adjudication and payment of service claims, the services generally encompass some level of other claims processing related functions; enrollment, service plan and pricing maintenance, service provider data management, service-authorization management, reporting of encounter data, financial reporting, provider management and claims related customer service support and other services, depending on the scope of the contract.

135. **Urgent Care:** medically necessary care that is required by an illness or accidental injury that is not life-threatening and will not result in further disability but has the potential to develop such a threat if treatment is delayed longer than twenty-four (24) hours.

136. **Voluntary Contributions, Payments or Repayments:** member choice to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, reduce potential claim in an estate, or in gratitude for Medicaid services that were provided. The payment is made to the State Medicaid program. A member cannot pay more than the amount Medicaid has paid for that individual.

137. **Vulnerable/High Risk Member (VHRM):** a member who is dependent on a single caregiver, or two or more caregivers all of whom are related, to provide or arrange for the provision of nutrition, fluids or medical treatment that is necessary to sustain life and to whom at least one of the following applies:

a) Is nonverbal and unable to communicate feelings or preferences; or

b) Is unable to make decisions independently; or

c) Is clinically complex, requiring a variety of skilled services or high utilization of medical equipment; or

d) Is medically frail.

II. MCO Governance and Consumer and Member Involvement

A. MCO Governing Board

The MCO shall have a governing board that provides input to the MCO decision-making process. When an MCO takes action that is not consistent with the input of the governing board, the MCO Director shall provide the governing board with a written justification for the decision and the rationale for diverging from the governing board recommendation.

The MCO governing board shall meet the following specifications:

1. *Consumer Representation*

   At least one-fourth of the members of the board of a managed care organization shall be representative of the target group or groups whom the managed care organization is contracted to serve or those members' family members, legal decision makers, or other advocates.

2. *Separation from Eligibility/Enrollment*

   Assurance of the MCO's separation from the eligibility determination and enrollment counseling functions. The separation shall meet criteria established by the Department in accordance with Wis. Stat. § 46.285 and applicable federal guidelines.

3. *Long-Term Care District*

   If the MCO is operated by a long-term care district, as described in Wis. Stat. § 46.2895, the district shall meet the requirements for governance in Wis. Stat. § 46.2895.

4. *Separation from the Aging and Disability Resource Centers*

   No member of the MCO board may also be a member of a Resource Center board.

B. Regional Long-Term Care Advisory Committees

Regional Long-Term Care Advisory Committees are responsible for general planning and oversight functions which are specified in Wis. Stat. § 46.2825. If requested, the MCO shall provide information to these committees to the Regional Long-Term Care Advisory Committees and where appropriate, consider their recommendations.

C. MCO Member Advisory Committee

1. *Purpose*

   The MCO shall create and staff a Member Advisory Committee to advise the MCO on its policies and operations, how it is meeting the needs of members and how operations and outcomes may be improved. The Committee shall in addition

be a vehicle for members to participate in the MCO's quality management program under Article XII.

2. *Composition*

   The Committee shall include at least a reasonably representative sample of members from the MCO's target populations or other community individuals representing those members.

3. *Frequency of Meetings*

   The Member Advisory Committee shall meet at least once per year.

4. *Documentation*

   The MCO shall maintain documentation of the Committee's meetings and actions, such as attendance records, minutes, votes, recommendations and MCO responses, to document the types and level of the Committee's participation in the Quality Management program and other aspects of MCO oversight. It shall make this documentation available to the Department upon request.

III. Eligibility

A. Eligibility Requirements

1. *Age and Target Group*

   In order to be eligible to enroll in a Family Care or Partnership MCO, an individual must be in the age and target groups served by the MCO as specified in Article XIX, MCO Specific Contract Terms.

2. *Medicaid Eligibility*

   An individual must be eligible for full-benefit Medicaid as described in Chapter 21.2 of the Medicaid Eligibility Handbook (http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm) . Eligibility for Medicaid is verified using the Department's ForwardHealth interChange system.

3. *Functional Eligibility*

   Functional eligibility for Family Care and Partnership is determined using the Long-Term Care Functional Screen (See Section F., Long-Term Care Functional Screen of this Article).

   a. In order to be functionally eligible for Partnership, an otherwise eligible individual must have a nursing home level of care as determined by the Long-Term Care Functional Screen. The benefit package available to a Partnership member is identified in Addendum VII.A. and C.

   b. In order to be functionally eligible for Family Care, an otherwise eligible individual must have either a nursing home level of care or a non-nursing home level of care as determined by the Long-Term Care Functional Screen.

      i. The benefit package available to a Family Care member who has a nursing home level of care is identified in Addendum VII.A. and B.

      ii. The benefit package available to a Family Care member who has a non-nursing home level of care is identified in Addendum VII.B.

4. *Residency*

   To be eligible for Family Care or Partnership, an otherwise eligible individual must be a resident, as determined by the Department or income maintenance agency, of an area served by an MCO that offers the Family Care or Partnership program in which the individual intends to enroll.

5. *Choice to Enroll*

   An otherwise eligible individual must make the choice to enroll in the MCO that operates the program in which the person intends to enroll. The choice to enroll is

verified by the signature of the member or the member's legal decision maker on an enrollment form approved by the Department.

6. *Medicare Election (Partnership Only)*

   a. To enroll in Partnership, a prospective member who is eligible for Medicare must:

      i. Enroll in and remain enrolled in all parts of Medicare for which the prospective member is eligible (Medicare Part A, Part B and/or Part D);

      ii. Enroll in the MCO's Special Needs Plan if the member is eligible; and

      iii. Obtain all Medicare Part A, Part B and Part D benefits, if eligible, from the MCO's Special Needs Plan.

   b. If a Partnership member becomes Medicare-eligible after enrollment, the member must enroll in all parts of Medicare for which the member is eligible and must enroll in the MCO's Special Needs.

7. *End Stage Renal Disease (ESRD) (Partnership Only)*

   The following eligibility criteria apply to individuals with a diagnosis of ESRD:

   a. Individuals who are dual eligible and have a diagnosis of ESRD at the time of application are not eligible to enroll unless the MCO has secured the appropriate Medicare ESRD waiver from CMS.

   b. If a dual eligible individual is diagnosed with ESRD while enrolled in Partnership the individual is eligible to remain enrolled.

   c. If a Medicaid-only eligible individual becomes a dual eligible after enrollment, then is diagnosed as ESRD, the member must enroll in the MCO's Special Needs Plan.

   d. Individuals who are eligible for Medicaid only and have a diagnosis of ESRD at the time of application are eligible to enroll.

B. MCO Specific Eligibility Criteria

Each MCO may have geographical criteria limiting eligibility for enrollment established in Article XIX, MCO Specific Contract Terms.

C. Eligibility Determination Process

1. *Eligibility Determination Prior to Initial Enrollment*

   a. The MCO will assure the MCO's separation from the initial eligibility determination and enrollment counseling functions. The separation shall meet criteria established by the Department in accordance with Wis. Stat. § 46.285 and applicable federal guidelines.

b. MCOs may market directly to members or potential members only in accordance with a marketing plan that has been approved by the Department and may use only marketing materials that have been approved by the Department (see Article IX, Marketing and Member Materials).

c. The resource center coordinates eligibility determination prior to an individual's initial enrollment in an MCO.

i. The resource center determines functional eligibility using the Long-Term Care Functional Screen and coordinates application for Medicaid as needed.

ii. The resource center provides individuals with counseling about the range of long-term care programs and MCOs available.

iii. The resource center determines the individual's choice of program and MCO, and then processes the enrollment in ForwardHealth interChange.

2. *Functional Eligibility Re-determination*

Once enrolled, the MCO is responsible to assure that all members have a current and accurate level of care as determined by the Long-Term Care Functional Screen, in accordance with Section F. of this article. This includes at minimum an annual re-determination of level of care. It may also include a post-enrollment re-determination shortly after enrollment or a re-determination necessitated by a change in the member's condition.

3. *Assisting Members to Maintain Medicaid Eligibility*

The MCO is responsible for assisting members in their responsibility to maintain Medicaid eligibility. This may include:

a. Reminding members of the required annual Medicaid recertification procedure and assisting them to get to any needed appointments;

b. Assisting members to understand any applicable Medicaid income and asset limits and as appropriate and needed, supporting members to meet verification requirements;

c. Assisting members to understand any deductible, cost share or patient liability obligation they may need to meet to maintain Medicaid eligibility;

d. Assisting members to understand the implications of their functional level of care as it relates to the eligibility criteria for the program;

e. If appropriate and needed, assisting members to obtain a representative payee or legal decision maker; and

f. Referring members as needed to other available resources in the community that may assist members in obtaining or maintaining eligibility

such as Elder and Disability Benefits Specialists and advocacy organizations.

4. *Providing Information that May Affect Eligibility*

Members have a responsibility to report certain changes in circumstances that may affect Medicaid eligibility to the income maintenance agency within ten (10) calendar days of the change.

Notwithstanding the member's reporting obligations, if the MCO has information about a change in member circumstances that may affect Medicaid eligibility, the MCO is to provide that information to the income maintenance agency as soon as possible but in no event more than ten (10) calendar days from the date of discovery (see Article IV.0.2.c.).

Members who receive SSI benefits are required to report certain changes to the Social Security Administration rather than the local IM agency. MCOs should assist members in meeting these reporting requirements since loss of SSI has a direct impact on Medicaid eligibility.

Reportable information includes:

a. The member's functional eligibility as determined by the Long-Term Care Functional Screen using procedures specified by the Department;

b. The average monthly amount of medical/remedial expenses the member pays for out-of-pocket;

c. The housing costs the member pays for out-of-pocket, either in the member's own home or apartment or in a community-based residential care facility (see Section E of this article);

d. Non-payment of any required cost share (post eligibility treatment of income);

e. The member has died;

f. The member has been incarcerated;

g. The admission of a member who is age 21 or over and under age 65 to an Institute for Mental Disease;

h. The member has moved out of the county or service area;

i. Any known changes in the member's income or assets;

j. Any disqualifying Medicare coverage elections (Partnership only);

k. Changes in the member's marital status.

5. *Medicare Coverage Elections - Partnership*

The MCO is responsible to assist members to understand any Medicare coverage choices, including Medicare Advantage plan election periods, in order to avoid unintended disenrollment from the Partnership program.

D. Medicaid Deductibles or Cost Share

1. *Deductibles*

A member may attain full-benefit Medicaid financial eligibility through meeting a deductible (see Medicaid Eligibility Handbook Ch. 24.2, http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm). Such members are eligible in Group A without a cost share for the remainder of the deductible period. This will happen rarely in the Family Care Program, but can occur in the following situations:

a. Members who meet a nursing home level of care and who are newly enrolling in a home and community-based waiver program may have met a Medicaid deductible prior to enrollment and thereby become financially eligible for the remainder of the six-month deductible period (see MEH Ch.24.3). Such persons have no cost share. At the end of the deductible period the income maintenance agency will re-determine the member's financial eligibility, which in almost all cases will be under the special Home and Community-Based Services (HCBS) waiver eligibility group (Group B or B+). The member will then not have to meet a deductible but may have to pay a cost share depending on income and allowable deductions. The MCO shall explain these circumstances to the member and assist the member with the financial eligibility re-determination by the income maintenance agency at the end of the deductible period.

b. Members who meet a non-nursing home level of care may have met a Medicaid deductible prior to enrollment and thereby become financially eligible for the remainder of the six-month deductible period. At the end of the deductible period, the income maintenance agency will re-determine the member's Medicaid eligibility.

   i. Prior to the end of the deductible period, the MCO shall explain to the member that upon re-determination, unless the member will be eligible under a different Medicaid eligibility category or is able to prepay the deductible, the member will lose Medicaid eligibility and be disenrolled when the current deductible period ends until the member can meet the deductible in the next deductible period. The MCO shall review with the member how to meet the new deductible amount, including the option to prepay it in order to avoid a period of ineligibility.

   ii. The income maintenance agency will determine if the person is eligible under a different category of full-benefit Medicaid. If not, the agency will determine the new deductible amount and monitor whether it's met, including explaining the option to prepay the deductible.

2. *Cost Share or Patient Liability*

   a. Members may be required to pay a monthly cost share or patient liability in order to be eligible for Family Care or Partnership.

      i. Cost share, also called post eligibility treatment of income, applies to members who live in their own home, an adult family home, a community-based residential facility or a residential care apartment complex.

      ii. Patient liability applies to members who reside in a nursing home or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) for 30 or more consecutive days or are likely to reside there for 30 or more consecutive days.

   b. The income maintenance agency is responsible for determining the member's cost share or patient liability. Cost share is imposed on members in accordance with 42 C.F.R. § 435.726. Patient liability is imposed in accordance with 42 C.F.R. § 435.725. The Department will ensure that a member who has a cost share is not required to pay any amount in cost share which is in excess of the average capitation payment attributable to waiver services, as determined by the Department.

   c. The MCO is responsible for collecting the members' monthly cost share or patient liability, subject to the following Department policies and procedures:

      i. The MCO will send a bill to any member who has a cost share or patient liability in advance of or as early as possible during the month in which the cost share or patient liability is due.

         Members who were enrolled in IRIS as of the first day of the month in which they transition to Family Care or Family Care Partnership, generally pay the cost share amount for that month to their IRIS fiscal employer agent. If the MCO capitation payment was offset by the cost share amount for that month, the MCO will attempt to verify whether the member paid his or her cost share to an IRIS fiscal employer agent. If the MCO has documentation to verify the member paid the cost share to the fiscal employer agent, the MCO may request a capitation payment adjustment on an enrollment discrepancy report (see Article IV.0.5.a.).

      ii. Cost share and patient liability are not prorated for partial months.

      iii. The system logic that determines a member's patient liability amount can offset either a MCO capitation payment or a Nursing Home Fee-for-Service (NH FFS) claim, but not both. ForwardHealth automatically deducts the appropriate monthly patient liability amount from the first NH FFS claim or capitation payment received for the member. (See Forward-Health Online

Handbook topic #3188: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx).

Generally, when members residing in a NH are enrolled into a MCO and the enrollment includes past months, the NH FFS claim will be offset by the patient liability amount for the past month(s), and the subsequent capitation payment(s) for the past month(s) will not be offset by the patient liability amount. However, this depends on when the NH FFS claim is submitted and processed in the system, so MCOs should monitor the 820 transaction to determine whether or not the patient liability amount was used to offset the capitation payment.

If the patient liability amount was used to offset the capitation payment, the MCO should collect the liability amount.

The MCO will attempt to collect the patient liability amount from the nursing home when the 820 Report (see Article XV.E) indicates that the capitation payment was offset by the patient liability amount but the member already paid the patient liability to the nursing home.

The MCO will attempt to collect the patient liability amount from the member when the 820 Report indicates the capitation payment was offset by the patient liability amount, the paid FFS NH claim was not offset by the patient liability amount, and the member did not pay the patient liability to the nursing home.

The MCO will transfer the patient liability amount to the nursing home when the 820 Report indicates that the capitation payment was not offset by the patient liability amount but the member already paid the patient liability amount to the MCO.

iv. If a member fails to pay the cost share or patient liability as billed by the due date, the MCO will:

a) Contact the member to determine the reason for non-payment.

b) Determine whether the cost share or patient liability presents an undue hardship for which the MCO is willing to waive some or the entire obligation.

c) Remind the member that non-payment may result in loss of eligibility and disenrollment.

d) Attempt to convince the member to make payment or negotiate a payment plan.

e) Offer the member assistance with financial management services or refer the member for establishment of a representative payee or legal decision maker if needed.

f) If all efforts to assist the member to meet the financial obligation are unsuccessful, refer the situation to the income maintenance agency for ongoing eligibility determination and the ADRC for options counseling.

3. *Monitoring Cost Share or Patient Liability*

The MCO is responsible for the ongoing monitoring of the cost share or patient liability amounts of its members. The MCO is also responsible for knowing what the member's ongoing medical/remedial expenses are and reporting changes in those amounts to the income maintenance agency. The MCO is also responsible to report changes in other circumstances of members that may affect the amount of cost share or patient liability to the income maintenance agency within ten (10) calendar days of the MCO becoming aware of the change.

E. Room and Board

Members shall use their own income to pay for the cost of room and board. Any MCO contribution to member room and board obligation from capitation revenue shall not be considered a countable expense in developing MCO capitation rates. For each member who resides in community-based residential care as defined in Addendum VII.A.17, the MCO is responsible for all of the following tasks:

1. *Determining the Member's Room and Board Obligation*

The MCO determines the member's room and board obligation in the facility in which the member resides. The MCO shall use one method for all its members. It shall select one of the three following methods:

a. Actual Cost Methodology

This method requires calculation of actual room and board costs for each community residential facility with which the MCO contracts. Facility-specific costs are split between care and supervision on the one hand and room and board on the other. Total costs attributable to room and board are divided by the number of residents licensed or certified for the living arrangement to get a room and board rate.

i. Costs attributable to Room and Board:

a) Rent, mortgage payments, title insurance, mortgage insurance

b) Property and casualty insurance

c) Building and grounds maintenance costs

d) Residents' food

e) Household supplies and equipment necessary for the room and board of the individual

f) Furnishings used by the individual (does not include office furnishings)

g) Utilities

h) Resident's telephone, cable television

i) Property taxes

j) Specific individual special dietary needs

ii. Costs attributable to Care and Supervision. The following are allowable elements in residential provider rates for which FFP can be claimed:

a) Staff Costs:

- Salaries. In certain circumstances, a staff person's wages and benefits may need to be apportioned between room and board costs and care and supervision.
- FICA
- Staff health insurance
- Worker's compensation
- Unemployment compensation
- Staff travel
- Staff liability insurance
- Staff development and education

b) Resident travel (includes depreciation on vehicle)

c) Administrative overhead-contractor's costs to do business, including:

- Office supplies and furnishings
- Percentage of administrative staff salaries
- Office telephone
- Recruitment
- Audit fees
- Operating fees/permits/licenses
- Percentage of office space costs
- Data processing fees
- Legal fees
- Agency liability insurance

An MCO that uses this method is responsible for assuring that each residential care provider with which it contracts uses this method for identifying the portion of the facility rate attributable to room and board, for maintaining documentation or auditing providers to verify the accuracy of these calculations and for updating this information annually.

b. SSI-E Methodology

SSI-E Payment Standard - SSI-E or the SSI Exceptional Expense Supplement represents the highest combined federal and state SSI payment amount in Wisconsin. Eligibility for the supplement is based on qualifying for SSI and either residing in community residential care or needing at least 40 hours a month of supportive services in one's personal home. The flat rate equals the SSI-E payment amount minus a personal needs allowance the MCO may set at either $80 or $100 a month (must be the same for all members in community residential care in the MCO's service area). This flat rate method is used regardless of whether the member receives SSI or her/his income comes from other sources. Since the SSI-E amount changes annually, the MCO must update this room and board flat rate annually.

c. HUD Fair Market Rent (FMR) Methodology

HUD Fair Market Rate (FMR) Method - This method uses HUD FMR rental amounts as a proxy for housing costs. HUD FMR rents are set at the 40% percentile of surveyed rental costs reflecting modest but reasonable housing, include utilities, vary by county and apartment size, and are updated yearly. MCO's using this method use the prior year's efficiency rent for owner-occupied Adult Family Homes; the one bedroom rent for corporate-operated Adult Family Homes and Community Based Residential Facilities; and the two bedroom rent for Residential Care Apartment Complexes.

The board portion is set at a flat amount equal to the maximum Supplemental Nutrition Assistance Program (SNAP, called FoodShare in Wisconsin), allocation for one person plus a small amount for ancillary costs not included in the FMR or FoodShare figures. Figures are updated yearly.

2. *Determining the Member's Room and Board Obligation (Replaces E.1 effective 2/1/2021)*

The MCO determines the member's room and board obligation in the facility in which the member resides, excluding members who reside in subsidized housing. MCOs must update member room and board obligations annually on February 1st or upon member request.

The member's room and board obligation is the lesser of:

- The prior calendar year's HUD FMR rental amounts, based on residential type by county, plus the prior calendar year's maximum Supplemental Nutrition Assistance Allocation for one person;
    - HUD FMR amounts: https://www.huduser.gov/portal/datasets/fmr.html
    - SNAP allocation: https://www.dhs.wisconsin.gov/foodshare/fpl.htm
- The member's available income for room and board.

Round HUD FMR, SNAP allocation, and member's available income down to the nearest dollar. Use the prior calendar year's efficiency rent for owner-occupied Adult Family Homes, the one bedroom rent for corporate-operated Adult Family Homes and Community Based Residential Facilities, and the two-bedroom rent for Residential Care Apartment Complexes. Use the HUD FMR amount for the county where the member lives. For a member residing in a shared room, divide the HUD FMR by two and add the maximum SNAP allocation. To calculate the amount of income the member has available for room and board, MCOs must use the following calculation:

Deduct from the member's gross monthly income:

a. Discretionary income allowance of $100 for basic living expenses;

b. Health insurance premiums, defined in MEH 28.6.4.4;

c. Spousal income allocation, defined in MEH 18.6;

d. Income used for supporting others, defined in MEH 15.7.2.1;

e. Expenses associated with establishing and maintaining a guardianship, defined in MEH 15.7.2.3;

f. Court ordered fees and payments, defined in MEH 15.7.2.3;

g. Garnishments;

h. Deductions from unearned income, including IRS and SSA paybacks; and

i. State and federal income taxes.

3. *Determining the Member's Available Income*

The MCO determines the amount of available income the member has to pay for room and board, using procedures specified by the Department.

Room and board is not pro-rated for partial months.

4. *Implementing Contingencies if the Member Lacks Funds for Room and Board*

   If the member lacks sufficient income available to pay room and board in the facility, the MCO either:

   a. Develops an alternative plan of care to support the member's needs and outcomes; or

   b. May contribute to the member's payment to the facility. The MCO may use its discretion to determine an amount to contribute to the member's room and board obligation. Any MCO contribution to a member's room and board obligation from capitation revenue shall not be considered a countable expense in developing MCO capitation rates.

5. *Collecting and Giving the Member's Room and Board Obligation to the Residential Facility*

   The MCO shall collect the member's room and board obligation and give it to the residential facility on behalf of the member.

6. *Sharing Information with Income Maintenance*

   The MCO shall inform the income maintenance agency of the room portion of the member's room and board obligation. The room portion is always the member's obligation minus the maximum SNAP allocation (which is the board portion).That information may be used by income maintenance to determine any allowable excess housing costs that may reduce the member's cost-share.

F. Long-Term Care Functional Screen

1. *Functional Screen Tool and Database*

   The tool used for determining level of care is the Long-Term Care Functional Screen (LTC-FS). Information about the LTC FS is found at: https://www.dhs.wisconsin.gov/functionalscreen/index.htm.

2. *Notification of Changes in Functional Eligibility Criteria*

   The Department will notify the MCOs of any changes in administrative code requirements related to functional eligibility, including, but not limited to, code changes that result in changes to the LTC FS algorithms or logic in determining functional eligibility for the programs.

3. *Reimbursement*

   If the trained screener administering the LTCFS is an employee, or under direct supervision, of the MCO, no Medicaid administration reimbursement may be claimed for administration of the screen.

4. *Initial Level of Care Determinations*

   In most circumstances the initial level of care determination for an individual is performed by a resource center prior to enrollment in an MCO. Level of care

determinations may only be completed by an individual trained and certified to administer the LTCFS.

5. *Level of Care Re-Determinations*

The MCO shall develop procedures to assure that all members have a current and accurate level of care as determined by the LTCFS. Level of care re-determinations may only be completed by an individual trained and certified to administer the LTCFS.

The responsibility to assure that all members have a current and accurate level of care shall include:

a. Post-Enrollment Re-Determination

The MCO may re-determine level of care for a new member shortly after enrollment if the interdisciplinary team believes that different or additional information has come to light as a result of the initial comprehensive assessment.

The MCO shall consult with the ADRC if the MCO re-determines level of care for a newly enrolled member or when a newly enrolled member is found to be functionally ineligible or eligibility changes to a non-nursing home level of care within six (6) months of the submission of the most recent pre-enrollment screen. The MCO shall review and compare the screens, attempt to resolve the differences, and contact the Department or its designee if differences cannot be resolved.

b. Annual Re-Determination

An annual re-determination of level of care shall be completed within 365 days of the most recent functional screen.

If the level of care re-determination is not completed in the designated timeframe, the MCO is required to inform the income maintenance agency of the lack of functional eligibility determination according to change reporting requirements identified in Article IV, Enrollment and Disenrollment. (The member will lose eligibility if the re-determination is not done timely.)

c. Change of Condition Re-Determination

A re-determination of level of care should be done whenever a member's situation or condition changes significantly.

6. *Level of Care Determinations and Redeterminations for Private Pay Individuals*

Private pay individuals must meet the functional eligibility conditions for eligibility (see Article I for definition of "Private Pay Individual"). The initial level of care determination for a private pay individual is performed by the resource center and the annual redetermination of level of care is performed by the MCO.

7. *Accuracy of Information*

   The MCO shall not knowingly misrepresent or knowingly falsify any information on the LTC FS. The MCO shall also verify the information it obtains from or about the individual with the individual's medical, educational, and other records as appropriate to ensure its accuracy.

8. *Long-Term Care Functional Screener Certification*

   a. Education and Experience

      Before being allowed to administer the functional screen on individuals, MCO staff or MCO contractors must satisfy the following standards:

      i. Be a representative of an MCO with an official function in determining eligibility for a specific program area.

      ii. Have a license to practice as a registered nurse in Wisconsin pursuant to Wis. Stat. § 441.06, or a Bachelor of Arts or Science degree or more advanced degree in a health or human services related field (e.g. social work, rehabilitation, psychology), and a minimum of one year of experience working with at least one of the target populations.

      iii. Successfully complete the online screener certification training course(s) and become certified as a functional screener by the Department. Information on the online web class can be found at: https://wss.ccdet.uwosh.edu/stc/dhsfunctscreen and

      iv. Meet all other training requirements specified by the Department.

   b. Certified Screener Documentation

      Each MCO shall maintain documentation of compliance with the requirements set forth in section (a) above and make this documentation available to the Department upon request.

9. *Administration of the Screening Program*

   a. Listing of Screeners

      Each MCO shall maintain an accurate, complete, and up-to-date list of all the staff members and/or MCO contractors who perform functional screens. MCOs shall submit to the Department requests to have a screener's security access deactivated as follows:

      i. If the MCO terminates the employment of a screener, the MCO shall submit the deactivation request within one (1) business day of the screener's termination.

      ii. When a screener leaves the MCO and/or no longer has a need for access to the functional screen application, the agency shall submit

the deactivation request within three (3) business days of the departure or reassignment of the screener.

b. Communications

Each MCO that administers functional screens shall ensure that each screener is able to receive communications from the Department's functional screen listserv(s).

c. Mentoring

Each MCO that employs newly certified screeners shall have a formal program for mentoring new screeners (that is providing them with close supervision, on-the-job training, and feedback) for at least six months.

This program shall be described in internal policy and procedures documents that are made available to new screeners and to the Department upon request. Each MCO will include activities that allow new screeners to:

i. Observe an experienced screener administering an actual screen;

ii. Complete practice screens on a paper version of the LTC FS;

iii. Be observed by an experienced screener while completing screens or to have his/her screens reviewed by an experienced screener; and

iv. Have the opportunity for discussion and feedback as a result of those observations or reviews.

d. Screen Liaison

Each MCO shall designate at least one staff member as "Screen Liaison" to work with the Department in respect to issues involving the screens done by the MCO. This person must be a certified functional screener and, at Department determined intervals, successfully pass the required continuing skills testing. This person's current contact information must be provided to the Department.

i. Screeners shall be instructed to contact the Screen Liaison with questions when they need guidance or clarification on the screen instructions, and shall contact the Screen Liaison whenever a completed screen leads to an unexpected result in terms of eligibility or level of care;

ii. The duties of the Screen Liaison are to:

a) Provide screeners with guidance when possible, or contact the Department's Functional Screen Staff for resolution;

b) Consult with the Department or its designee on all screens that obtain an unexpected result or that are especially difficult to complete accurately;

c) Oversee new screener mentoring program as listed in 9.c.

d) Act as the contact person for all communications between the Department or its designee relating to functional screens and the screening program;

e) Ensure that all local screeners have received listserv communications and updates from the Department;

f) Act as the contact person other counties/agencies can contact when they need a screen transferred;

g) Act as the contact person for technical issues such as screen security and screener access;

h) Consult with the ADRC when the MCO re-determines level of care for a newly enrolled member or a newly enrolled member is found to be functionally ineligible or eligibility changes to a non-nursing home level of care within six months of the submission of the most recent pre-enrollment screen. Review and compare the screens and attempt to resolve differences. Contact the Department or its designee if differences cannot be resolved.

iii. Either through the screeners' supervisor or through the Screen Liaison, or both, provide ongoing oversight to ensure that all screeners:

a) Follow the most current version of the WI Long Term Care Functional Screen Instructions and all updates issued by the Department, including technical assistance documents and frequently asked questions. These are available and maintained on the Department's website at: https://www.dhs.wisconsin.gov/functionalscreen/ltcfs/instructions.htm.

b) Meet all other training requirements as specified by the Department.

10. *Screen Quality Management*

MCOs shall have a screen quality management program developed in internal policies and procedures. These policies and procedures shall be made available to the Department upon request.

Activities documented in these policies and procedures shall include:

a. Monitoring Screeners

The policies and procedures shall describe the methods by which the Screen Liaison(s) monitors the performance of individual screeners and provides each screener with prompt guidance and feedback. Minimum monitoring methods include:

i. Participation of the Screen Liaison(s) in staff meetings where screeners discuss and consult with one another on recently completed functional screens;

ii. Identification of how the accuracy, completeness, and timeliness of annual and change-in-condition screens submitted by screeners will be monitored;

iii. Identification of how changes of condition are communicated between IDT staff and screeners when screens are completed by non-IDT staff; and

iv. Identification of the methods that will be employed to improve screener competency given the findings of the monitoring.

b. Continuing Skills Testing

The MCO shall require all of its certified screeners to participate in continuing-skills testing required by the Department. The Department requires each screener to pass a test of continuing knowledge and skills at least once every two years, in order to maintain their certification. The MCO will:

i. Provide for the participation of all certified screeners in any continuing-skills training that is required by the Department.

ii. Administer continuing-skills testing required by the Department in accordance with instructions provided by the Department at the time of testing.

iii. Cooperate with the Department in planning and carrying out remedial action if the results of the continuing-skills testing indicate performance of any individual screener or group of screeners is below performance standards set for the test result, including retesting if the Department believes retesting to be necessary.

c. Annual Review

At a minimum, annually review a sample of screens from each screener. This is to determine whether the screens were done in a complete, accurate, and timely manner and whether the results were reasonable in relation to the person's condition.

d. Remediation

Review and respond to all quality assurance issues detected by the Department or its designee. The MCO shall correct errors in evaluating level of care within 10 days of notification by the Department or its designee.

e. Quality Improvement

Implement any improvement projects or correction plans required by the Department to ensure the accuracy and thoroughness of the screens completed by the agency.

f. Subcontracts

MCOs that subcontract with another entity or organization to conduct functional screens on behalf of the MCO must adopt policies and procedures to ensure subcontractor screen quality.

IV. Enrollment and Disenrollment

A. Enrollment

For Family Care, the MCO shall comply with the following requirements and use Department issued forms related to enrollment. For Partnership the MCO shall comply with the following requirements and use Department issued and CMS approved forms related to enrollment.

1. *Open Enrollment*

   Conduct enrollment consistent with the resource center enrollment plan approved by the Department. All applicants shall be enrolled provided the individual meets eligibility requirements as defined in Article III.A., Eligibility Requirements. Practices that are discriminatory or that could reasonably be expected to have the effect of denying or discouraging enrollment are prohibited.

2. *Voluntary Enrollment*

   Enrollment in the MCO is a voluntary decision on the part of an applicant who is determined to be eligible.

3. *Provision of Services While Financial Eligibility is Pending*

   The MCO will cooperate fully in executing a memorandum of understanding or other written agreement with each ADRC within its service area that describes the circumstances in which the MCO will provide services to an individual who is functionally eligible but whose financial eligibility is pending.

   This agreement can be to serve individuals whose financial eligibility is pending at the time of initial enrollment or during a period of disenrollment due to loss of financial eligibility. The MOU shall include a process for the resource center to inform the individual, or their legal decision maker, that if he/she is determined not to be eligible, he/she will be liable for the cost of services provided by the MCO.

   The MCO will not receive a capitation payment for an individual during the time financial eligibility is pending. If and when eligibility is established, the MCO will receive a capitation payment retroactively to the date indicated as the "effective date of enrollment" on the Enrollment Request form, up to a maximum of ninety (90) calendar days of serving the person while financial eligibility was pending.

   The effective date of enrollment entered on the Enrollment Request Form shall also be no earlier than the date on which an individual or their legal decision maker signs an explicit agreement (not just the enrollee's signature on the enrollment form) to accept services during the period of pending financial eligibility.

If the individual is determined not to be eligible, the MCO may bill that individual for the services the MCO has provided. The MCO shall pay providers for services which were provided and prior authorized by the MCO. MCO providers may not directly collect payment from the individual.

The timelines for completion of the comprehensive assessment and member-centered plan shall be the same as those indicated in Article V, Care Management.

4. *Enrollment of Persons Wanting to Relocate from a Nursing Home When There is a Waiting List During the Transition to Entitlement*

   a. Applicability

      This subsection applies when all the following criteria are met:

      i. The person is receiving Medicaid funded nursing home care (excluding situations where the facility is closing) in a county where there is a waiting list while the county is in transition to entitlement status;

      ii. The person is eligible for Family Care (or Family Care-Partnership if available in the county) and wants to enroll in the MCO for the program of her or his choice;

      iii. The person wants to relocate to a non-institutional setting but cannot do so without Medicaid-funded long-term services and supports available through MCO enrollment; and

      iv. The person may or may not be on the waiting list.

   b. Policy

      The MCO shall accept enrollment of persons meeting the above criteria, whether or not they are on the waiting list and regardless of position on the waiting list, after the enrollment counseling session with the ADRC and the enrollment form have been completed and according to the normal enrollment timeframe, unless the applicant prefers a later date.

   c. Implementation

      i. If the MCO policy is to accept enrollments of such persons earlier than four weeks after enrollment counseling, it shall inform the ADRC in writing of the earlier date at which it will generally accept such enrollments.

      ii. If the MCO follows the four week timeframe for enrolling persons wanting to relocate from the nursing home, the MCO shall contact the resident to begin relocation planning including an initial in-person contact with the resident within two weeks after the referral date.

      iii. Whether the MCO's policy is to begin such relocation enrollments within four weeks or the policy specifies an earlier date, if the

resident prefers to relocate before the date the policy provides and the MCO agrees to arrange an earlier relocation date, it shall notify both the resident and the ADRC, which will submit the revised enrollment date to the income maintenance agency.

iv. If the nursing home is not in the MCO provider network and is not willing to contract with the MCO, the MCO enrollment date shall be the date the person relocates.

B. Disenrollment

For Family Care, the MCO shall comply with the following requirements and use Department issued forms related to disenrollment. For Partnership the MCO shall comply with the following requirements and use Department issued and CMS approved forms related to disenrollments.

1. *Processing Disenrollments*

The enrollment plan, developed in collaboration with the resource center and income maintenance agency, shall be the agreement between entities for the accurate processing of disenrollments. The enrollment plan shall ensure:

a. That the MCO is not directly involved in processing disenrollments although the MCO shall provide information relating to eligibility to the income maintenance agency.

b. That enrollments and disenrollments are accurately entered in ForwardHealth interChange so that correct capitation payments are made to the MCO; and

c. That timely processing occurs, in order to ensure that members who disenroll have timely access to any Medicaid fee-for-service benefits for which they may be eligible, and to reduce administrative costs to the MCO and other service providers for claims processing.

2. *MCO Influence Prohibited*

The MCO shall not counsel or otherwise influence a member due to his/her life situation (e.g., homelessness, increased need for supervision) or condition in such a way as to encourage disenrollment.

3. *Types of Disenrollment*

a. Member Requested Disenrollment

All members shall have the right to disenroll from the MCO without cause at any time.

If a member expresses a desire to disenroll from the MCO, the MCO shall provide the member with contact information for the resource center; and, with the member's approval, may make a referral to the resource center for options counseling. If the member chooses to disenroll, the member

will indicate a preferred date for disenrollment. The date of voluntary disenrollment cannot be earlier than the date the individual last received services authorized by the MCO.

The resource center will notify the MCO that the member is no longer requesting services and the member's preferred date for disenrollment as soon as possible but this notification will be no later than one (1) business day following the member's decision to disenroll. The resource center will process the disenrollment. The MCO is responsible for covered services it has authorized through the date of disenrollment.

b. Involuntary Disenrollment

i. Involuntary Disenrollment - General

The member will be involuntarily disenrolled from Family Care or Partnership if the member:

a) Fails to meet functional eligibility requirements as specified in Article III.A.3;

b) Initiates a move out of the MCO service area as defined in Article XIX.B., Geographic Coverage Where Enrollment Is Accepted. MCO responsibilities in such moves are specified in Article V.M.;

c) Dies; or

d) Is age 21-64 and admitted to an Institution for Mental Disease (IMD). Partnership members admitted to an IMD as an in lieu of service or an alternate service should not be disenrolled.

ii. Disenrollment due to Loss of Medicaid Eligibility

a) The member will lose Medicaid eligibility if the member:

1) Fails to meet financial eligibility requirements;

2) Fails to pay or to make satisfactory arrangements to pay, any cost share amount due the MCO after a thirty (30) calendar day grace period;

a. The MCO shall specify the cost share due date. That is the date by which any payment received shall be considered timely.

b. If cost share is paid for calendar months, the due date shall be the end of the calendar month for which payment is due. If cost share is paid for a period other than calendar months, it shall be the 30th day of that period.

c. The MCO shall inform members of this date in member materials and through oral and written communications.

d. The thirty (30) day grace period begins on the day after the payment due date and ends on the 30th calendar day after the payment due date.

3) Is incarcerated as an inmate in a public institution.

b) The member will be involuntarily disenrolled from Family Care and Partnership if the member is determined ineligible for Medicaid. The disenrollment will occur automatically in ForwardHealth interChange.

iii. Disenrollment Due to Loss of Program Eligibility

Partnership members may make choices below, that result in the loss of program eligibility. When a member makes one of the following choices, the MCO will complete the change routing form and send it to the income maintenance agency and the resource center. The income maintenance agency will end the waiver eligibility and the resource center will process the disenrollment:

a) Chooses a primary care physician who is not in the MCO provider network, except, per Article VIII.O.1.b, Indian members shall not be disenrolled for choosing a non-network Indian health care provider as a primary care provider;

b) Chooses to disenroll from, or if newly Medicare eligible chooses not to enroll in, any part(s) of Medicare for which s/he is eligible; or

c) Chooses to disenroll from, or if newly eligible chooses not to enroll in, the MCO's Special Needs Plan.

iv. Informing the Resource Center

When the MCO provides information to income maintenance or another agency that may result in the member being disenrolled, the MCO will also inform the resource center.

c. MCO-Requested Disenrollment

When requested by the MCO, a member may be disenrolled with the approval of the Department and in accordance with the following procedures:

i. The MCO's intention to disenroll a member shall be submitted to the Department for a decision and shall be processed in accordance with (ii) - (v) below.

ii. The MCO may request a disenrollment if:

a) The member has committed acts or threatened to commit acts that pose a threat to the MCO staff, subcontractors, providers, or other members of the MCO. This includes harassing and physically harmful behavior.

b) The MCO is unable to assure the member's health and safety because:

1) The member refuses to participate in care planning or to allow care management contacts; or
2) The member is temporarily out of the MCO service area and does not meet the requirements in Article V.L.

d) The member is no longer accepting services.

1) The MCO is responsible to monitor whether the services authorized for a member are received and to make good faith efforts to maintain contact with the member.
2) If the member is no longer accepting services authorized by the MCO, other than care management efforts to contact the member, and the MCO is unable to determine the reason the member is not accepting services, the MCO shall send a certified letter to the member. Fourteen (14) calendar days after the MCO has sent the certified letter to the member, if the member is still refusing to accept services, the MCO shall complete and submit form F-02403 to the contract coordinator requesting disenrollment due to refusal to accept services.

iii. The MCO may not request a disenrollment for any of the following reasons:

a) The member experiences an adverse change to his/her health status;

b) The member's utilization of medical services changes;

c) The member exhibits a diminished mental capacity;

d) The member exhibits uncooperative or disruptive behavior that results from his/her special needs with the following exception:

1) Due to the member's uncooperative or disruptive behavior, the member's continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either the member or other enrollees.

iv. The MCO must have written policies and procedures that identify the impermissible reasons for disenrollment described in Section B.3.c.iii.

v. MCO-Requested Disenrollment Procedure.

a) The MCO shall complete and submit to the Department contract coordinator form F-02403 requesting the member's disenrollment along with documentation of the basis for the request, a thorough review of issues leading to the request and evidence that supports the request. For disenrollment requests based on a member no longer accepting services authorized by the MCO, this documentation must include the last date on which services were provided to the member, a copy of the certified letter sent to the member and relevant case notes.

b) At the time the request is made to the Department, the MCO shall notify the member of the request for disenrollment, including a copy of the request and all supporting documentation, and make any appropriate referrals to adult protective services or other crisis services.

c) The Department contract coordinator will consult with the MCO including problem-solving, alternative steps for providing services, assistance in managing a difficult case, and recommendations of outside experts who might be able to assist in resolving issues without disenrollment.

d) The Department contract coordinator will, within fifteen (15) business days from the date the Department has received all information needed for a decision:

1) Approve the disenrollment request; or

2) Disapprove the disenrollment request; or

3) Notify the MCO and the member that a process to consult and problem-solve with the MCO and member will be initiated.

e) If a disenrollment request is approved:

1) The Department contract coordinator will set a disenrollment date consistent with the requirements of IV.C.4.c and send form F-02403 to the MCO. The disenrollment shall be effective on the date approved by the Department as the disenrollment date, but no later than the first day of the second month following the month in which the MCO filed the request.

2) DHS will process the disenrollment which generates a notice of disenrollment to the member.

3) The MCO will forward form F-02403 to the applicable ADRC for disenrollment counseling and the appropriate regional Income Maintenance agency. The MCO is responsible for covered services it has authorized through the date of disenrollment.

f) If a disenrollment request is not approved, the Department contract coordinator will send form F-02403 to the MCO. The MCO shall continue to serve the member and provide written notice to the member that the disenrollment request was not approved.

g) If a disenrollment request results in the Department contract coordinator deciding to consult and problem-solve with the MCO and member:

1) The Department contract coordinator shall plan that process with the MCO.

2) The MCO shall cooperate with the contract coordinator's efforts to problem-solve.

3) If the Department contract coordinator determines that the effort to consult and problem-solve with the member has been unsuccessful, the disenrollment will be approved.

4. *Continuity of Services*

a. Until the date of disenrollment, members are required to continue using the MCO's providers for services in the benefit package. The MCO shall continue to provide all needed services in the benefit package until the date of disenrollment.

b. The MCO shall assist participants whose enrollment ceases for any reason in obtaining necessary transitional care through appropriate referrals and by making member records available to participant's new providers with appropriate releases; and (if applicable) by working with the Department to reinstate participants' benefits in the Medicaid system or other programs, if eligible.

C. Monitoring, Coordination, Transition of Care, Discrimination and Dates

1. *Monitoring by the Department*

The MCO shall permit the Department to monitor enrollment and disenrollment practices of the MCO under this contract.

2. *Interactions with Other Agencies Related to Eligibility and Enrollment*

   a. The MCO shall fully cooperate with other agencies and personnel with responsibilities for eligibility determination, eligibility re-determination, enrollment and disenrollment in the MCO. This includes, but is not limited to, the resource center, income maintenance, and the enrollment consultant if any.

   b. The MCO shall participate in the Department's annual review and revision of the enrollment/disenrollment resource guide, which describes how the agencies will work together to assure accurate, efficient, and timely eligibility determination, eligibility re-determination, enrollment and disenrollment. The enrollment/disenrollment resource guide shall describe the MCO's responsibility to timely report known changes in members' level of care, finances, or other circumstances that may affect eligibility, and the manner in which to report those changes.

   c. The MCO shall support members in meeting Medicaid reporting requirements as defined in Wis. Admin. Code § DHS 104.02(6). Members are required to report changes in circumstances to income maintenance within ten (10) calendar days of the change.

3. *Transition of Care*

   The MCO shall comply with the Department's transition of care policy to ensure that members transitioning to the MCO from FFS Medicaid or transitioning from one MCO to another have continued access to services if the member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The Department's transition of care policy can be found at:
   https://www.dhs.wisconsin.gov/publications/p02364.pdf

4. *Discriminatory Activities*

   Enrollment continues as long as desired by the eligible member regardless of changes in life situation or condition, until the member voluntarily disenrolls, loses eligibility, or is involuntarily disenrolled according to terms of this contract.

   The MCO may not discriminate in enrollment and disenrollment activities between individuals on the basis of age, disability, association with a person with a disability, national origin, race, ancestry or ethnic background, color, record of arrest or conviction which is not job-related, religious belief or affiliation, sex or sexual orientation, marital status, military participation, political belief or affiliation, use of legal substance outside of work hours, life situation, condition or need for long-term care or health care services. The MCO shall not discriminate against a member based on income, pay status, or any other factor not applied equally to all members, and shall not base requests for disenrollment on such grounds.

5. *Dates of Enrollment and Disenrollment*

The enrollment date for an otherwise eligible individual can be set for the first day of the month in which she or he achieves the age specified in Article XIX, MCO Specific Contract Terms, Section E.

The MCO shall begin serving individuals as of the effective date of enrollment recorded in ForwardHealth interChange.

The MCO is responsible to monitor ForwardHealth interChange enrollment reports for discrepancies in persons the MCO considers enrolled.

a. The Department will consider requests for correction of enrollment and payment discrepancies if the MCO:

   i. Submits the request to the Department on a Discrepancy Report F-01655 (https://www.dhs.wisconsin.gov/forms/f01655.xlsx);

   ii. Follows all of the procedures and guidelines specified in technical assistance memo 15- 02, (https://www.dhs.wisconsin.gov/publications/p01048-15-02.pdf) effective 11/2/2015, as amended;

   iii. Provides evidence of the individual's effective date of enrollment or disenrollment and proof that during the time in question the MCO was providing services to the individual; and

   iv. The date of the enrollment discrepancy does not exceed 18 months previous to the report submission or correction request date.

b. A member-requested disenrollment shall be effective on the date indicated on the disenrollment form signed by the member or the member's legal decision maker. The effective date cannot be earlier than the date the individual last received services authorized by the MCO.

c. An MCO-requested disenrollment shall be effective on the date approved by the Department as the disenrollment date as follows:

   i. A disenrollment date due to member no longer accepting services will be set according to adverse action date logic, as defined in Article I.8.

   ii. A disenrollment date due to inability to assure health and safety will be set according to adverse action date logic, as defined in Article I.8.

   iii. A disenrollment date due to member acts that pose a threat will be set and processed immediately.

d. If the member dies, the date of disenrollment shall be the date of death.

e. Loss of eligibility resulting in disenrollment shall have the effective dates as identified in i. through v. below.

i. If an MCO member is planning to or has moved out of the MCO service area, the date of disenrollment shall be the date the move occurs.

ii. If an individual has been incarcerated, the MCO shall report this change in circumstance to the income maintenance agency as this change may result in a loss of Medicaid eligibility. The MCO disenrollment date shall be the date of incarceration.

iii. If a member who is at least 21 years old and less than 65 years old has been admitted to an IMD, the MCO shall report this change in circumstance to the income maintenance agency as this change may result in a loss of Medicaid coverage of services. The MCO disenrollment date shall be the date of admission to the IMD. For Partnership members this requirement does not apply when an IMD stay is covered as an in lieu of or alternate service.

iv. If an MCO member loses Medicaid eligibility for a reason other than those identified in (i) through (iii) above, the last day of eligibility shall be set by the CARES system or by SSA according to adverse action date logic, as defined in Article I.8. The disenrollment date will be the date eligibility ends. The MCO shall continue to provide services to the member through the date of disenrollment.

v. If a member loses functional eligibility, the date of disenrollment shall be set according to adverse action date logic, as defined in Article I.8.

V. Care Management

Functions of the MCO should support and enhance member-centered care. Designing member-centered plans that effectively and efficiently identify the personal experience outcomes and meet the needs and support the long term care outcomes of members and monitor the health, safety, and well-being of members are the primary functions of care management. Member-centered planning supports: 1) the success of each individual member in maintaining health, independence and quality of life; 2) the success of the MCO in meeting the long-term care needs and supporting member outcomes while maintaining the financial health of the organization; and 3) the overall success of the Department's managed long-term care programs in providing eligible persons with access to and choices among high quality, cost-effective services.

A. Member Participation

1. The MCO is required to ensure that each member has a meaningful opportunity to participate in the initial development of, and updating of, his/her member-centered plan (MCP). The MCO is required to encourage members to take an active role in decision-making regarding the long-term care and health care services they need to live as independently as possible.

   The MCO is expected to ensure that the member, the member's legal decision maker and any other persons identified by the member will be included in the care management processes of assessment, member outcomes identification, member-centered plan development, and reassessment. This process must reflect cultural considerations of the individual and must be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities through the provision of auxiliary aids and services at no cost to the individual and for persons who are limited English proficient through the provision of language services at no cost to the member. The MCO shall provide information, education and other reasonable support as requested and needed by members, other persons identified by the member or legal decision makers in order to make informed long-term care and health care service decisions.

2. Members shall receive clear explanations of:

   a. His/her health conditions and functional limitations;

   b. Available treatment options, supports and/or alternative courses of care;

   c. The member's role as part of the interdisciplinary care team;

   d. The full range of residential options, including in-home care, residential care and nursing home care when applicable;

   e. The benefits, drawbacks and likelihood of success of each option;

   f. Risks involved in specific member preferences;

   g. The possible consequences of refusal to follow the recommended course of care; and

h. His/her available choices regarding the services and supports he/she receives and from whom.

3. The MCO shall inform members of specific conditions that require follow-up, and if appropriate, provide training and education in self-care. If there are factors that hinder full participation with recommended treatments or interventions, then these factors will be identified and explained in the member-centered planning process.

B. Interdisciplinary Team Composition

The interdisciplinary team (IDT) is the vehicle for providing member-centered care management. The full IDT always includes the member and other people specified by the member, as well as IDT staff. Throughout this article the term "IDT staff" refers to the social service coordinator, registered nurse and any other staff who are assigned or contracted by the MCO to participate in the IDT and is meant to distinguish those staff from the full IDT.

1. The member receives care management through designated IDT staff, which at a minimum include the following:

   a. For Family Care, a social service coordinator and a Wisconsin licensed registered nurse;

   b. For Partnership, a social service coordinator, a Wisconsin licensed registered nurse and a Wisconsin licensed nurse practitioner.

   The team may include additional persons with specialized expertise for assessment, consultation, ongoing coordination efforts and other assistance as needed.

2. A "social service coordinator" is required to be one of the following:

   a. A social worker certified in Wisconsin with a minimum of one (1) year's experience working with at least one of the Family Care target populations; or

   b. An individual with a four-year bachelor's degree or more advanced degree in the human services area and a minimum of one (1) year's experience working with at least one of the Family Care target populations; or

   c. An individual with a four-year bachelor's degree or more advanced degree in any area other than human services with a minimum of three (3) years' experience working with at least one of the Family Care target populations.

3. The IDT staff shall have knowledge of community alternatives for the target populations served by the MCO and the full range of long-term care resources. IDT staff shall also have specialized knowledge of the conditions and functional limitations of the target populations served by the MCO, and of the individual members to whom they are assigned.

The MCO shall establish a means that ensures ease of access and a reasonable level of responsiveness for each member to their IDT staff during regular business hours.

The Department recognizes that in the Partnership Program an MCO may encounter a shortage of available nurse practitioners.

a. In order to make best use of the time of nurse practitioners while still assuring Partnership members have access to a nurse practitioner, an MCO may develop policies and procedures to apportion, in a way that is responsive to individual member needs, the time nurse practitioners work with the IDT of each individual member. Such policies and procedures may be guided by the needs of the population and could, under some circumstances use the time of a nurse practitioner solely to access prescriptions, provide triage services and as an educational resource for the IDT staff. All such policies and procedures will:

   i. Assure that every member's IDT has some level of participation by a nurse practitioner;

   ii. Establish procedures for identifying the most appropriate level of participation by a nurse practitioner with the IDT of each individual member by taking into account the unique conditions and circumstances of the member; and

   iii. Assure that nurse practitioners are readily available to members who have the most need for advanced practice health care.

b. On a case-by-case basis, the MCO may choose to use a physician assistant or advanced practice nurse prescriber with experience working with the target groups and with demonstrated capacity to work independently to fulfill the need for advanced practice health care. The MCO will continue to ensure each member has access to an appropriate level of advanced practice health care.

C. Assessment and Member-Centered Planning Process

Member-centered planning is an ongoing process and the member-centered plan (MCP) is a dynamic document that must reflect significant changes experienced in members' lives. Information is captured through the initial comprehensive assessment and changes are reflected through ongoing re-assessments.

Member-centered planning reflects understanding between the member and the IDT staff and will demonstrate changes that occur with the member's outcomes and health status. The member is always central to the member centered planning and comprehensive assessment process. The IDT staff will ensure that the member is at the center of the member centered planning process. The member will actively participate in the planning process, in particular, in the identification of personal outcomes and preferences. All aspects of the member centered planning and comprehensive assessment process

involving the participation of the member must be timely and occur at times and locations consistent with the requirements of Article V.C and H. The member centered plan incorporates the following processes:

1. *Comprehensive Assessment*

   a. Purpose

      i. The purpose of the comprehensive assessment is to provide a unique description of the member to assist the IDT staff, the member, a service provider or other authorized party to have a clear understanding of the member, including their strengths, the natural and community supports available to the member, and the services and items necessary to support the member's individual long term care outcomes, needs and preferences.

      ii. The comprehensive assessment is essential in order for IDT staff to comprehensively identify the member's personal experience outcomes (as defined in Addendum VI), long-term care outcomes, strengths, needs for support, preferences, natural supports, and ongoing clinical or functional conditions that require long-term care, a course of treatment or regular care monitoring.

   b. Procedures

      i. The MCO shall use an assessment protocol that includes a face-to-face interview in the member's current residence by the IDT social service coordinator and registered nurse every twelve (12) months (or every six (6) months for a vulnerable/high risk member) with the member and other people identified by the member as important in the member's life.

      ii. As a part of the comprehensive assessment, the IDT staff shall review the functional screen, all available medical records of the member and any other available background information.

      iii. The IDT staff shall encourage the active involvement of any other supports the member identifies at the initial contact to ensure the initial assessment as described in Section D.1.c. of this article is member-centered and strength-based. The IDT staff, member and other supports shall jointly participate in completing an initial assessment.

      iv. The MCO shall use a standard format developed or approved by the Department for documenting the information collected during the comprehensive assessment. The standard format will assist the IDT staff to gather sufficient information to identify the member's strengths and barriers in each area of functional need and natural supports available to the member. It will also assist the IDT staff to identify the associated clinical supports, including assessment of

any ongoing conditions of the member that require long-term care, a course of treatment or regular care monitoring, needed to support the member's long term care outcomes.

The MCO's standard assessment format will be designed to facilitate, for each member, comprehensive assessment by the IDT staff of the domains of personal experience outcomes and the member's values and preferences, including preferences in regard to services, caregivers, and daily routine.

c. Documentation

The comprehensive assessment will include documentation by the IDT staff of all of the following:

i. The registered nurse on the IDT is responsible to assure that a full nursing assessment is completed. This assessment identifies risks to the member's health and safety, including but not limited to risk assessments for falls, skin integrity, nutrition and pain as clinically indicated. The nursing assessment also includes an evaluation of a member's ability to set-up, administer, and monitor their own medication. This includes medication review and intervention.

ii. A member of the IDT staff is responsible for reviewing and documenting in the comprehensive assessment, the member's medications every six months or whenever there is a significant change in the member's health or functional status. When a complex medication regimen or behavior modifying medication or both are prescribed for a member, the IDT staff nurse or other appropriately licensed medical professional shall ensure the member is assessed and reassessed, as needed, but at least every six months for the desired responses and possible side effects of the medication, and understands the potential benefits and side effects of the medication and that all assessments results and follow-up have been completed and documented in the member record. If a complex medication regimen or behavior modifying medication or both are prescribed, the IDT staff nurse or other appropriately licensed medical professional shall ensure that the comprehensive assessment includes the rationale for use and a detailed description of the behaviors which indicate the need for administration of the complex medication regime or behavior modifying medication.

iii. When there is a discrepancy between medications prescribed and medications being taken, the IDT staff nurse is responsible, in accordance with state and professional nursing standards, to assure that efforts are made to clarify and reinforce with the member the correct medication regimen.

iv. An exploration with the member of the member's understanding of self-directed supports and any desire to self-manage all or part of his/her care plan.

v. An exploration with the member of the member's preferences in regard to privacy, services, caregivers, and daily routine, including, if appropriate, an evaluation of the member's need and interest in acquiring skills to perform activities of daily living to increase his/her capacity to live independently in the most integrated setting.

vi. An assessment of mental health and alcohol and other drug abuse (AODA) issues, including risk assessments of mental health and AODA status as indicated.

vii. An assessment of the member's overall cognition and evaluation of risk of memory impairment.

viii. An assessment of the availability and stability of natural supports and community supports for any part of the member's life. This shall include an assessment of what it will take to sustain, maintain and/or enhance the member's existing supports and how the services the member receives from such supports can best be coordinated with the services provided by MCO.

ix. An exploration with the member of the member's preferences and opportunities for community integration including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.

x. An exploration with the member of the member's preferred living situation and a risk assessment for the stability of housing and finances to sustain housing as indicated.

xi. An exploration with the member of the member's preferences for educational and vocational activities, including supported employment in a community setting.

xii. An assessment of the financial resources available to the member.

xiii. An assessment of the member's understanding of his/her rights, the member's preferences for executing advance directives and whether the member has a guardian, durable power of attorney or activated power of attorney for health care.

xiv. An assessment of vulnerability and risk factors for abuse and neglect in the member's personal life or finances including an assessment of the member's potential vulnerability/high risk per Article V.J.1.

2. IDT staff will work with the member to identify and document in the comprehensive assessment and MCP the long term care and personal experience outcomes.

3. *Member-Centered Planning*

   a. Purpose

      i. Member-centered planning is a process through which the IDT identifies appropriate and adequate services and supports to be authorized, provided and/or coordinated by the MCO.

      ii. Member-centered planning results in a member-centered plan (MCP) which identifies the long term care and personal experience outcomes. The plan identifies all services and supports whether authorized and paid for by the MCO, or provided by natural and/or community supports that are consistent with the information collected in the comprehensive assessment and are:

         a) Sufficient to assure the member's health, safety and well-being;

         b) Consistent with the nature and severity of the member's disability or frailty; and

         c) Satisfactory to the member in supporting the member's long term care outcomes.

   b. Procedures

      i. Member-centered planning shall be based on the comprehensive assessment. IDT staff shall involve the member and other parties in accordance with the member's preference and the parties' ability to contribute to the development of the MCP.

      ii. As requested by the member, the IDT staff shall encourage the active involvement of the member's natural and community supports in the member-centered planning process and in development of the MCP. For members with communicative or cognitive deficits, the IDT staff shall encourage family members, friends and others who know the member and how the member communicates to assist in conveying the member's preferences in the member-centered planning process and in development of the MCP.

      iii. IDT staff shall provide assistance as requested or needed to members in exercising their choices about where to live, with whom to live, work, daily routine, and services, which may include involving experts in member outcomes planning for non-verbal people and people with cognitive deficits.

iv. The member-centered planning process shall include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. The IDT staff shall identify potential conflict of interest situations that affect the member's care and, either eliminate the conflict of interest or, when necessary, monitor and manage it to protect the interests of the member. Providers of home and community-based services, or those who have an interest in or are employed by a provider of home and community-based services, shall not provide case management or develop the member centered plan. When the only willing and qualified entity to provide case management and/or develop member centered plans in a geographic area also provides home and community-based services, the Department may consider granting a waiver of this prohibition. Waiver of this prohibition requires specific, prior approval from CMS.

v. The written member centered plan resulting from the member centered planning process shall be understandable to the member and the individuals important in supporting the member. At a minimum, this requires that the plan be written in plain language and in a manner that is accessible to individuals with disabilities through the provision of auxiliary aids and services at no cost to the individual and for persons who are limited English proficient through the provision of language services at no cost to the member.

c. Documentation

i. The MCP shall document the member's long term care and personal experience outcomes. It must document the actions to be taken and the services needed to support the long term care outcomes. The MCP must document which IDT staff will monitor and evaluate these actions and services.

ii. The MCP shall document areas of concern or risk that IDT staff have identified and which they have discussed with the member, but that the member has not agreed to as a priority at the present time.

iii. The MCO shall use a standard format for documenting the information collected during the assessment and member-centered planning process. The IDT staff shall use the MCO's approved service authorization policies and procedures in order to produce an MCP that supports the member's outcomes and is cost-effective.

iv. The MCP shall document at least the following:

a) The member's personal experience and long term care outcomes;

b) The member's strengths and preferences;

c) The frequency of face-to-face and other contacts, consistent with the minimums required by Article V.H, and an explanation of the rationale for that frequency. These figures and the supporting rationale shall be based upon the assessment of the complexity of the member's needs, preferences, risk factors including potential vulnerability/high risk, and any other factors relevant to setting the frequency of face to face visits;

d) The paid and unpaid supports, services, strategies and backup plans to mitigate risk and help the member work toward achieving his/her long term care outcomes, including those services, the purchase or control of which the individual elects to self-direct;

e) The natural and community supports that provide each service or support that is identified by the assessment and verification from the member/legal decision maker that natural supports included in the MCP are available and willing to provide assistance as identified in the MCP;

f) The home and community-based residential setting option chosen by the member and other options presented to the member unless the member declines to consider other options;

g) How the setting in which the member resides supports integration into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community;

h) For members residing in a provider-owned or controlled residential setting, the MCP must document that any modification of the standards listed under 42 C.F.R. § 441.301(4)(vi) A through D are supported by a specific assessed need and justified in the MCP. Specifically, this documentation must include: (1) the identification of a specific and individualized assessed need; (2) the positive interventions and supports used prior to any modifications to the MCP; (3) the less intrusive methods of meeting the need that have been tried but did not work; (4) a clear

description of the condition that is directly proportionate to the specific assessed need; (5) the regular collection and review of data to measure the ongoing effectiveness of the modification; (6) the established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; (7) the informed consent of the individual and (8) an assurance that interventions and supports will cause no harm to the individual.

i) The plan for coordinating services outside the benefit package received by the member;

j) The plan to sustain, maintain and/or enhance the member's existing natural supports and community supports and for coordinating services the member receives from such supports;

k) The specific period of time covered by the MCP;

l) Any areas of concern that IDT staff see as a potential risk that have been discussed with the member, including instances when:

1) The member refuses a specific service or services that IDT staff believes are needed and IDT staff have attempted to make the member aware of any risk associated with the refusal.

2) The member engages in behavior that IDT staff view as a potential risk but the member does not want to work on that behavior at this time, and IDT staff have offered education about the potential negative consequences of not addressing the risk; and

v. Partnership MCOs shall have Department-approved written policies and procedures for defining and documenting the elements considered to be part of the Partnership MCP and for informing members about all of the elements of the Partnership MCP. The policies and procedures shall include:

a) A description of the comprehensive plan of care and how it integrates:

1) Items i. through iv. above; and

2) The member's clinical care.

b) Such policies and procedures shall, at minimum, address the MCO's approach to:

1) Documentation of each member's clinical plan of care;

2) Verifying that members are informed of all of the elements of their Partnership MCP and how to request documents considered part of the Partnership MCP that are not routinely provided to the member; and

3) Training and oversight of IDT staff on these policies and procedures.

d. Authorizing Services

IDT staff will prepare service authorizations in accordance with the MCO's approved service authorization policies and procedures and Section K., Service Authorization, of this article.

e. Documenting Services Authorized by the MCO

The IDT staff shall give the member, as part of the MCP, a listing of the services and items that will be authorized by the MCO. The list shall include at a minimum:

i. The name of each service or item to be furnished;

ii. For each long-term care service, the units authorized;

iii. The frequency and duration of each service including the start and stop date; and

iv. For each service, the provider name.

f. Cost of Services

Upon the member's request, the IDT staff shall provide information on the current cost per unit for services authorized by the MCO.

g. Member-Centered Plan Signatures

i. Member or Legal Decision Maker Signature

IDT staff shall review the MCP with the member and legal decision maker, if applicable, and obtain the signature of the member or the member's legal decision maker to indicate his/her agreement with the MCP.

If a member declines to sign the MCP, the IDT staff shall:

a) Document in the member record the request to the member to sign the MCP and the reason(s) for refusal; and

b) If the refusal to sign the MCP reflects the member's disagreement with the MCP, the IDT staff shall discuss theissues with the member and provide the member with information on how to file a grievance or appeal.

If the member's record contains documented evidence, including case notes or, when available, documentation from a mental health professional, that obtaining the member's signature on the MCP is detrimental to the member's clinical or functional well-being, the IDT staff shall:

a) Document in the member record the specific reason(s) why the IDT staff and/or mental health professional believe that the member's signature should not be obtained; and

b) At each subsequent MCP review, reevaluate the decision to not obtain the member's signature on the MCP or provide the member with a copy of the MCP.

ii. Provider Signatures

a) Essential Providers

The IDT shall obtain the signatures of all essential waiver service providers. Providers of the following waiver services are essential service providers:

1) Adult Day Care Services;

2) Day Habilitation Services;

3) Daily Living Skills Training;

4) Prevocational Services;

5) Adult residential care (adult family homes, community-based residential facilities, residential care apartment complexes);

6) Respite;

7) Skilled nursing services RN/LPN;

8) Supported employment (individual and small group employment support); and

9) Supportive home care (excluding routine chore services).

b) Non-Essential Providers

For non-essential providers, the MCO must attach a copy of the provider's current signed provider agreement or service authorization to the MCP.

iii. Methods and Frequency for Obtaining Essential Provider Signatures

Acceptable methods to obtain essential provider signatures are: electronic, telephonic, secure email, mail, fax, electronic access through a case management system, and face-to-face.

Signatures shall be obtained at the initial MCP development and annually. A signature must be obtained from a new essential provider when that provider is added to the MCP.

h. Member-Centered Plan Distribution

The MCO shall distribute a copy of the MCP to the member or the member's legal decision maker and essential provider(s). For self-directing members, the MCO shall provide enough copies of the MCP for members and/or their legal decision makers to give to the member's essential providers. Distribution of the MCP shall occur at the initial MCP development and annually.

i. Electronic Signature

If the member, the member's legal decision maker, or a provider prefers to sign the MCP electronically and the MCO offers this option, it is allowable when the following standards are met:

i. The MCO provides the member, the member's legal decision maker, or a provider with access to the documents to be electronically signed for through a secure website or email system which includes a secure log-in, user name, and unique password.

ii. The documents to be electronically signed meet all applicable electronic media accessibility requirements under Article IX.B.3.

iii. The MCO has a DHS approved electronic signature policy and procedure for staff that:

a) Satisfies all contract MCP signature timeframes; and

b) Includes a process to verify the date of the electronic signature.

iv. The MCO uses a DHS approved electronic signature template that includes the following:

a) The member, member's legal decision maker, or provider's full name; and

b) IDT staff signatures; and

c) A list of the documents to which the electronic signature of the member, member's legal decision maker, or provider

applies and a statement that the electronic signature is only valid for these documents; and

d) A date range during which the signed documents must be accessible to the member, member's legal decision maker, or provider including a statement that the documents will be available to the member, member's legal decision maker, or provider during this time period.

v. Distribution of, and access to, signed materials must meet contract requirements including all applicable HIPAA and confidentiality requirements.

D. Timeframes

1. *Initial Assessment and MCP Timeframes*

a. Immediate Service Authorization

Beginning on the date of enrollment, the MCO is responsible for providing the member with needed services in the benefit package. This includes responsibility to continue to provide services or supports the member is receiving at the time of enrollment if they are necessary to ensure health and safety and continuity of care until such time as the IDT staff has completed the initial assessment. Such services may have time limited authorizations until completion of the member's full assessment and member-centered plan.

b. Initial Contact

The MCO shall contact the member (face-to-face or via telephone) within three (3) calendar days of enrollment to:

i. Welcome the member to the MCO;

ii. Make certain that any services needed to assure the member's health, safety and well-being are authorized;

iii. Provide the member with immediate information about how to contact the MCO for needed services;

iv. Review the stability of current supports in order to identify the services and supports necessary to sustain the member in his/her current living arrangement; and

v. Schedule a face-to-face contact with the IDT and member.

c. Initial Assessment

Within ten (10) calendar days from enrollment, the IDT shall meet face-to-face with the member to:

i. Review the member's most recent long-term care functional screen and any other available information.

ii. Explain the MCO's program and the philosophy of managed long-term care, including the member's responsibility as a team member of the IDT;

iii. Conduct the initial assessment, including an initial brief nursing assessment to examine the member's needs which at a minimum must include:

a) Are there imminent dangers to self or others (physical and/or behavioral);

b) Does the member require assistance with medication administration?

c) Is there a support system change/concern (i.e., loss of spouse, caregiver, no support available, etc.)?

d) Is the member demonstrating severe impairment of cognition or orientation?

e) Have there been any recent transitions of care (i.e., hospital to home) or recent ER/Urgent Need visits?

f) Assess the stability of current supports in order to identify the services and supports necessary to sustain the member in his/her current living arrangement.

d. Initial Service Authorization

i. The initial service authorization shall be developed by the IDT staff in conjunction with the member and shall immediately authorize needed services.

ii. The initial service authorization shall be developed and implemented within five (5) calendar days of enrollment and signed by the member or the member's legal decision maker within ten (10) calendar days of enrollment.

e. Initial MCP Development

The initial assessment and service authorization completed within the first ten (10) calendar days of enrollment is the beginning of the initial MCP. The initial MCP might not yet reflect all of the member's personal experience, or long term care outcomes, but it will reflect health and safety issues the IDT staff have assessed and will provide or arrange for basic services and items that have been identified as needed. It is expected that as the member and IDT staff complete further assessment together, the initial MCP will be more comprehensively developed.

2. *Timeframes for Comprehensive Assessment and Signed MCP*

   a. Comprehensive Assessment

      A comprehensive assessment shall be completed within thirty (30) calendar days of the enrollment date.

   b. Member-Centered Plan (MCP)

      A fully developed MCP shall be completed and signed by the member or the member's legal decision maker within sixty (60) calendar days of the enrollment date.

3. *Documentation Timelines*

   The MCO shall document all billable case management activities within a case note within the timeframe(s) defined in a MCO policy approved by DHS.

E. Providing, Arranging, Coordinating and Monitoring Services

1. *Providing and Arranging for Services*

   The IDT staff is formally designated as being primarily responsible for coordinating the member's overall long-term care and health care. In accordance with the MCP, the IDT staff shall authorize, provide, arrange for or coordinate services in the benefit package in a timely manner.

2. *Coordination with Other Services*

   The IDT staff shall ensure coordination of long-term care services with health care services received by the member, as well as other services available from natural and community supports.

   This includes but is not limited to assisting members to access social programs when they are unable to do so themselves and, if requested, providing information to a member about how to choose a Medicare Part D Prescription Drug Plan.

   This also includes assisting the member to obtain and maintain eligibility for SSI-E, if applicable (refer to the SSI-E Policy Handbook: http://www.emhandbooks.wisconsin.gov/ssi-e/ssi-e.htm).

3. *Access to Services*

   The IDT staff will arrange for, and instruct members on how to obtain, services. The IDT staff shall at a minimum:

   a. Within thirty (30) calendar days of enrollment, document the member's primary care provider, specialty care provider(s), and psychiatrist (if applicable);

   b. Obtain the member's authorization, as required by law, to receive and share appropriate health care information;

c. Provide information about the MCO's procedures for accessing long-term care services in the benefit package;

d. Provide the member with education on how to obtain needed primary and acute health care services;

e. Educate members in the MCO's expectations in the effective use of primary care, specialty care and emergency services; including:

i. Any procedures the provider must follow to contact the MCO before the provision of urgent or routine care;

ii. Procedures for creating and coordinating follow-up treatment plans;

iii. Policies for sharing of information and records between the MCO and emergency service providers;

iv. Processes for arranging for appropriate hospital admissions;

v. Processes regarding other continuity of care issues; and

vi. Agreements, if any, between the MCO and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the MCO or emergency services provider in the absence of such an agreement.

4. *Monitoring Services*

IDT staff shall, using methods that include face-to-face and other contacts with the member, monitor the services a member receives. This monitoring shall ensure that:

a. The member receives the services and supports authorized, arranged for and coordinated by the IDT staff;

b. The services and supports identified in the MCP as being provided by natural and community supports are being provided; and

c. The quality of the services and supports received is adequate and still necessary to continue to meet the needs and preferences of the member and support the member's outcomes identified in the MCP.

5. *MCO Coordination With the DWD's Division of Vocational Rehabilitation (DVR)*

When the MCO receives an updated coordination plan from the DVR, the MCO must either upload the plan to the member's record or document the updated plan in the member's record.

F. Re-Enrollment Assessment and MCP Update

1. *When to Use Expedited Procedures*

   The MCO may use the expedited procedures and reduced documentation requirements listed below in place of the procedures and documentation requirements set forth in Article V. Sec. C.1.b. and c. if:

   a. The member is a re-enrollee;

   b. An assessment that complies with the procedures and documentation requirements set forth in Article V. Sec. C.1.b. and c. is on file and has been performed within the past 180 calendar days; and

   c. There has been no significant change in the member's health or other circumstances since the date of disenrollment.

2. *Expedited Procedures*

   a. The IDT staff must review the most recent assessment that was conducted pursuant to the procedural and documentation requirements set forth in Article V. Sec. C.1.b. and c.

   b. IDT staff must review the most recent long term care functional screen.

   c. Within three (3) calendar days of re-enrollment IDT staff must contact the re-enrolled member by telephone and an RN must conduct a health and safety assessment. This assessment can be done by telephone.

   d. If the health and safety assessment reveals that there has been a significant change in the member's circumstances, the MCO may not utilize the expedited assessment procedures. The MCO must instead comply with the assessment procedures and documentation requirements set forth in Article V. Sec. C.1.b. and c.

3. *Reduced Documentation*

   The MCO must include the following in the member's file:

   a. Evidence that the IDT contacted or made reasonable attempts to contact the member within three (3) calendar days of re-enrollment and evidence of a completed health and safety assessment as required by Article V. Sec. F.2.c.

   b. Any updates the IDT makes to the most recent comprehensive assessment conducted per Article V. Sec. C.1.

4. *MCP Update*

   The IDT must at a minimum review the MCP following an expedited assessment. If there are any changes made to the MCP following an expedited assessment, IDT staff shall review the MCP with the member and obtain the member's signature or the signature of the member's legal decision maker.

G. Reassessment and MCP Update

1. *Reassessment*

IDT staff shall routinely reassess, and as appropriate update, all of the sections in the member's comprehensive assessment and MCP as the member's long-term care outcomes change. At a minimum, the reassessment and MCP review shall take place no later than the end of the sixth month after the month in which the previous comprehensive assessment was completed. The reassessment shall include a review of previously identified or any new member long-term care outcomes and supports available. At a minimum:

a. The IDT social services coordinator and registered nurse shall conduct this reassessment and, for vulnerable/high risk members, the reassessment shall occur in the member's current residence;

b. The IDT staff conducting the re-assessment shall ensure that the other IDT members are updated and involved as necessary on the reassessment;

c. When a complex medication regime or behavior modifying medication or both are prescribed for a member, the requirements in C.1.c.i. shall be met;

d. The entire IDT shall participate in the annual reassessment that is done no later than the end of the twelfth month after the previous comprehensive assessment was completed, including a face-to-face interview with the member by the IDT social services coordinator and registered nurse in the member's current residence.

In addition, the most appropriate IDT staff shall conduct a reassessment whenever there is:

e. A significant change in the member's long term care or health care condition or situation; or

f. A request for reassessment by the member, the member's legal decision maker, the member's primary medical provider.

2. *MCP Update*

The IDT shall review, update, and obtain the member's signature or the signature of the member's legal decision maker on the MCP and review and update the service authorization document periodically as the member's outcomes, preferences, situation and condition changes, but not less than the end of the sixth month after the month in which the previous MCP review and update occurred.

H. Interdisciplinary Team and Member Contacts

1. *Minimum Required Face-to-Face Contacts*

IDT staff shall establish a schedule of face-to-face contacts based upon the complexity of the member's needs and the risk in the member's life including an

assessment of the member's potential vulnerability/high risk per Article V.J.1. At minimum, IDT staff is required to conduct a face-to-face visit with a member every three months and both the social services coordinator and registered nurse are required to conduct a face-to-face visit in the member's residence at minimum:

a. Every twelve (12) months as part of the annual comprehensive assessment; and

b. Every six (6) months for vulnerable/high risk members as part of the annual comprehensive assessment and subsequent six month reassessment. The annual comprehensive assessment visit and subsequent six month reassessment visit count for two of the face-to-face contacts required by this subsection. MCOs shall notify the DHS assigned oversight team of members who meet the vulnerable/high risk criteria but refuse face-to-face visit(s) in their primary residence.

2. *Minimum Required Telephone or Live Video Messaging Contacts*

For any month in which there is not a face-to-face meeting with the member, IDT staff is required to make telephonic or live video contact with the member, the member's legal decision maker, or an appropriate person associated with the member (for example, a provider, friend, neighbor, or family member) who has been authorized by the member or the member's legal decision maker to speak with IDT staff. IDT staff shall document that each telephone or live video contact covered all aspects of service monitoring as required under section V.E.4., including assuring the member is receiving the services and supports authorized, arranged for and coordinated by the IDT staff and the services and supports identified in the MCP as being provided by natural and community supports are being provided, and that the quality of the services and supports received is adequate and still necessary to continue to meet the needs and preferences of the member and support the member's outcomes identified in the MCP. For live video messaging to be used it must occur in real time and be interactive. The MCO may not record the live video conference with the member without prior consent from the member; if consent is given orally, the MCO shall follow-up with the member or the member's legal decision maker to confirm the consent in writing. The plan for member's contacts should be discussed with the member, follow MCO policy and be documented in the member's record.

3. *Documentation*

The MCO shall document care management contacts in a format agreed to by the MCO and the Department and provide care management contact data to the Department upon request.

I. Member Record

The MCO shall develop and maintain a complete member record as specified in Article XIII.A.10., Contents of Member Records, for each person enrolled. A complete

and accurate account of all care management activities shall be documented by IDT staff and included in the member's record. The MCO shall document all billable case management activities within a case note within the timeframe(s) defined in a MCO policy approved by DHS.

J. Member Safety and Risk

1. *Policies and Procedures Regarding Member Safety and Risk*

The MCO shall have policies and procedures in place regarding member safety and risk, which shall be submitted to the Department for approval prior to implementation, whenever a change occurs, and upon request. MCO staff and other appropriate individuals shall be informed of these policies on an ongoing basis.

The purpose of these policies and procedures is to balance member needs for safety, protection, good physical health and freedom from accidents, with over-all quality of life and individual choice and freedom. These policies and procedures shall identify:

a. How IDT staff will assess and respond to risk factors affecting members' health and safety;

b. Guidelines for use by IDT staff in balancing member rights with member safety through a process of ongoing negotiation and joint problem solving;

c. Criteria for use by IDT staff to identify risk, including vulnerable/high risk members as defined in Article I.137;

d. Training for all IDT staff in identifying risk and coordinating care;

e. Guidelines and tools to assist IDT staff in identifying and mitigating risk; and

f. Protocols for use by IDT staff to identify, implement and document appropriate, individualized monitoring and safeguards to address and mitigate potential concerns and assure the health and safety of all members including those identified as vulnerable/high risk as defined in Article I.137. At a minimum these protocols must include:

i. Documentation of ongoing assessment of risk and conflict of interest, as required under sections V.C.3.b.iv., VIII.N.2.c. and X.B.8.d. of this Contract;

ii. Assessment of caregiver stress using caregiver stress tool;

iii. Validation of backup plans to assure caregivers who have been identified are capable and willing to provide support as documented in the comprehensive assessment and member centered plan;

iv. Validation by appropriate MCO staff or arrangement for validation of supportive home care workers pursuant to the *Managed Care Organization Training and Documentation Standards for Supportive Home Care* https://www.dhs.wisconsin.gov/publications/p01602.pdf within 10 days of enrollment;

v. Documented attempts to collect data and information from the member's support network, including primary care and other health care providers, caregivers identified in the backup plan, and other significant people who regularly see the member to determine if there are any areas of concern or need that IDT staff should consider in connection with their duty to monitor and coordinate services as required in section V.E.4. of this Contract;

vi. Considerations of how to add additional external caregivers, as appropriate, to provide additional risk mitigation.

2. *Abuse, Neglect, Exploitation and Mistreatment Prohibited*

The MCO shall implement a policy that expressly prohibits all forms of abuse, neglect, exploitation and mistreatment of members by MCO employees and contracted providers. This policy shall include instruction in the proper reporting procedures when abuse or neglect is suspected.

3. *Individual Choices in Safety and Risk*

The MCO shall have a mechanism to monitor, evaluate and improve its performance in the area of safety and risk issues. These mechanisms shall ensure that the MCO offers individualized supports to facilitate a safe environment for each member. The MCO shall assure its performance is consistent with the understanding of the desired member outcomes and preferences. The MCO shall include family members and other natural and community supports when addressing safety concerns per the member's preference.

4. *Use of Isolation, Seclusion and Restrictive Measures*

The MCO shall comply with, and as needed, provide training for its providers in compliance with the following requirements:

a. MCOs are required to have an internal restrictive measures oversight committee. The MCO oversight committee must review restrictive measures proposals prior to submitting the request to DHS.

b. The MCO oversight committee must review restrictive measures proposals and either approve the proposal as submitted, approve the proposal with conditions, deny the proposal, or return it because additional information is needed. All MCO decisions must be in writing, must identify each measure separately, describe reasons for the denial (if applicable), include any conditions of approval along with adequate descriptions of these

conditions, and be signed by someone in a management position designated by the director of the MCO. Denials must also offer information for the member or legal decision maker to grieve the decision including the MCO internal grievance procedure, contacting DHS Client Rights Office, or requesting a Department Review.

c. Requests for use of restrictive measures must be submitted to DHS via the Restrictive Measures database: https://ltcareies.forwardhealth.wi.gov/restrictiveMeasures/#/login.

d. The MCO and its providers shall follow the Department's written guidelines and procedures on the use of isolation, seclusion and restrictive measures in community settings, and follow the required process for approval of such measures (httpshttps://www.dhs.wisconsin.gov/publications/p02572.pdf).

e. The use of isolation, seclusion and restrictive measures in licensed facilities in Wisconsin is regulated by the Department's Division of Quality Assurance. When providers are subject to such regulation, the MCO shall not interfere with the procedures of the Division of Quality Assurance.

f. The MCO and its providers shall comply with Wis. Stat. §§ 51.61(1)(i) and 46.90(1)(i) and Wis. Admin. Code § DHS 94.10 in any use of isolation, seclusion and restrictive measures.

5. *Identifying and Responding to Member Incidents*

a. The MCO shall develop and maintain an incident management system, which manages incidents occurring at the member and provider levels, in order to assure member health and safety, reduce member incident risks, and enable development of strategies to prevent future incident occurrences.

b. The incident management system shall include policies and procedures to ensure that:

i. The MCO IDT staff inform members/legal decision makers (and involved family and other unpaid caregivers, as appropriate) about abuse, neglect, and exploitation protections, at the initial assessment upon member enrollment or at the initial comprehensive assessment, and at each annual comprehensive assessment thereafter. Completion of this task shall be documented in the member record.

ii. MCO members/legal decision makers (and involved family and other unpaid caregivers, as appropriate) are informed of the process used to report member incidents.

iii. MCO staff and providers are trained in identifying, responding to, documenting, and reporting member incidents. Completion of training for MCO staff shall be documented in the staff member's file. Completion of training for providers shall be documented and provided upon request to DHS.

iv. Contracted providers must report member incidents to designated MCO staff no later than one (1) business day after the incident was discovered;

v. Effective steps are taken immediately to prevent further harm to or by the affected member(s);

vi. Incidents wherein the member is a victim of a potential violation of the law are reported to local law enforcement authorities. Incidents where the member is suspected of violating the law are reported to local law enforcement, to the extent required by law;

vii. Incidents meeting criteria in Wis. Stat. §§ 46.90(4) or 55.043(1m) are reported in accordance with the applicable statute to the appropriate authority; the MCO is not responsible for or a substitute for Adult Protective Service investigations;

viii. The MCO, within three (3) calendar days of learning of the incident, notifies the member/legal decision maker of the incident, unless the member/legal decision maker reported the incident to the MCO, the MCO has within that time determined that the report was unfounded or unsubstantiated, or unless the legal decision maker is a subject of the investigation;

ix. The MCO has designated staff to conduct incident investigations who:

a) Are not directly responsible for authorizing or providing the member's care;

b) Have sufficient authority to obtain information from those involved and;

c) Have clinical expertise to evaluate the adequacy of the care provided relevant to the member incident.

x. The MCO will designate staff to provide oversight of MCO staff or the provider who shall investigate the incident in a manner consistent with the relative scope, severity and implications of any given member incident and determine and document, at a minimum, the following:

a) The facts of the reported incident (including the date and location of occurrence), the type and extent of harm experienced by the member, any actions that were taken

immediately to protect the member and to halt or ameliorate the harm;

b) The cause(s) of the incident;

c) Whether reasonable actions by the provider or others with responsibility for the health, safety and welfare of the member would have prevented the incident; and

d) Interventions and/or preventative strategies which may include changes in the MCO's or provider's policies or practices to help prevent occurrence of similar incidents in the future.

xi. When warranted, an investigation of each reported member incident shall be completed within thirty (30) calendar days of the incident's discovery. If information or findings necessary for completion of the investigation cannot be obtained within 30 days for reasons beyond the MCO's control, the investigation shall be completed as promptly as possible.

xii. The MCO shall report member incident data in accordance with the Department's incident data report specifications. The report submission is due on the thirtieth day after the end of the month, or the first business day following the thirtieth day when the thirtieth day is not a business day. The report shall be submitted electronically through the Long Term Care Information Exchange System. (https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html)

xiii. Within five (5) business days of completion of the investigation, the MCO shall provide notification to the member/legal decision maker (and/or the member's family, as appropriate) of the results or outcomes of the investigation. This notification shall be documented in the member record.

K. Service Authorization

1. *Service Authorization Policies and Procedures*

a. Services in the Long-Term Care Benefit Package

The MCO may use the Resource Allocation Decision Method (RAD) as its service authorization policy. If the MCO does not use the RAD, it must seek Department approval of alternative service authorization policies and procedures. The policies and procedures must address how new and continuing authorizations of services are approved and denied.

The MCO may choose to create decision-making guidelines for more frequently used items and/or services. When the MCO wishes to utilize these guidelines as part of the RAD or alternative service authorization

documentation (instead of documenting evidence), the guidelines must be approved by the Department. Services shall be authorized in a manner that reflects the member's ongoing need for such services and supports as determined through the comprehensive assessment and consistent with the member-centered plan.

b. Acute and Primary Care Services in the Partnership Benefit Package

The MCO shall have documented and Department-approved service authorization policies and procedures for services in the acute and primary care benefit package. Policies and procedures may differ from the authorization policies and procedures for services in the long-term care benefit package, and may be based on accepted clinical practices. Decisions about the authorization of services in the acute and primary care benefit package may be made outside of the IDT by other clinical professionals with consideration for member preferences.

c. Authorization of Medicare Services in the Partnership Benefit Package for Dual Eligibles

Notwithstanding any other provision of this section, pursuant to their status as Medicare Advantage plans and their Medicare agreement or contract with CMS, MCOs in making authorization decisions about Medicare coverable services for dual eligible members in Partnership shall first use and follow Medicare coverage and authorization policies, procedures and requirements rather than the RAD or other Department-approved service authorization policies and procedures used for the authorization of Medicaid services under this contract. If the MCO determines that Medicare will not cover the service, the MCO must then use and follow the Medicaid coverage rules, including the RAD, to determine if Medicaid will cover the service.

d. Procedures

The MCO's service authorization policies and procedures shall be submitted to the Department for approval prior to implementation, whenever a change occurs, and upon request.

In addition, the MCO must submit any decision-making guidelines referenced in section 1.a. above to the Department for approval prior to implementation.

IDT staff shall use the MCO's approved standardized service authorization policies, procedures and guidelines, as applicable. IDT staff shall explain to the member the MCO's standardized service authorization process (RAD process), the member's role and responsibilities in that process, and when the service authorization process is being used.

The MCO's approved service authorization policies and procedures may address the provision of supports or services that are not specified in the benefit package.

The MCO must have in effect mechanisms to ensure consistent applications of review criteria for authorization decisions; and consult with the requesting provider when appropriate.

For Partnership, the MCO's service authorization policies and procedures must be comparable and applied no more stringently for mental health/substance use disorder benefits than they are for medical/surgical benefits as required by the Mental Health Parity and Addiction Equity Act.

2. *Necessity or Appropriateness of Services*

a. Use of Approved Service Authorization Policies

The IDT shall use the MCO's Department-approved service authorization policies and procedures to authorize services. The IDT shall not deny services that are reasonable and necessary to cost-effectively support the member's long term care outcomes identified in the comprehensive assessment as well as those necessary to assist the member to be as self-reliant and autonomous as possible. Long-term care outcomes for which services are authorized may relate to:

i. The prevention, diagnosis, and treatment of a disease, condition, and/or disorder that results in health impairments and/or disability;

ii. The ability to achieve age-appropriate growth and development;

iii. The ability to attain, maintain, or regain functional capacity; and

iv. The opportunity to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

b. Amount, Duration and Scope of Medicaid Services

Members shall have access to services in the benefit package that are identified as necessary to support the long term care outcomes in an amount, duration and scope that will support member outcomes and are no less effective than would be achieved through the amount, duration and scope of services that would otherwise be furnished to fee-for-service Medicaid recipients, as set forth in 42 CFR § 440.230 and, for members under the age of 21, as additionally set forth in 42 CFR §§ 441.50 – 441.62 (EPSDT).

c. Most Integrated Services

The IDT staff shall provide services in the most integrated residential setting consistent with the member's long-term care outcomes, and

identified needs, and that is cost-effective when compared to alternative services that could meet the same needs and support similar outcomes.

Residential care services are services through which a member is supported to live in a setting other than the member's own home. Residential Care services include Residential Care in Addendum VII.A.17 and Nursing Home in Addendum VII.B.10. or C.1.

Residential care services are appropriate when:

i. The member's long-term care outcomes cannot be cost-effectively supported in the member's home, or when the member's health and safety cannot be adequately safe-guarded in the member's home; or

ii. Residential care services are a cost-effective option for meeting that member's long-term care needs.

d. Discrimination Prohibited

The IDT staff shall not arbitrarily deny or reduce the amount, duration, or scope of services necessary to support outcomes solely because of the diagnosis, type of illness, disability or condition.

e. Resolving Disputes

Disputes between the MCO and members about whether services are necessary to support outcomes are resolved through the grievance and appeals processes identified in Article XI, Grievances and Appeals.

3. *Authorization Limits*

The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for the purpose of utilization management, provided the services furnished can reasonably be expected to support the member's long term care outcomes as defined in Article I, Definitions.

After the initial MCP, when a specific service is identified as necessary to support a member's long term care outcomes on an ongoing basis and the IDT has determined that the current provider is effective in providing the service, the service shall generally be authorized for the duration of the current MCP (i.e., until the next regularly scheduled MCP update) in an amount necessary to support the member's outcomes.

The number of units of service or duration of a service authorized may be more limited when the authorization is for:

a. An episodic service or course of treatment intended to meet a need that is anticipated to be short term in nature, which may be authorized for a limited length of time or number of units of service that is expected to be sufficient to meet the short term need.

b. A trial-basis service or course of treatment intended to test whether a particular service or course of treatment is an effective way to support the long term care outcome or need of the member, which may be authorized for a length of time or number of units of service that is expected to be sufficient for the IDT, including the member, to determine whether or not the services or course of treatment is in fact effective in meeting the member's outcome or need.

Services may be discontinued when a limitation in an original service authorization for an episodic service or course of treatment is reached. If the member requests additional services the IDT staff must respond in accordance with paragraph 8, Responding to Direct Requests By a Member for a Service, of this section.

4. *Service Authorization Decisions Made Outside the IDT*

If the MCO has Department-approved policies and procedures that require service authorization decisions to be made outside the IDT, including any situations in which IDT staff are required to seek approval for an authorization it would like to make from supervisory, clinical or administrative staff within the MCO, the MCO shall:

a. Maintain Written Decision-Making Criteria

The review criteria used for decision-making shall have prior approval by the Department, shall be clearly documented, regularly updated and available for review by members and IDT staff. The criteria shall determine the necessity and/or appropriateness of services based on reasonable evidence or a consensus of relevant clinical practitioners, and shall assure that members are provided with services necessary to support long term care outcomes.

b. Information Required for a Decision

The policies and procedures approved by the Department shall specify the information required for service authorization decisions, shall have mechanisms to ensure consistent application of the review criteria for service authorization decisions, and shall include consultation with the requesting provider when appropriate.

5. *Coordination with Primary Care and Health Care Services*

The MCO must implement procedures to:

a. Ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.

b. Coordinate the services the MCO furnishes to the member with the services the member receives from any other provider of health care or insurance plan, including mental health and substance abuse services.

c. Share with other agencies serving the member the results of its identification and assessment of special health care needs so that those activities need not be duplicated.

d. Ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in Article XIII.A.1.

6. *Prohibited Compensation*

The MCO shall not compensate individuals or entities that conduct utilization management or prior authorization activities in such a way as to provide incentives for the individual or entity to deny, limit, or discontinue for members services necessary to support outcomes.

7. *Communication of Guidelines*

The MCO shall disseminate to all affected providers practice guidelines used for review and approval of requests for services. Upon request, MCOs shall disseminate practice guidelines to members and potential members.

8. *Responding to Direct Requests By a Member for a Service*

When a member requests a health or long-term care service or item, IDT staff shall do all of the following:

a. Acknowledge receipt of the request and explain to the member the process to be followed in processing the request;

b. Using the RAD or other Department approved guidelines, promptly determine what the core issue is in relation to the request. Assess if the request meets a need defined in the member's long term outcomes.

c. Determine whether the request is for an item or service included in the Family Care Benefit package (if not, the MCO may authorize the service only if it complies with the requirements set forth in Article VII.A.7.);

d. Promptly determine whether the IDT has the authority to authorize the requested service or whether the authorization decision must be made outside the IDT (see Section K.4., Service Authorization Decisions Made Outside the IDT, in this article);

e. Consult as needed with other health care professionals who have appropriate clinical expertise in treating the member's condition or disease necessary to reach a service authorization decision.

f. Issue a prompt decision as follows:

i. If IDT staff are authorized to provide or arrange the service, make a prompt decision to approve or to disapprove the request based on the RAD or other Department-approved service authorization policies and procedures. The member is always a participant in the RAD or other Department-approved service authorization policies and procedures.

ii. If the service authorization process requires that additional MCO employees or other professionals be involved in decision-making about a member request for service, the MCO shall assure that:

a) The additional MCO employee(s) shall join with the IDT staff;

b) The expanded IDT shall use the RAD or other Department-approved service authorization policies and procedures with the member; and

c) The IDT shall make the final decision taking into consideration the recommendations of the MCO employees or other professionals.

iii. If the service authorization process requires that the IDT seek additional information outside the team prior to authorization or approval, assure that the additional information is obtained promptly.

iv. The timeframe for decision-making must be in accordance with the timeframe outlined in paragraph 9, Timeframe for Decisions, below.

g. If the IDT staff determines that the service or the amount, duration, or scope of the service is not necessary or appropriate and therefore approves less service than requested or declines to provide or authorize the service, the IDT staff shall do all of the following:

i. Within the timeframes identified in paragraph 9 below, if the service or item requested is in the benefit package, provide the member notice of adverse benefit determination of any decision by the team to deny a request, or to authorize a service in an amount, duration, or scope that is less than requested.

ii. Failure to reach a service authorization decision within the timeframes specified in paragraph 9, Timeframe for Decisions, below constitutes a denial and therefore requires a notice of adverse benefit determination. The adverse benefit determination notice must meet the requirements of Article XI, Grievances and Appeals.

iii. When appropriate, notify the rendering provider of the authorization decision. Notices to providers need not be in writing.

iv. All service requests, which are denied, limited, or discontinued, shall be recorded, along with the disposition. Aggregate data on service requests that are denied, limited, or discontinued are compiled for use in quality assessment and monitoring and shall be made available to the Department upon request.

v. Although the MCO may cover alternative services (i.e., services outside the benefit package) as described in Article VII, Section A.7., an MCO is not required to provide a notice of adverse benefit determination when it denies a member's request for alternate service. However, the MCO is required to inform the member in writing within 14 (fourteen) days when a request for an alternative service is denied. The MCO must utilize DHS' Notification of Non Covered Benefit template (https://www.dhs.wisconsin.gov/library/f-01283.htm). The IDT staff will continue to ensure that the member's health and long-term care outcomes are supported.

9. *Timeframe for Decisions*

The IDT staff shall make decisions on direct requests for services and provide notice as expeditiously as the member's health condition requires.

a. Standard Service Authorization Decisions

i. Standard service authorization decisions shall be made no later than fourteen (14) calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to fourteen (14) additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request The notification of extension must inform the member that:

a) The member may file a grievance if dissatisfied with the extension, in which case the extension will be considered a denial, and

b) The member may contact the Member Rights Specialist for assistance.

b. Expedited Service Authorization Decisions

For cases in which a member or provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited service

authorization no later than seventy two (72) hours after receipt of the request for service.

The MCO may extend the timeframes of expedited service authorization decisions by up to eleven (11) additional calendar days if the member or a provider requests the extension or if needed by the MCO to gather more information. For any extension not requested by the member, the MCO must give the member written notice of the reason for delay.

c. Failure to Comply with Service Authorization Decision Timelines

Failure to reach a service authorization decision within these specified timeframes constitutes a denial and therefore requires a notice of adverse benefit determination. The adverse benefit determination notice must meet the requirements of Article XI, Grievances and Appeals.

10. *Notice of Adverse Benefit Determination*

In accordance with Article XI, Section D.1., the MCO shall provide written notice of an adverse benefit determination to the member when a decision is made to:

a. Deny or limit a member's request for a service in the benefit package;

b. Terminate, reduce, or suspend any currently authorized service; or

c. Deny payment for services in the benefit package.

11. *Notification of Non Covered Benefit*

In accordance with Article XI, Section D.1., the MCO shall provide a Notification of Non Covered Benefit (https://www.dhs.wisconsin.gov/library/f-01283.htm) to the member when a decision is made to:

a. Deny a member's request for a service outside the benefit package; or

b. Deny a member's request for payment of a service outside of the benefit package.

L. Services During Periods of Temporary Absence

Services are provided during a member's temporary absence from the MCO service area in accordance with Medicaid rules as specified in Wis. Admin. Code §§ DHS 103.03(3) and 104.01(6). If a member asks the MCO to provide services during a temporary absence from its service area, the MCO shall conduct two tests to determine whether to provide the services:

1. *Income Maintenance Residency Test*

Request that Income Maintenance complete a residency test to determine whether the member is still considered a resident of a county within the MCO's service area.

a. If no, the member is no longer a resident and he/she loses eligibility and must be disenrolled.

b. If yes, the member remains a resident and the MCO must go on to the second test.

2. *Cost-effective Plan Test*

Using the Department-approved service authorization policy, test whether a cost-effective plan can be developed for supporting the member's outcomes and assuring the member's health and safety during the absence by considering:

a. Is there a reason, related to the member's long term care outcomes, for the member to be out of the MCO service area?

b. Is there a way for the MCO to effectively arrange and manage the member's services during the absence? Factors to consider include:

i. Duration of absence;

ii. Distance from MCO;

iii. Availability of providers; and

iv. Ability to monitor the care plan directly, through contracting or other arrangements.

c. Is there an effective way to arrange and manage the member's services during the absence that is cost-effective? Factors to consider include:

i. Cost in comparison to effectiveness in supporting the member's long term care outcomes;

ii. Cost in comparison to the member's care plan costs when in the service area;

iii. MCO staff time and effort in comparison to time and effort when in the service area; and

iv. Duration of absence.

3. *Cost-Effective Plan*

If the MCO decides that it can establish a cost-effective care plan for supporting a member's outcomes and assuring health and safety during the absence, it must do so.

4. *Possible MCO-Requested Disenrollment*

If the MCO decides that it <u>cannot</u> establish a cost-effective care plan for supporting a member's outcomes and assuring health and safety during the absence, it may request Department approval for disenrollment.

In considering whether to allow an MCO-requested disenrollment, the Department will expect the MCO to demonstrate that it is unable to continue to support the member's outcomes and assure the member's health and safety with reasonable cost and effort.

The member will be given the opportunity to challenge this contention and demonstrate that her/his outcomes can be met and health and safety assured with reasonable cost and effort, which could include a SDS plan.

M. MCO Responsibilities When a Member Changes County of Residence

1. *Definition*

Geographic Service Region (GSR) means a county or group of counties for which the MCO has applied and been certified by the Department to provide the Family Care benefit, the Family Care-Partnership benefit, or both.

2. *MCO Responsibilities*

When the MCO becomes aware that a member intends to change her or his residence, the MCO shall, in addition to updating its records when the change of address occurs, do the following:

a. For Moves Within the Geographic Service Region:

i. Inform the member of any changes in IDT staff, service providers or other aspects of the member's care plan that may result from the move.

ii. Complete Section D of the Family Care /Partnership /PACE Change Routing Form per instructions. The form is available at Family Care/Partnership/PACE/IRIS - Change Routing Form (F-02404). Do not disenroll the member; only a transfer of Medicaid eligibility between income maintenance consortia is necessary if applicable.

b. For Moves to Another Geographic Service Region Served by the MCO:

i. Inform the member of any changes in IDT staff, service providers or other aspects of the member's care plan that will result from the move.

ii. Complete Section D of the Family Care /Partnership /PACE Change Routing Form per instructions. The form is available at Family Care/Partnership/PACE/IRIS - Change Routing Form (F-02404). Do not disenroll the member; only a transfer of Medicaid eligibility between income maintenance consortia is necessary if applicable.

iii. Inform the member that options counseling is available from the ADRC in the county to which the member is moving should the member wish to consider a change in MCO (if another MCO

operates in the geographic service region) or in long term care program.

c. For Moves to Another Geographic Service Region Not Served by the MCO:

i. Unless the move is due to an MCO-initiated placement in a nursing home or community residential facility, inform the member that she or he will be disenrolled, will need to select a different MCO, and that the IDT staff will help with this transition.

ii. Explain to the member that to assure uninterrupted services, and in the case of a member in the special home and community-based waiver eligibility group (Group B or B+) uninterrupted Medicaid eligibility, it is necessary to contact the ADRC in the new county of residence to enroll in another MCO or another long term care program, preferably with the same effective date as the disenrollment from the current MCO. The MCO should facilitate this contact and coordinate disenrollment/enrollment dates with the receiving ADRC.

iii. Complete Section D of the Family Care /Partnership /PACE Change Routing Form per instructions, initiating disenrollment. The form is available at Family Care/Partnership/PACE/IRIS - Change Routing Form (F-02404).

N. Department Review

The Department will review the performance of the MCO and its staff in carrying out the care management functions specified in this article. The MCO shall make readily available member records and any other materials the Department deems necessary for such reviews in accordance with Article XIII.J., Access to Premises and Information.

O. MCO Duty to Immediately Report Certain Member Incidents

1. *The MCO is required to report immediately to its DHS Member Care Quality Specialist any of the following:*

a. Upon learning a member's whereabouts are not known for 24 hours or more, under any of the following circumstances:

i. The member is under guardianship/protective placement;

ii. The member has been identified as a vulnerable/high risk member as defined under Article I.137;

iii. The MCO has reason to believe that the member's health or safety is at risk;

iv. The member is a potential threat to the community or self;

v. The member has a significant medical condition that would deteriorate without medications/care;

vi. The member lives in a residential facility; or

vii. The area is experiencing potentially life-threatening weather conditions.

b. Upon learning a member has died under any of the following circumstances:

i. Death involving unexplained, unusual, or suspicious circumstances;

ii. Death involving apparent abuse or neglect;

iii. Apparent homicide;

iv. Apparent suicide;

v. Apparent poisoning;

vi. Apparent accident, whether the resulting injury is or is not the primary cause of death; or

vii. When a physician refuses to sign the death certificate.

c. Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances:

i. When unexplained, unusual, or suspicious circumstances exist;

ii. When physical abuse, sexual abuse, or neglect exist;

iii. When the member has been poisoned; or

iv. When law enforcement or a court of law have investigated and/or are involved;

d. Upon learning a member has been admitted to a state IMD or Intensive Treatment Program (ITP). A list of both county and privately operated IMDs in Wisconsin can be found in section 27.11 of the Medicaid Eligibility Handbook.

2. *In addition to the immediate reporting requirements provided by Article V.O.1., MCOs shall also comply with all other reporting requirements in this contract, including, but not limited to, the reporting requirements provided at https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf.*

VI. Self-Directed Supports

A. Option to Self-Direct

Under Self Directed Supports (SDS) a member may purchase long-term care benefits listed in Addendum VII, Sections A, Home and Community-Based Waiver Services (except for residential care services and care/case management services), if they are identified by the IDT as consistent with the member's outcomes.

B. MCO Requirements

The MCO must present SDS as a choice to all members as specified in Wis. Admin. Code § DHS 10.44(6). Specific responsibilities of the MCO are to:

1. Ensure that SDS funds are not used to purchase residential services that are included as part of a bundled residential services rate in a long-term care facility. Members who live in residential settings can self-direct services that are not part of the residential rate.
2. Determine the cost of services to be self-directed, which shall be used in establishing the member's SDS budget.
3. Continue to expand the variety of choices and supports available within SDS.
4. Ensure that all IDT staff understand SDS or have access to MCO staff who have expertise in SDS.
5. Ensure that all IDT staff understand how to create a budget with a member or have access to MCO staff who have expertise in SDS who can assist with setting budgets.
6. Ensure that all IDT staff understand how to monitor SDS with a member and their IDT or have access to MCO staff who have expertise in SDS who can assist with monitoring for quality and safety.
7. Ensure that all IDT staff understand how to mitigate the potential conflicts inherent when a legal decision maker is self-directing on behalf of the member or have access to MCO staff who have expertise in SDS who can assist with mitigating such conflicts.
8. Collaborate with the Department in its efforts to develop systems for evaluating the quality of SDS, including members' experiences with SDS.
9. Develop and implement a Department-approved policy and procedure describing conditions under which the MCO may restrict the level of self-management exercised by a member where the team finds any of the following:
    a. The health and safety of the member or another person is threatened.
    b. The member's expenditures are inconsistent with the established plan and budget.

c. The conflicting interests of another person are taking precedence over the outcomes and preferences of the member.

d. Funds have been used for illegal purposes.

e. The member has been identified as a Vulnerable/High Risk member and insufficient measures have been taken to mitigate risk.

f. The member refuses to provide access to the home or otherwise refuses to provide information necessary for the IDT to adequately monitor member health and safety.

g. Additional criteria for restricting the level of self-management exercised by a member may be approved by the Department in relation to other situations that the MCO has identified as having negative consequences.

The MCO's policy and procedure for limiting SDS shall be submitted to the Department for approval prior to implementation, whenever a change occurs, and upon request.

10. Assure that persons providing services to members on a self-directed basis who do not otherwise have worker's compensation coverage for those services have coverage provided as follows:

a. Where the member is the common law employer of the person providing services, the fiscal services management entity (also called the fiscal/employer agent) that performs employer-related tasks for the member shall purchase and manage a worker's compensation policy on behalf of the member, who shall be the worker's compensation employer.

b. Where the member is the managing co-employer of the person providing services with a co-employment agency (also called an agency with choice) as the common law employer, the co-employment agency shall provide worker's compensation coverage as the worker's compensation employer.

C. IDT Staff Responsibilities

It is the responsibility of the IDT staff to:

1. Provide information regarding the philosophy of SDS and the choices available to members within SDS. The information provided to members must include:

a. A clear explanation that participation in SDS is voluntary, and the extent to which members would like to self-direct is the members' choice;

b. A clear explanation of the choices available within SDS;

c. An overview of the supports and resources available to assist members to participate to the extent desired in SDS; and

d. An overview of the conditions in which the MCO may limit the level of self-management by members, the actions that would result in the removal

of the limitation, and the members' right to participate in the grievance process, as specified in Article XI, Grievances and Appeals.

1. On a yearly basis, obtain a dated signature from the member or member's legal decision maker on a form, or section of an existing form, where the member must do the following:
   a. Affirm the statement below:

      "My interdisciplinary team has explained the self-directed supports option to me. I understand that under this option I can choose which services and supports I want to self-direct. I understand that this includes the option to accept a fixed budget that I can use to authorize the purchase of services or support items from any qualified provider."
   b. Affirm one of the two statements below:
      i. "I accept the offer of self-directed supports and the interdisciplinary team is helping me explore that option."
      ii. "I decline self-directed supports at this time but understand I can choose this option at any time in the future by asking my interdisciplinary team."
2. Maintain the signed form required in paragraph 1 above as part of the member's file.
3. Work jointly with members during the comprehensive assessment and member-centered planning process to ensure all key SDS components are addressed, including:
   a. What specific service/support do members want to self-direct;
   b. To what extent does the member want to participate in SDS in this service area;
   c. Are there areas within the comprehensive assessment that indicate that members may need assistance/support to participate in SDS to the extent they desire;
   d. Identification of resources available to support members as needed, including a thorough investigation of natural supports, as well as identifying the members' preferences regarding how/by whom these supports are provided;
   e. Identification of potential health and safety issues related to SDS and specific action plans to address these;
   f. Development of a budget for the support members have chosen to self-direct, and a plan that clearly articulates to what extent members would like to participate in the budgeting/payment process;

g. Identification of what mechanism members have chosen to assure compliance with requirements for the deduction of payroll taxes and legally mandated fringe benefits for those employed by members; and

h. For members with legal decision makers, the identification of the need for their training in the area of identification of member preferences, and member self-advocacy training.

4. Ensure all key SDS components are included in the member-centered plan, including:

   a. Desired outcomes related to SDS;

   b. Supports/resources that will be utilized to ensure members' participation in SDS to the extent they desire; and

   c. Identification of potential health and safety issues, and a plan of action to address them.

   d. Identification of how the member's SDS plan will be monitored to ensure member health, safety and welfare.

5. Ensure mechanisms are in place for ongoing check-in and support regarding the members' participation in SDS, including:

   a. Systems for ensuring member's expenditures are consistent with the agreed upon budget;

   b. Identification of any changes needed in the SDS budget or identified supports/resources;

   c. Check-in regarding potential health and safety issues and the action plans developed to address them; and

   d. Check-in regarding potential conflicts of interest – other persons' views taking precedence over the members' outcomes and preferences.

6. Implement the policies and procedures regarding member safety and risk described under Article V.J.1, including the identification of vulnerable/high risk members and documentation of the specific measures implemented to assure the health and safety of such members.

7. Validate or arrange for validation of supportive home care workers pursuant to the *Managed Care Organization Training and Documentation Standards for Supportive Home Care*: https://www.dhs.wisconsin.gov/publications/p01602.pdf

VII. Services

A. General Provisions

1. *Comprehensive Service Delivery System*

   The MCO will provide members with high-quality long-term care and health care services that:

   a. Are from appropriate and qualified providers;

   b. Are fair and safe;

   c. Serve to maintain community connections, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community; and

   d. Are cost effective.

   Services are delivered through a comprehensive interdisciplinary health and social services delivery system appropriate to the benefit package pursuant to this contract and any applicable state and federal regulations.

2. *Sufficient Services*

   Services must be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO's benefit package services that are Medicaid state plan services as defined in Addendum VII, Section B for Family Care and Section C for Partnership must be no more restrictive than the Medicaid fee-for-service coverage.

3. *Coverage Responsibility*

   The MCO is responsible for covering services in the benefit package that cost-effectively address any of the following:

   a. The prevention, diagnosis, and treatment of a disease, condition, and/or disorder that results in health impairments and/or disability;

   b. The ability to achieve age-appropriate growth and development;

   c. The ability to attain, maintain, or regain functional capacity; and

   d. The opportunity to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

4. *Medically Necessary Services*

   Services must be medically necessary as defined in Article I.86.

5. *Benefit Package Services*

   Benefit package services must minimally include the services outlined in Addendum VII, Benefit Package Service Definitions.

6. *Inform Members of the Benefit Package*

   The MCO will inform members of the full range of services in the benefit package appropriate for their level of care. The MCO will provide a range of services to meet the needs and outcomes of its members, as identified in the member-centered planning process (described in Article V.C.).

7. *Alternate Services*

   Members have a right to request any covered service, whether or not the service has been recommended as necessary or appropriate by a professional or the interdisciplinary team responsible for coordinating their care.

   The MCO is not restricted to providing only the services in the benefit package. The MCO may provide, but is not required to provide, a support or service to a specific member that is not specified in the benefit package if the alternative support or service is:

   a. An alternative to a support or service that is in the benefit package otherwise available to the member, and

   b. Cost-effective in comparison to the support or service in the benefit package for which it is substituting, and

   c. Appropriate to support that member's long-term care outcomes and needs, and

   d. The member agrees to the alternative.

   The cost of such alternatives that are specifically documented in the LTCare IES defined in Article XIV, Reports and Data, will be examined by the Department's actuary and, if appropriate, will be included in the development of actuarially sound rates as defined in Addendum I, Actuarial Basis.

8. *In Lieu of Services*

   a. Definition

      In lieu of services are a subset of alternate services that the Department has determined are medically appropriate and cost-effective substitutes for covered services or settings in Addendum VII.B for Family Care or Addendum VII.C for Partnership; and:

      i. Are offered to a member at the discretion of the MCO; and

      ii. The member is not required by the MCO to use the alternative service or setting; and

      iii. Utilization and cost are taken into account in setting capitation rates, unless a statute or regulation explicitly requires otherwise.

   b. In Lieu of Services for Members Functionally Eligible at the Non-Nursing Home Level of Care

For a member functionally eligible at the non-nursing home level of care the MCO may:

i. Provide the following services in lieu of home health care in Addendum VII.B.7 or personal care in Addendum VII.B.14:

a) Supportive home care in Addendum VII. A.24.;

b) Respite care in Addendum VII.A.18.;

c) Personal emergency response system in Addendum VII.A.14.;

d) Daily living skills training in Addendum VII.A.11.a.;

e) Day habilitation services in Addendum VII.A. 11.b.;

f) Prevocational services in Addendum VII.A.15.;

g) Residential care services in Addendum VII.A.17.;

h) Home delivered meals in Addendum VII.A.12.;

i) Counseling and therapeutic services in Addendum VII.A.8.; or

j) Congregate nutrition services under 42USC § 3030e.

ii. Provide specialized transportation–other transportation in Addendum VII.A.27 in lieu of transportation services in Addendum VII.B.17.

c. For a member in the Partnership program age 21 through 64, an MCO may provide inpatient services in an IMD hospital or IMD nursing home for a stay of no more than 15 days during the period of the monthly capitation payment in lieu of hospital services in Addendum VII.C.1, provided the conditions in paragraph a. are met.

d. An MCO may only provide a service as an in lieu of service if it is so specified in this Contract.

9. *Long-term Care Services Where Members Live*

Members shall receive the long-term care services in the benefit package where they live, including:

a. The member's own home, including supported apartments.

b. Alternative residential settings including, but not limited to:

i. State Certified Residential Care Apartment Complexes (RCAC).

ii. Community-Based Residential Facilities (CBRF).

iii. Adult Family Homes (AFH).

c. Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID).

10. *Services During Temporary Absence*

The MCO shall provide services during periods of temporary absence as described in Article V.L., Services During Periods of Temporary Absence.

11. *Self-Directed Supports*

The MCO shall provide support for self-directed care as described in Article VI, Self-Directed Supports.

B. Provision of Services in the Family Care Benefit Package

1. *Services for Members at the Nursing Home Level of Care*

The MCO shall promptly provide or arrange for the provision of all health and long-term care services in the benefit package, consistent with the member-centered plan (MCP) described in Article V.C., Assessment and Member-Centered Planning Process.

Coverage of services identified in each individual member's MCP must be consistent with the definition of "Services Necessary to Support Outcomes," in Article I, Definitions.

Family Care services include all of the following:

a. The home and community-based waiver services defined in Addendum VII.A.;

b. The long term care Medicaid State Plan Services identified in Addendum VII.B.; and

c. Any cost-effective health care services the MCO substitutes for a long term care service in the Medicaid State Plan identified in Addendum VII.B.

2. *Services for Members at the Non-Nursing Home Level of Care – Family Care*

The following policies apply to Family Care members who are at the non-nursing home level of care:

a. The MCO shall promptly provide or arrange for the provision of all services in the benefit package, consistent with the Member-Centered Plan, and as defined in Addendum VII.B.

b. If a member at the non-nursing home level of care is admitted to a nursing facility or ICF-IID, the LTC Functional Screen must be updated by a certified screener within ten (10) business days of admission to determine whether changes in the member's long-term health and care needs are consistent with the nursing home level of care. If the re-screening result continues to indicate a non-nursing home level of care, before notifying

the member and nursing facility that nursing home services are not coverable for the member, the MCO shall:

i. Within three (3) business days of the rescreening result contact the Division of Medicaid Services Nursing Home Section in the Bureau of Rate Setting at DHSDMSBRS@dhs.wisconsin.gov with "Attention Nursing Home Section" as the subject line and provide the member's name, Medicaid ID, facility name and date of admission. The Nursing Home Section will within three (3) business days determine whether the member's most recent Minimum Data Set (MDS) assessment indicates the member's nursing home services are Medicaid reimbursable and inform the MCO of that determination by reply email.

ii. If the MDS assessment indicates that the member's nursing home services are Medicaid reimbursable, to assure per 42 C.F.R. §438.210 that the MCO's coverage of nursing home services is no more restrictive than what applies under FFS, the MCO shall continue to cover the services for the member through discharge or until the most recent MDS assessment indicates that the member's nursing home services no longer qualify for Medicaid reimbursement. The MCO may re-query the Nursing Home Unit as in i. above every 90 days after the initial query to obtain the latest MDS determination.

iii. If the MDS assessment indicates that the member's nursing home services are not Medicaid reimbursable, the MCO shall notify the member and nursing facility that this service is not in the member's benefit package. If the MCO will terminate the nursing home service, it must provide appropriate notice in accordance with Article XI.D., Notice of Adverse Benefit Determination.

As a consequence of the nursing home stay, the Member-Centered Plan must be updated based upon review of the changes in care needs and the preferences of the member. The member must be rescreened to determine level of care within sixty (60) calendar days following discharge from the nursing home or ICF-IID.

c. If a member at the non-nursing home level of care enrolls when residing in a nursing facility or ICF-IID, the LTC Functional Screen must be updated by a certified screener within three (3) business days of enrollment to determine the appropriate level of care. If the re-screening result continues to indicate a non-nursing home level of care, before notifying the member and nursing facility that nursing home services are not coverable for the member, the MCO shall follow the steps and requirements under b. i.-iii above

If the member remains at the non-nursing home level of care and the most recent MDS assessment indicates that the member's nursing home services are not Medicaid reimbursable, the MCO shall notify the member and nursing facility that this service is not in the member's benefit package and the member must be referred to the ADRC. If the MCO will terminate the nursing home service, it must provide appropriate notice in accordance with Article XI.D., Notice of Adverse Benefit Determination.

C. Provision of Services in the Partnership Benefit Package

1. *Services for All Members*

All members of Partnership shall receive integrated acute, primary and long-term care services pursuant to this contract, state and federal regulations.

a. The MCO shall promptly provide or arrange for the provision of all health and long-term care services in the benefit package, consistent with the member-centered plan described in Article V.C., Assessment and Member-Centered Planning Process.

b. Coverage of services identified in each individual member's MCP must be consistent with the definition of "Services Necessary to Support Outcomes" in Article I, Definitions.

c. Partnership services include all the following:

i. The home and community-based waiver services defined in Addendum VII.A.;

ii. All Medicaid State Plan Services identified in Addendum VII.C.;

iii. Any cost-effective health care services the MCO substitutes for a service in the Medicaid State Plan identified in Addendum VII.C.; and

iv. Medicare Part A/B deductibles, co-payments and co-insurance.

2. *Requirements Related to Delivery of Specific Services in Partnership*

a. Provision of Family Planning Services

i. When applicable, MCO members must have access to family planning services, whether the provider is or is not part of the network. If the member chooses an out of plan provider, the MCO will reimburse the out-of-plan provider of those family planning services according to the Wisconsin Medicaid Fee-for-Service rule and rates. All such information and medical records relating to family planning shall be kept confidential.

ii. The MCO must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care

services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

b. Provision of Abortions, Hysterectomies and Sterilizations

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

i. Abortions must comply with the requirements of Wis. Stat. § 20.927 and with 42 C.F.R. § 441 Subpart E - Abortions.

ii. Hysterectomies and sterilizations must comply with 42 C.F.R. § 441 Subpart F - Sterilizations.

iii. Sanctions in the amount of ten thousand dollars ($10,000.00) may be imposed for non-compliance with the above compliance requirements.

iv. The MCO must abide by Wis. Stat. § 609.30.

v. The MCO must comply with all record keeping and retention requirements for abortions, hysterectomies and sterilizations.

c. Transplants

i. As a general principle, the MCO shall cover the same transplants as covered by Medicare regardless of whether the member is enrolled in Medicare. If the transplant is not covered by Medicare, the MCO shall follow the procedure outlined in Section G., Determining if Services, Procedures, Items and Treatments are Proven and Effective, to determine coverage.

ii. In applying the procedure in Section G to determine coverage of transplants for persons not enrolled in Medicare, the MCO shall follow the written standards in the State Plan that provide for similarly situated individuals to be treated alike and for any restrictions on facilities or practitioners to be consistent with the accessibility of high quality care to members.

iii. All individuals who need a transplant, or who have received a transplant are eligible to enroll or remain enrolled in the Program.

d. Emergency and Urgent Care

i. Coordination of 24-Hour Emergency Care

a) The MCO coordinates all emergency contract services and post-stabilization services as defined in this contract twenty-four (24) hours each day, seven (7) days a week, either by the MCO's own facilities or through arrangements approved by the Department with other providers.

b) Services shall include but not be limited to one (1) phone line in a service area to receive emergency calls. Individuals with authority to authorize treatment as appropriate must be accessible via this phone number.

c) The MCO is responsible for coverage and payment of emergency services and post stabilization care services. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO in a manner consistent with Medicare and Medicaid regulations.

d) The MCO may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. § 438.114(a) of the definition of emergency medical condition or when a representative of the MCO instructs the member to receive emergency care.

e) The MCO may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

f) The MCO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or MCO of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

g) The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO as identified in 42 C.F.R. § 438.114(b) as responsible for coverage and payment.

h) The MCO is financially responsible for emergency services and post-stabilization services obtained within or outside the MCO's network that are pre-approved by the MCO. Post-stabilization services are covered and paid for in accordance with provisions set forth at 42 C.F.R. § 422.113(c).

i) The MCO is financially responsible for post-stabilization care services obtained within or outside the MCO's network that are not pre-approved by the MCO, but administered to maintain, improve or resolve the member's stabilized condition if:

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

2) The MCO cannot be contacted; or

3) The MCO and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with the MCO care team or medical director. The treating physician may continue with care of the patient until the MCO care team or medical director is reached or one of the criteria in subsection l) below, is met.

j) Payment for post-stabilization service must be made in a manner consistent with Medicare and Medicaid regulations.

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

l) The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

1) The member's primary care physician assumes responsibility for the member's care;

2) The member's primary care physician assumes responsibility for the member's care through transfer;

3) The MCO and the treating physician reach an agreement concerning the member's care; or

4) The member is discharged.

ii. Urgent Care

MCO members must have access to urgent care services during regular business hours of Urgent Care facilities. The Emergency Room (ER) is used when Urgent Care facilities are closed.

e. Mental Health and Substance Use Disorder Services

Partnership MCOs must comply with provisions of the Mental Health Parity and Addiction Equity Act (U.S. Public Law 110-343, section 512), as interpreted in 42 C.F.R. Part 438 Subpart K.

i. Mental health and substance use disorder services shall be provided to members in all classifications (inpatient, outpatient, emergency care, prescription drugs) in which medical/surgical benefits are provided.

ii. The MCO shall not impose aggregate lifetime, or annual dollar limit, or cumulative financial requirements on mental health or substance use disorder benefits.

iii. The MCO shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members.

iv. The MCO shall not apply any non-quantitative limitations, as described in 42 C.F.R. § 438.910(d), for mental health or substance use disorder services in any classification, unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitations to mental health or substance use disorder benefits in the classification are comparable and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

v. The MCO may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits.

D. Prohibited Services

1. *Provider Preventable Conditions*

The MCO is prohibited from making payment to a provider for any provider preventable condition as defined in Article I, Definitions.

2. *Assisted Suicide*

The MCO may not pay for an item or service (other than in an emergency but not including when furnished in a hospital emergency room) for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

3. *Physical Infrastructure*

The MCO may not pay for an item or service (other than in an emergency but not including when furnished in a hospital emergency room) with respect to any amount expended for roads, bridges, stadiums or services not covered under the Medicaid State Plan, including waivers thereof, except for coverage of alternate services under A.5.

E. Primary Care and Coordination of Health Care Services

The MCO must implement procedures to:

1. *Ensure an Ongoing Source of Primary Care*

Ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.

1. *Coordinate Services*

Coordinate the services the MCO furnishes to the member with the services the member receives from any other provider of health care or insurance plan.

2. *Share Results*

Share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities need not be duplicated.

3. *Protect Privacy*

Ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in Article XIII.A.1.

F. Second Opinion

The MCO, consistent with the scope of the MCO's benefit package, must provide for a second opinion from a qualified health care professional within the network. The MCO shall arrange for the member to obtain a second opinion outside the network, at no cost to the member, if the MCO does not have a health professional qualified to provide a second opinion.

G. Determining if Services, Procedures, Items and Treatments are Proven and Effective

1. *Non-coverage of experimental services, procedures, items and treatment*

As a general principle, Medicaid does not pay for services, procedures, items and treatments that it determines to be experimental in nature and which are not a proven and effective treatment for the condition for which it is intended or used. Experimental services are defined in Wis. Admin. Code §§ DHS 107.035(1) and (2).

2. *Services, procedures, items or treatments that are proven and effective*

   A service, procedure, item or treatment is not considered experimental when it is proven and effective, generally accepted medical practice and clinically appropriate to treat the member's condition.

3. *Determining if a service, procedure, item or treatment is proven and effective*

   The MCO shall utilize a process to determine whether a service, procedure, item or treatment is proven and effective.

   In this process, the MCO can consider:

   a. The current and historical judgment of the medical community as evidenced by medical research, studies, journals or treatises;

   b. The extent to which Medicare and private health insurers recognize and provide coverage; and

   c. The current judgment of experts and specialists in the medical specialty area or areas in which the service is applicable or used.

4. *Coverage of proven and effective services, procedures, items or treatment that is cost effective*

   After following the procedures outlined in this section, the MCO may cover services, procedures, items and treatments that the MCO has determined are proven and effective treatments for the conditions for which they are intended or used, if the services, procedures, items and treatments are cost effective.

H. Changes to Medicaid Covered Services Mandated by Federal or State Law

1. *Effective Date*

   Changes to Medicaid covered services mandated by federal or state law shall be effective as of the date specified in the federal or state law.

2. *Capitation Payment Adjustment*

   If any change in services in the benefit package occurs that are mandated by federal or state law, the Department shall adjust the capitation rate if necessary for the capitation rate to remain actuarially sound.

3. *Notification to MCOs*

   The Department will notify MCOs at least forty-five (45) calendar days prior to the effective date of any changes to services in the benefit package resulting from changes to Medicaid covered services mandated by federal or state law.

4. *Notification to Members*

   The MCO shall notify members at least thirty (30) calendar days prior to the effective date of changes in the type of services in the benefit package due to changes mandated by federal or state law.

I. 24-Hour Coverage

1. *Responsibility*

   The MCO shall be responsible twenty-four (24) hours each day, seven (7) days a week for providing members with services necessary to support outcomes including:

   a. Immediate access to urgent and emergency services needed immediately to protect health and safety.

   b. Access to services in the benefit package;

   c. Coordination of services that remain Medicaid fee-for-service for Family Care members who are Medicaid beneficiaries; and

   d. Linkages to Adult Protective Services.

2. *Policies and Procedures*

   The MCO shall develop and submit to the Department for approval a policy and procedure on the twenty-four (24)-Hour Coverage/On-Call system. The policy and procedure shall identify how the MCO meets the following requirements:

   a. Provide a telephone number that members or individuals acting on behalf of members can call at any time to obtain advance authorization for services in the benefit package. This number must provide access to individuals with authority to authorize the services in the benefit package as appropriate. Individuals at this number must also have familiarity with the MCO and the MCO's provider network.

   b. Respond to such calls within thirty (30) minutes.

   c. Assure adequate communication with the caller in the language spoken by the caller.

   d. Document these calls with time, date and any pertinent information related to person(s) involved, resolution and follow-up instructions and submit this documentation to the Department upon request.

   e. Notify members and the Department of any changes of the phone number within seven (7) business days of change.

J. Billing Members

1. *Prohibition on Billing Recipients for Covered Services*

   The MCO, its providers and subcontractors shall not bill a member for services in the benefit package provided during the member's enrollment period in the MCO, except for the purchase of enhanced services as allowed under this article, Section K., Department Policy for Member Use of Personal Resources. Post-eligibility treatment of income is not a bill for services. This provision pertains even if the:

   a. MCO becomes insolvent;

b. Department does not pay the MCO for covered services provided to the member;

c. Department or the MCO does not pay the provider that furnishes the services under a referral or other arrangement; and

d. Payment for services furnished under a subcontract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the service directly.

2. *Prohibition on Billing in Insolvency*

In the event of the MCO's insolvency, the MCO shall not bill members for debts of the MCO or for services in the benefit package and provided during the member's period of MCO enrollment.

3. *Prohibition on Billing Indian Recipients Premiums and Cost-Sharing for Items and Services Furnished by an Indian Health Care Provider*

The MCO, its providers and subcontractors, shall not require an Indian member to pay any enrollment fees, premiums, deductibles, co-payments, coinsurance or similar charges if he or she is furnished an item or service by an Indian health care provider (as defined under Article I.64). This prohibition does not apply to any cost-sharing for home and community-based waiver services or patient liability for nursing home services as specified in Article III.E.0. All members who owe such a cost share or patient liability are required to pay it as a condition for continued eligibility for Medicaid.

K. Department Policy for Member Use of Personal Resources

1. *Prohibited Use of Member Resources*

The MCO is responsible for items and services in the benefit package that are needed to support the member's individual long term care outcomes. The MCO and its providers are strictly prohibited from billing members for such services.

2. *Permitted Uses of Member Resources*

The MCO, an MCO provider, or the State Medicaid Program may accept personal resources in excess of cost share or patient liability from a member or the member's family or significant others in the following limited circumstances:

a. The member, member's family, or significant other wants to voluntarily purchase services or items that are not in the benefit package, which the MCO has denied, pursuant to Article V.K.8.g.v., as not being cost-effective substitutions for services or items in the benefit package, provided proper notice of that decision has been given to the member;

b. The member, member's family, or significant other wants to voluntarily purchase a service or item that is within the benefit package, limited to the services or items in paragraph 4.a. below, which has not been authorized by the MCO or included in the MCP because it has not been identified as

needed to support the member's long term care outcomes, provided proper notice of the MCO's decision denying the service or item has been given to the member;

c. The member, member's family, or significant other wants to voluntarily purchase a service or item that is within the benefit package, limited to the services or items in paragraph 4.a. below, as a substitute for an item or service authorized in the MCP where the member prefers a more costly alternative because it offers a broader scope or additional features than the service or item authorized by the IDT, or because the member prefers an additional amount or longer duration of the service or item authorized by the IDT;

d. The member, member's family, or significant other wants to voluntarily purchase a non-emergency, non-court-ordered service or item within the benefit package that is authorized by the MCO from an out-of-network provider, none of the conditions in Article VIII.A.3. or 5.b. applies, and the MCO has considered but decided not to authorize the out-of network provider because it does not meet the MCO's standards or accept the MCO payment rate for the service.

e. The member, member's family, or significant other wants to make a voluntary donation of cash or something else of value to the MCO (see Article I. for definition); or

f. The member, member's family, or significant other wants to make a voluntary payment to the State Medicaid Program.

3. *Counseling to Assure the Use of Personal Resources is Voluntary*

a. If a member-requested or received item or service has been denied, reduced, suspended, or terminated through the RAD or other department-approved authorization process with notice that meets the requirements under Article XI.D. (Notice of Adverse Benefit Determination), no additional counseling is required.

b. In any other situation where use of personal resources is permitted under sub-section 2 the MCO shall counsel the member that such use of personal resources is entirely voluntary and shall document this counseling in the case record. The counseling may be done by IDT staff or other MCO staff.

4. *Additional Conditions, Considerations and Limitations on Member, Family or Significant Others Purchasing Services or Items if in the Benefit Package*

These conditions and limits apply to the circumstances set forth in paragraphs K.2.b. and c. above where the MCO has not authorized a requested service or has authorized a less costly service than requested which differs in amount, duration, scope or features from the requested service.

a. Members, family and significant others may use their personal resources to purchase the requested service or item from the MCO or an MCO provider only for the following benefits, if covered in the benefit package:

   i. All long-term care services included in the Family Care benefit package that are listed in the Benefit Package Service Definitions, Addendum VII, Section A.

   ii. Private hospital room when not medically necessary;

   iii. Durable medical equipment;

   iv. Prosthetic dental services;

   v. Prosthesis;

   vi. Disposable medical supplies;

   vii. Eyeglasses; and

   viii. Hearing aids.

b. Members, family and significant other may not use their personal resources to purchase services or items for the following benefits, if covered in the benefit package:

   i. Physician services;

   ii. Hospital inpatient services, except a private room (MCO must cover private rooms when medically necessary);

   iii. Lab and x-ray

   iv. Therapies covered by Medicaid;

   v. Prescribed drugs under the State Plan drug benefit;

   vi. Acute and primary care and other benefits listed in the Benefit Package Service Definitions, Addendum VII, Section C, , unless listed in paragraph 4.a. above.

c. Payment Amounts for Services or Items

   The member's payment amount for such services or items will be based on the following payment policies:

   i. If the service or item substitutes for a service or item in the member's care plan or is an added value service or item (see paragraph 2.c. above), then the member is responsible for paying the difference between the plan's payment for a covered service or item and the cost of the substitute service or item.

   ii. If the service or item is not a substitute for a service or item in the member's care plan and is not an added value service or item, and is determined to be not necessary to support the member's

outcomes (see paragraphs 2.a. and b.), or if it's a non-emergency service the member chooses to purchase from an out-of network provider not authorized by the MCO and none of the conditions in Article VIII.A.3. or 5.b applies (see paragraph 2.d.), the member is responsible for paying the full cost of the service or item.

5. *Family or Others Payment for Services for a Member*

Payment for services by someone else on behalf of a member on an ongoing basis may be considered income for the member if the payment is made directly to the member rather than directly to the provider. In this situation, the MCO shall refer the member to the income maintenance agency.

6. *Purchase of Services through a Medicaid Eligibility Self-Support Plan*

Nothing in this section precludes a member from establishing a Medicaid eligibility self-support plan in accordance with Medicaid rules and using the income set aside under the self-support plan for the purchase of services related to training or purchasing equipment necessary for self-support. See Medicaid Eligibility Handbook, Section 15.7.2.2, http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm.

7. *Donations*

A member or the member's family or significant others may make a voluntary choice to transfer cash or something else of value to the MCO as a recognition of or expression of gratitude for services to the member. Such a choice is considered a donation.

A voluntary transfer of assets for the purpose of becoming or remaining eligible for Medicaid may be considered divestment of an asset and could lead to loss of Medicaid eligibility. When the MCO becomes aware that a member has made or plans to make a donation to the MCO or any other organization, the MCO shall always advise the member to consult with the local income maintenance agency to determine whether the donation will be considered a divestment.

8. *Voluntary Payments, Prepayments or Repayments*

The voluntary choice of a member or the member's family or significant others to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible or reduce potential claim in an estate is considered a voluntary payment, prepayment or repayment.

When the MCO is aware of a planned payment, the MCO shall refer to the income maintenance agency a member or the member's family or significant others who wish to make voluntary payments to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, or reduce the potential claim in an estate.

9. *Reporting*

a. The MCO shall report to the MCO Governing Board and in the MCO quarterly report it submits to the Department:

i. All circumstances within the scope of this section where a member or the member's family or significant others made a choice to voluntarily purchase items or services within the benefit package;

ii. All donations directly received by the MCO; and

iii. All circumstances when the member uses personal resources for an item or service in the benefit package from an out-of-network provider as indicated in Article VII.K.2.d.

b. The MCO does not need to report to the MCO Governing Board and in the MCO quarterly report it submits to the Department:

i. Voluntary payments the MCO is unaware of.

ii. Use of member resources that amount to less than $100 for a one time purchase or less than $50 per month for a service or item purchased on an on-going basis.

10. *Preventing Unacceptable Use of Member Resources*

Notwithstanding any other provision in this Section, the MCO shall take steps to investigate any situation in accordance with its Program Integrity Plan under Article XIII, Section K of this contract if the MCO learns that:

a. A member or the member's family or significant others has privately purchased a service or item in the benefit package or has made a donation directly; and

b. The MCO has reason to believe that this purchase or donation might involve a violation of, or be contrary to its Program Integrity Plan.

L. Prevention and Wellness

1. *Prevention and Wellness Plan*

Prevention and wellness shall be part of the normal course of communications with members, and the development of the member's MCP. The MCO shall inform all members of contributions they can make to the maintenance of their own health and the proper use of long-term care and health care services.

The activities and materials used in the prevention and wellness activities shall be accessible by the Department and the Centers for Medicare & Medicaid Services (CMS). The MCO's plan for implementing the prevention and wellness program must be approved by the Department. At any time the Department determines there has been a significant change in the MCO's capacity to offer prevention and wellness services or in the MCO's projected membership, the Department may

require the MCO to submit documentation to demonstrate its capacity to provide prevention and wellness services.

2. *Prevention and Wellness Program*

The MCO's prevention and wellness program shall include the following components:

a. Program Coordination

Designated staff are responsible for the coordination and delivery of services in the program.

b. Practice Guidelines

Practice guidelines are guidelines that are developed in consultation with contracting professionals to assist them to apply the current best evidence in making decisions about the care of individual members. The MCO will review and update practice guidelines periodically, as appropriate.

The MCO shall use practice guidelines for prevention and wellness services that include member education, motivation and counseling about long-term care and health care related services. The MCO must disseminate or make available the guidelines to providers for whom the guidelines apply and, upon request, to members.

Practice guidelines that are condition-specific and/or disease related shall include the following elements:

i. Overview of condition/disease;

ii. Information related to anticipating, recognizing and responding to condition/disease related symptoms;

iii. Information related to best practice standards for prevention and management of condition/disease;

iv. Guidelines/process for interdisciplinary team to use regarding negotiating incorporation of condition/disease prevention and management plan with member into the MCP; and

v. Plan for quality assurance monitoring of guideline effectiveness.

c. Measurement

The capacity to collect, analyze and report data necessary to measure the performance of the prevention and wellness program. The reports based on this data shall be communicated to providers and members.

d. Program Resources

Mechanisms for facilitating appropriate use of prevention and wellness services and educating members on health promotion.

e. Disease Prevention

Information and policies on the prevention and management of diseases which affect the populations served by the MCO. This includes specific information for persons who have or who are at risk of developing health problems that are likely to benefit from preventive practices. Hypertension and diabetes are examples of such health problems.

f. Independent Functioning

Information and policies on maintaining and improving members' functional status, and the ability to perform ADLs and IADLs more independently, for the populations served by the MCO. This includes specific information for persons who have or who are at risk of impaired ability to function independently and are likely to benefit from preventive practices.

g. Outreach Strategies

Outreach strategies for identifying and reaching members who are least likely to receive adequate preventive services.

h. Special Health Issues

The dissemination of information relevant to the membership, such as nutrition, alcohol and other drug abuse (AODA) prevention, reducing self-mutilation behaviors, exercise, skin integrity, self care training, and coping with dementia.

i. General Information

The dissemination of information on how to obtain the services of the prevention and wellness program (e.g., resource center, public health department etc.), as well as additional information on, and promotion of, other available prevention services offered outside of the MCO, such as special programs on women's health.

j. Sensitivity to Population

Long-term care and health care related educational materials produced by the MCO shall be appropriate for its target population(s) and reflect sensitivity to the diverse cultures served.

M. Court-Ordered Services

1. *Coordinate with County Agencies*

The MCO shall attempt to coordinate the provision of court-ordered services with the county agencies that provide services to the court.

2. *Provide Court-ordered Services*

   The MCO shall provide for court-ordered services and treatment if the service is a benefit package service for which the MCO would be the primary payer and the member has been court ordered into placement or to receive services such as through Wis. Stats. Chs. 51, 54, or 55.

3. *Prompt Referrals or Authorization*

   Necessary MCO referrals or treatment authorizations for court-related protective, Alcohol and Other Drug Abuse (AODA) and/or mental health services must be furnished promptly. For AODA any services requiring a referral or authorization of services it is expected that no more than five (5) business days will elapse between receipt of a written request by the MCO and the issuance of a referral or authorization for treatment. Such referral or authorization, once determined to be medically necessary, will be retroactive to the date of the request. After the fifth 5th) business day an assumption will exist that an authorization has been made until such time as the MCO responds in writing.

4. *Emergency Court-Ordered Services*

   The MCO has responsibility to pay for protective treatment services in the benefit package provided on an emergency basis or as ordered by the court as the result of court action or as part of a stipulated agreement between the county protective service unit and the member.

5. *Collaborate on the Plan of Care*

   Whenever possible, the MCO shall collaborate with the appropriate county agency to develop recommendations to the court for a plan of care that meets the protective service and/or treatment needs of the member.

6. *Utilize the MCO Network of Providers*

   Whenever possible, protective and/or treatment services shall be provided within the MCO network of providers.

7. *Non-network Providers*

   The MCO will pay for covered services provided by a non-network provider to any member pursuant to a court order, effective with the receipt of a written request for authorization from the non-network provider, and extending until the MCO issues a written denial of authorization. This requirement does not apply if the MCO issues a written denial of authorization within five (5) business days of receiving the request for referral.

N. Elder Adults/Adults at Risk Agencies and Adult Protective Services

1. *MCO Responsibility*

   MCOs shall make reasonable efforts to ensure that their members are free from abuse, neglect, self-neglect and exploitation.

2. *Policies and Procedures*

   The MCO shall have policies, procedures, protocols and training to ensure that MCO staff:

   a. Are able to recognize the signs of abuse, neglect, self-neglect, and exploitation as defined in Wis. Stats. §§ 46.90 and 55.01.

   b. Identify members who may be at risk of abuse, self-neglect and exploitation and in need of elder adult/adult-at-risk or adult protective services (EA/AAR/APS).

   c. Report incidents involving member abuse, neglect, self-neglect and exploitation as provided in Wis. Stats. §§ 46.90(4)(ar) and 55.043(1m)(br).

   d. Refer members at risk or in need of services to the appropriate EA/AAR/APS agency.

   e. Update the member's care plan as needed to balance member needs for safety, protection, physical health, and freedom from harm with overall quality of life and individual choice.

   f. Follow-up to ensure that member needs are addressed on an ongoing basis.

3. *Access to Elder Adults/Adults at Risk (EA/AAR) and Adult Protective Services (APS)*

   For members in need of services provided by EA/AAR Agencies or APS, the MCO shall involve the entity or Department (which the County has designated to administer EA/AAR/APS) in the following capacities:

   a. The MCO shall, as appropriate, invite an EA/AAR/APS staff person to participate in the member-centered planning process including plan development and updates, comprehensive assessment and re-assessments;

   b. The MCO shall, as appropriate, invite an EA/AAR/APS staff person to participate on the interdisciplinary team to the extent that the staff person makes recommendations as necessary to fulfill their EA/AAR/APS responsibilities; and

   c. The MCO shall designate a contact person to assist staff working in county EA/AAR/APS agencies to develop service options for MCO members or potential members. This contact person, or a representative of the member's MCO interdisciplinary team, may participate in the county EA/AAR interdisciplinary team.

4. *Examination and Treatment Services*

   The MCO shall arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of elder abuse, abuse of vulnerable adults, and domestic violence. Such expertise shall include the identification of possible and potential victims of elder abuse and domestic violence, statutory

reporting requirements, and local community resources for the prevention and treatment of elder abuse and domestic violence.

The MCO shall consult with human service agencies on appropriate providers in their community.

The MCO shall further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

5. *Memoranda of Understanding on Adult Protective Services*

The MCO shall enter into memorandums of understanding with the Elder Adults/Adults-At-Risk/Adult Protective Services agencies in each of the counties in its service area. These MOUs shall follow the policies and procedures issued by the Department and shall be submitted to the Department for review and approval.

6. *Court Ordered Services*

The MCO shall comply with the provisions in Section L, Court-Ordered Services, in this article for all adult protective services through Wis. Stats. §§ 51, 54, or 55.

O. Facility Closures

The MCO shall ensure participation by staff with knowledge about community services at Chapter 50 facility closure/relocation meetings for facilities in the MCO service area. Participation will be:

1. At initial closure planning meetings; and
2. When one or more residents of the facility are MCO members or are interested in and eligible for enrollment in the MCO.

Participation may be in person or by telephone. The MCO will abide by the direction of the Department relative to the placement of monitors and/or the appointment of receivership under Wis. Stats. § 50.05.

P. MOU on Institute for Mental Disease (IMD) Discharge Planning

MCOs will negotiate, or make a “good faith” effort to negotiate, an MOU with all counties within their service areas addressing expectations for discharge planning when the member, someone who was a member prior to losing eligibility due to institutional status, or someone who is eligible to enroll upon discharge, is currently a resident of an IMD. The purpose of this discharge planning will be to return the individual to the most integrated setting appropriate to his/her needs. The MOU will state that as part of the discharge planning, a crisis plan will be established for each member designed to maintain the person in his/her community. This plan will be developed in collaboration between the MCO, County crisis programs, providers and other stakeholders.

Q. Private Pay Care Management

The MCO shall provide care management to private pay individuals as follows (Refer to Article I for definitions of "Care Management" and "Private Pay Individual"):

1. *Care Management Available for Purchase*

   An MCO shall offer care management services, at rates approved by the Department, to private pay individuals who wish to purchase the services. A private pay individual may purchase from the MCO any types and amounts of care management. The types and amounts of care management and the cost of the services shall be specified in a written agreement signed by the authorized representative of the MCO and the individual purchasing the service or the person's legal decision maker. The private pay care management agreement shall meet the following:

   a. The MCO's rates for private pay care management shall either:

      i. Be no higher than the Medicaid targeted care management rates which are in effect at the time of providing the service; or

      ii. Be approved by the Department.

   b. The MCO shall meet with the individual to achieve the following:

      i. Fully review the specific aspects of care management the individual may purchase;

      ii. Clearly explain the cost of the service, and the billing and payment arrangements, including provisions for discontinuing service for failure to pay;

      iii. Clarify the specific care management tasks the individual agrees to purchase, the amount (e.g., number of hours) of care management that is being purchased, and who will be providing the care management;

      iv. Inform private pay individuals of their rights under federal and state law (such as the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990) and their rights to have access to their service records in accordance with applicable Federal and State laws;

      v. Inform private pay individuals that they are not eligible to purchase services from MCO's contracted providers at rates the MCO has negotiated for services it purchases for its Medicaid members.

      vi. Private pay individuals may purchase services from the MCO or the MCO's contracted providers at rates the MCO has negotiated for private pay individuals if the MCO chooses to do this; and

      vii. Execute a written agreement containing the specific information described above. This agreement shall be signed by an authorized

representative of the MCO and by the individual purchasing the service, or that person's legal decision maker.

c. The MCO's private pay care management service shall contain the following aspects at a minimum:

i. A comprehensive assessment of the person's long-term care and health care needs;

ii. Development of a care plan to meet the needs identified in the comprehensive assessment, as well as the person's identified outcomes and lifestyle preferences. The care plan in no way limits the person's ability to purchase services at his/her own expense from providers;

iii. Implementation and coordination of the care plan;

iv. As appropriate, either assisting the person in filing appeals and grievances with non-network providers, or referring the person for advocacy services; and

v. Periodic reassessment, with appropriate updates to the care plan.

d. Individuals purchasing private pay care management may access the MCO's appeal and grievance process only insofar as those appeals or grievances pertain to the care management provided by the MCO. Appeals or grievances about other non-network services, which may be coordinated by the MCO, shall be filed with the service provider and if desired, with the appropriate regulatory agency.

e. The MCO shall provide all ADRCs in its service area with copies of its policies, procedure and rates regarding care management and other MCO services available for purchase by privately paying customers.

2. *Limitations on Purchase of Other Services*

a. A private pay individual may not enroll in Family Care or Partnership, but, subject to Section Q.1.b. of this article may purchase services other than care management services, at private pay rates, subject to the following limitations:

i. A private pay individual as defined in Article I.115.b).i (i.e. not financially eligible) may only purchase services that the MCO provides directly and offers to the general public, at prices normally charged to the public.

ii. A private pay individual as defined in Article I.116.b).ii and iii may purchase any service purchased or provided by the MCO for its members (i.e. services that the MCO provides directly and services the MCO provides indirectly through its provider network).

R. Provider Moral or Religious Objection

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

- To the Department;
- With the MCO's application for a Medicaid contract;
- Whenever the MCO adopts the policy during the term of the contract;
- It must be consistent with the provisions of 42 C.F.R. § 438.10;
- It must be provided to potential members before and during enrollment;
- It must be provided to members at least thirty (30) days before the effective date of the policy; and
- In a written and prominent manner, the MCO shall inform an applicant, on or before an individual enrolls, of any benefits to which the member may be entitled under the benefit package but which are not available through the MCO because of an objection on moral or religious grounds.

As specified in 42 C.F.R. § 438.10(g)(2)(ii)(A) and (B), the MCO must inform enrollees how they can obtain information from the Department about how to access the excluded service

S. Electronic Visit Verification (EVV)

The MCO shall implement EVV for designated service codes by the deadlines established by the Department. The MCO will use data collected from the EVV system to validate claims pertaining to affected service codes against approved authorizations during the claim adjudication process. Encounters without a valid EVV record may be excluded in future rate setting development. Prior to implementation, the MCO shall outline expectations for contracted providers regarding the use of the EVV data collection system within the subcontract. MCOs shall also provide assistance and support to DHS and contracted EVV vendor for training, outreach, and utilization of the data collection system, as requested.

VIII. Provider Network

The MCO shall establish and maintain a provider network that furnishes timely, quality services in the benefit package.

A. Member Choice

1. *Information to Members*

   The MCO shall inform members about the full range of provider choice available to them, including free choice of medical and other providers that remain fee-for-service for Family Care members, as applicable.

2. *Member Choice of Interdisciplinary Teams*

   The MCO shall allow a member to change interdisciplinary teams up to two times per calendar year if the MCO has additional interdisciplinary teams to offer the member.

3. *Member Choice of Intimate Care Providers and Providers Regularly in the Home*

   For services in the LTC benefit package that involve providing intimate personal care or when a provider regularly comes into the member's home, the MCO shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the MCO's standards and reimbursement rates for providers of the same service. (See Section N.3., Intimate Care Services, in this article for intimate care services standards when the MCO employs the care worker.) These services include, but are not limited to, personal care, home health, private duty nursing, supportive home care and chore service.

   The provisions of provider agreements for services mentioned in this paragraph shall focus on quality and cost effectiveness, and not be constructed in such a way so as to limit the network of providers.

4. *Choice of Network Provider*

   Members must choose a provider from the MCO's provider network, except an Indian member in the Partnership program may, per Article VIII.O.1.b. choose to obtain primary care services from an out-of-network Indian health care provider that meets the state's provider qualifications other than having a provider contract with the MCO. The MCO will honor member's requests to enroll a provider in the MCO's provider network to the extent appropriate and possible.

   The MCO shall inform members at the time of enrollment that they have the right to change providers. If the MCO is not able to accommodate a member's choice of provider, the member may voluntarily disenroll from the program.

5. *Non-Network Providers*

   a. The MCO shall maintain a process to consider a member's request for a non-network provider, which is a provider who does not have an agreement with the MCO for providing services in the benefit package to

members. The MCO processes, strategies, evidentiary standards, or other factors in determining access to non-network mental health or substance use disorder providers shall be comparable to and applied no more stringently than the process for non-network medical or surgical providers. Only Non-network providers that satisfy the MCO's standards will be considered.

b. The MCO shall adequately and timely authorize and arrange for services with non-network providers when:

i. The MCO does not have the capacity to meet the need(s) of the member and provide medically necessary services or necessary long-term care services in the benefit package;

ii. The MCO does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers;

iii. The MCO cannot meet the need(s) of the member on a timely basis;

iv. Transportation or physical access to the MCO providers causes an undue hardship to the member; or

v. The member is an Indian who wants to obtain covered services in the benefit package from an out-of-network Indian health care provider that meets the state's provider qualifications other than having a provider contract with the MCO.

c. The MCO must coordinate payment with non-network providers for out-of-network services authorized by the MCO, as well as emergency or court ordered services obtained out-of-network. The MCO must ensure that cost to the member is no greater than it would be if the services were provided within the Network.

d. Second Opinion from a Non-Network Provider

If the MCO does not have a health professional qualified to provide a second opinion in accordance with Article VII.F., Second Opinion , the MCO shall arrange for the member to obtain a second opinion outside the network, at no cost to the member.

B. Member Communications

1. *Licensed Health Care Providers Advising and Advocating*

An MCO may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an member who is his/her patient, including any of the following:

a. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

b. For any information the member needs in order to decide among all relevant treatment options;

c. For the risks, benefits, and consequences of treatment or non-treatment;

d. For the member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2. *Information to Members*

Upon the request of members, the MCO shall make available:

a. The licensure, certification and accreditation status of the managed care organization, its staff and providers in the MCO's provider network;

b. The education, board certification and recertification of health professions who are certified by Medicaid and the qualifications of other providers; and

c. Information about the identity, locations, and availability of services in the benefit package from providers that participate in the MCO.

C. Provider Agreements

In addition to the requirements specified at Article XIII.C and D. provider agreements must meet the following requirements under Article VIII.C and D.

1. *Certification of Provider Agreements*

a. The Department shall review MCO provider agreements. The Department's provider agreement review will assure that the MCO has the standard language in this article in its provider agreements.

b. By the effective date of this contract, the MCO shall have submitted to the Department its provider agreements, or revisions to previously approved provider agreements, for approval. This can occur by one of two means:

i. The MCO submits each provider agreement; or

ii. The MCO submits template language planned for use in the MCO's provider agreements.

c. The MCO shall attest annually that all provider agreements include the required provisions for provider agreements in this article.

D. Provider Agreement Language

All provider agreements for member services shall be in writing, shall include the provisions of this subsection, and shall include and comply with any general requirements of this contract that are appropriate to the service. All amendments to provider agreements shall be in writing and signed and dated by both the provider and the MCO.

The provider must agree to abide by all applicable provisions of this contract. Provider compliance with this contract specifically includes, but is not limited to, the following requirements (except for specific areas that are inapplicable in a specific provider agreement):

1. *Parties of the Provider Agreement*

   The MCO and provider entering into the agreement are clearly defined.

2. *Purpose of the Program*

   The provider agreement clearly defines the purpose of the program.

3. *Services*

   The provider agreement clearly delineates the services being provided, arranged, or coordinated by the provider.

4. *Compensation*

   The provider agreement specifies rates for purchasing services from the provider. The provider agreement specifies payment arrangements in accordance with Section L., Payment, of this article.

5. *Term and Termination*

   a. The provider agreement specifies the start date of the provider agreement and the means to renew, terminate and renegotiate. The provider agreement specifies the MCO's ability to terminate and suspend the provider agreement based on quality deficiencies and a process for the provider appealing the termination or suspension decision.

      The MCO will ensure that provider agreements reflect all current MCO contract and provider agreement requirements.

   b. Residential rates

      Residential rates shall be for a period of not less than one year, unless there is mutual agreement upon a shorter term. Residential services provider agreements or amendments shall specify a contracted rate, include a fee schedule or reference an acuity-based rate setting model. Rates may be changed:

      i. Anytime, through mutual agreement of the MCO and provider.

      ii. When a member's change in condition warrants a change in the acuity-based rate setting model.

      iii. When a rate has been in effect for at least twelve (12) months, and a change is proposed for an individual member or facility:

         a) The MCO must provide a sixty-day written notice to the provider prior to implementation of the new rate.

b) The rate change may apply to the entire contract or to specific rates within the contract, but only on a prospective basis.

c) Rates which are reduced using sub iii are protected from additional decreases during the subsequent twelve (12) month period.

Nothing herein shall impair the right of either party to terminate a residential services contract as otherwise specified therein.

6. *Supportive Home Care and In-Home Respite Services*

The MCO shall specify in its provider agreements with providers of supportive home care or in-home respite care services that the provider shall comply with the *Family Care Training and Documentation Standards for Supportive Home Care and In-Home Respite*, https://www.dhs.wisconsin.gov/publications/p01602.pdf.

7. *Legal Liability*

The provider agreement must not terminate legal liability of the MCO.

If the MCO delegates selection of providers to another entity, the MCO retains the right to approve, suspend, or terminate any provider selected by that entity.

8. *Quality Management (QM) Programs*

The provider agrees to participate in and contribute required data to the MCO's QM programs as required in Article XII, Quality Management (QM).

9. *Utilization Data*

The provider agrees to submit MCO utilization data in the format specified by the MCO, so the MCO can meet the Department's specifications required by Article XIV, Reports and Data.

10. *Restrictive Measures*

The MCO must require its providers to adhere to regulatory requirements and standards set by the MCO relative to restrictive measures including any type of restraint, isolation, seclusion, protective equipment, or medical restraint as required in Article V.J.4. Use of Isolation, Seclusion and Restrictive Measures.

11. *Member Incidents*

The MCO shall require its providers to identify, respond to, document, and report member incidents as required in Article V.J.5. Identifying and Responding to Member Incidents.

12. *Non-Discrimination*

The provider agrees to comply with all non-discrimination requirements and all applicable affirmative action and civil rights compliance laws and regulations as

described in Article XIII.B. (also reference https://www.dhs.wisconsin.gov/civil-rights/index.htm).

13. *Insurance and Indemnification*

The provider attests to carrying the appropriate insurance and indemnification.

The provider agreement shall state the specific indemnification requirements the provider is required to satisfy and the minimum insurance the provider is required to carry.

14. *Notices*

The provider agreement specifies a means and a contact person for each party for purposes related to the provider agreement (e.g., interpretations, provider agreement termination).

15. *Access to Premises and Audit Rights*

The provider agrees to provide representatives of the MCO, as well as duly authorized agents or representatives of the Department and the Federal Department of Health and Human Services, access to its physical premises, equipment, books, contracts, records, and computer or other electronic systems in accordance with Article XIII.J., Access to Premises and Information.

16. *Certification and Licensure*

The provider agrees to provide applicable licensure, certification and accreditation status upon request of the MCO and to comply with all applicable regulations. Health professions which are certified by Medicaid agree to provide information about their education, board certification and recertification upon request of the MCO. The provider agrees to notify the MCO of changes in licensure.

17. *Sanctions/Criminal Investigations*

The provider must notify the MCO of any sanctions imposed by a governmental regulatory agency and /or regarding any criminal investigations(s) involving the provider.

18. *Cooperation with Investigations*

To the extent permitted by law, the provider agreement shall require the provider to fully cooperate with any member-related investigation conducted by the MCO, the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity.

19. *Records*

The provider agrees to comply with all applicable Federal and State record retention requirements in Article XIV.F., Records Retention.

20. *Member Records*

The provider agrees to the requirements for the confidentiality protection, maintenance and transfer of member records described in Article XIII.A.

The provider agrees to make records available to members and his/her legal decision makers within ten (10) business days of the record request if the records are maintained on site and sixty (60) calendar days if maintained off site in accordance with the standards in 45 C.F.R. Wis. Stats. § 164.524 (b)(2).

The provider agrees to forward records to the MCO pursuant to grievances and appeals within fifteen (15) business days of the MCO's request or, immediately, if the appeal is expedited. If the provider does not meet the fifteen (15) business day requirement, the provider must explain why and indicate when the records will be provided.

21. *Confidentiality*

The provider agrees otherwise to preserve the full confidentiality of records, in accordance with Article XIII.A., Member Records, and protect from unauthorized disclosure all information, records, and data collected under the provider agreement. Access to this information shall be limited to persons who, or agencies such as the Department and CMS which, require information in order to perform their duties related to this contract.

22. *Access to Services*

The provider agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services in the benefit package that are necessary to support outcomes.

23. *Authorization for Providing Services*

The provider agreement directs the provider on how to obtain information that delineates the process the provider follows to receive authorization for providing services in the benefit package to members. The provider agrees to clearly specify authorization requirements to its providers and in any provider agreements with its providers.

MCOs shall ensure service authorization is given to the provider prior to the start date of designated services by the provider. When prior written authorization is not practicable, verbal authorization should be provided for the service and written authorization issued thereafter. Services provided on an emergency basis should be followed up with written confirmation of the service, when appropriate.

Revised service authorizations shall be issued to providers promptly, with sufficient notice to allow providers to comply with the terms of the revised service authorization (for example, to prevent providers from unknowingly exceeding reduced authorized service units) and to timely submit accurate claims during the appropriate billing period.

24. *Billing Members /Hold Harmless*

The payments by the MCO and/or any third party payer will be the sole compensation for services rendered under the contract. The provider agrees not to bill members and to hold harmless individual members, the Department and CMS in the event the MCO cannot pay for services that are the legal obligation of the MCO to pay, including, but not limited to, the MCO's insolvency, breach of contract, and provider billing.

The MCO and the provider may not bill a member for covered and non-covered services, except in accordance with provisions in Article VII, Sections J. Billing Members, and K. Department Policy for Member Use of Personal Resources and Article IV, Section A.3.

25. *Provider Appeals*

The provider agrees to abide by the terms of Section VIII.M,

Appeals to the MCO and Department for Payment/Denial of Providers Claims of this article.

The MCO must furnish all providers information regarding the provider appeals process at the time they enter into the contract, and through provider materials posted on the MCO's website or sent to providers, upon request.

26. *Member Appeals and Grievances*

The provider must recognize that members have the right to file appeals or grievances and assure that such action will not adversely affect the way that the provider treats the member.

The provider agrees to cooperate and not interfere with the members' appeals, grievances, and State Fair Hearings procedures and investigations and timeframes in accordance with Article XI, Grievances and Appeals.

The MCO must furnish the following grievance, appeal, and State Fair Hearing procedures and timeframes to all providers and subcontractors at the time that they enter into a contract:

a. The member's right to request a State Fair Hearing after the member has exhausted the MCO's appeal process, the process the member must follow to obtain a State Fair Hearing, and the representation rules at a hearing;

b. The member's right to file grievances and appeals and their requirements and timeframes for filing;

c. The availability of assistance in filing;

d. The toll-free numbers to file oral grievances and appeals;

e. The member's right to request the continuation of his or her benefits throughout the appeal and State Fair Hearing process when the MCO is seeking to reduce or terminate those benefits and, if the MCO's adverse

benefit determination is upheld in a hearing, the member may be liable for the cost of any continued benefits; and

f. The member's appeal rights to challenge the failure of the MCO to cover a service.

27. *Prohibited Practice*

a. The MCO and the provider agree to prohibit communication, activities or written materials that make any assertion or statement, that the MCO or provider is endorsed by CMS, the Federal or State government, or any other entity.

b. Marketing/outreach activities or materials distributed by a residential services provider, which claim in marketing its services to the general public, that the Family Care or Partnership programs will pay for an individual to continue to receive services from the provider after the individual's private financial resources have been exhausted are prohibited.

c. Marketing/outreach activities as described in Article IX.A.5.a.-g., are prohibited.

28. *Provider Preventable Conditions*

The provider must report to the MCO all provider preventable conditions with claims for payment or member treatments for which payment would otherwise be made.

29. *Provider Claim Submission Deadline*

The provider agreement shall specify the number of days that a provider has from the date of service to file a claim.

The provider agreement shall also specify how the above deadline is applied to claims consisting of multiple dates of service.

In the absence of the above required information, the 12-month timeframe specified in 42 C.F.R. § 447.45(d) will apply to the submission of claims.

30. *Overpayments*

The provider agreement requires the provider to do all of the following when it has received an overpayment from the MCO:

a. Report the overpayment to the MCO when identified;

b. Return the overpayment to the MCO within sixty (60) calendar days of the date on which the overpayment was identified; and

c. Notify the MCO in writing of the reason for the overpayment. (See Article XIV, Reports and Data, for encounter reporting of recoveries of provider overpayments when received).

31. *Direct Care Workforce Provider Payment Permitted Uses and Reporting Requirements*

    a. Definition of Direct Care Worker

    Under this section, a "direct care worker" is defined as an employee who contracts with or is an employee of an entity that contracts with an MCO to provide adult day care services, daily living skills training, habilitation services, residential care (adult family homes of 1-2 beds, adult family homes of 3-4 beds, community-based residential facilities, residential care apartment complexes), individual and group supported employment, prevocational employment, vocational futures planning, respite care services provided outside of a nursing home, and supportive home care, and who provides one or more of the following services through direct interaction with members: assisting with activities of daily living or instrumental activities of daily living, administering a member's medications, providing personal care or treatments for a member, conducting activity programming for a member, assisting with employment activities and skills, or providing services such as food service, housekeeping or transportation to the member. Staff who would be excluded from the definition of "direct care worker" include but are not limited to: licensed practical nurses, registered nurses, nurse practitioners, nursing home staff, personal care agency staff, staff in marketing, sales, reception, finance, maintenance/plant operations and those staff who work exclusively in food service, transportation, and housekeeping and do not have direct contact with members.

    b. Provider Use of Direct Care Workforce Funds

    The provider agreement shall include the following provisions regarding the use of any funds received pursuant to Article VIII.L.9.:

    i. That the funds shall only be used for the following purposes or to pay for employer payroll tax increases that result from using the funds for one of the following purposes:

        a) Wage increases;

        b) Retention/longevity bonuses;

        c) Performance bonuses;

        d) Employee paid time off;

        e) Staff referral bonus;

        f) Sign on bonus;

        g) Supplemental payments to workers during the declared state of emergency in response to the COVID-19 pandemic that are above and beyond a worker's normal reimbursement for hours worked

ii. That providers must complete making payments to direct care workers within 6 months of receiving te payment from the MCOs they contract with.

iii. That providers may claim expenditures they made in the 12 months prior to receiving the direct care workforce payment as appropriate uses of the direct care workforce funding.

iv. That providers must distribute the direct care workforce funding to direct care workers providing services to Family Care or Family Care Partnership members in Wisconsin.

v. Providers must submit the signed provider agreement to the MCO within 45 days from when the MCO sent the agreement to the provider to be eligible for the initial direct care workforce payment; and

vi. Providers that submit the signed provider agreement to the MCO after 45 days will only be eligible for direct care workforce funding distributed after the signed provider agreement was received by the MCO.

c. Provider Documentation and Reporting

The provider agreement shall require the provider, upon acceptance of the above-referenced funds, to respond to Department-developed surveys regarding the funds' use and effectiveness, to attest to the manner in which the funds were used, and to retain documentation proving the funds were paid to individual workers.

d. Provider Ineligibility for Direct Care Workforce Funding

i. The provider agreement shall specify that when a direct care workforce provider discontinues operations or enters bankruptcy, the provider will not be eligible for direct care workforce payments.

ii. Subject to iii. below, The provider is only eligible for direct care workforce funding if they have a contract with the MCO to provide Family Care or Family Care Partnership services at the time the MCO distributes the direct care workforce funding. Providers that do not have an active service contract with the MCO are not eligible to receive direct care workforce funding.

iii. If an MCO discontinues operations in a geographic service region in which the provider is located, providers remain eligible for direct care workforce funding from that MCO if they had a contract with that MCO to provide the specified Family Care or Family Care Partnership services 30 days prior to that MCO discontinuing operations in the geographic service region.

e. Changes in Provider Identification

i. The Department will specify information unique to each provider to calculate the amount of direct care workforce funding for each provider. Providers that change or discontinue their unique identifying information will only receive funding after the Department gives the MCO approval to distribute the funding. Providers that change their unique identifying information are required to submit documentation to the MCO that the old and new information belong to the same provider.

32. *Accessibility*

The provider agreement must contain the following language: "The provider agrees to provide, as appropriate, physical access, reasonable accommodations, and accessible equipment to members with physical and/or mental disabilities."

33. *Electronic Visit Verification*

The MCO shall require applicable providers to utilize the DHS EVV system.

E. Prohibited Provider Agreement Language

In accordance with Wis. Stats. § 46.284(2)(d), MCOs are prohibited from including in a contract for residential services, prevocational services, or supported employment services a provision that requires a provider to return to the MCO any funding that exceeds the cost of those services.

F. Network Providers

1. *MCO Provider Selection and Retention Process*

a. The MCO shall implement written policies and procedures for network provider selection and retention process that meet the requirements of this article.

b. The MCO must allow any community-based residential facility (CBRF), residential care apartment complex (RCAC), community rehabilitation program, home health agency, day service provider, personal care provider, or nursing facility to serve as a network provider if:

i. The provider agrees to be reimbursed at the MCO's contract rate negotiated with similar providers for the same care, services, and supplies; and

ii. The facility or organization meets all guidelines established by the MCO related to quality of care, utilization, and other criteria applicable to facilities or organizations under contract for the same care, services, and supplies.

c. If the MCO declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.

d. In establishing provider agreements and subcontracts, the MCO shall seek to maximize the use of available resources and to control costs.

e. In establishing a provider network, an MCO is:

i. Not required to contract with providers beyond the number necessary to meet the needs of its members;

ii. Not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

iii. Not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

2. *Discrimination*

a. The MCO shall not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.

b. The MCO shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

3. *Training*

The MCO will ensure that providers of services maintain a level of training appropriate to the services that they provide.

a. The MCO will identify areas where the need for further provider training is evident and share information with providers about available resources and training.

b. The MCO shall facilitate training provided by the Department to network providers.

G. Provider Certification and Standards

1. *Wisconsin Provider Standards*

The MCO shall use only providers that meet Department requirements, and

a. For waiver services in Addendum VII.A.:

i. Meet the provider standards in Wisconsin's approved s. 1915 (c) home and community-based waiver,

ii. Meet all required licensure and/or certification standards applicable to the service provided,

iii. Are enrolled with the Department; and

iv. If a newly licensed or certified residential provider*or a newly operating non-residential setting in which adult day care, prevocational, adult day habilitation, or group supported employment services are provided, the setting has been determined by the certification agency or the Department to be in compliance with the home and community based setting requirements under 42 C.F.R. § 441.301(c)(4). An exception to this requirement is a setting that was operating prior to March 17, 2014 that is subject to heightened scrutiny and is awaiting a determination of compliance from CMS. Any new residential setting or new non-residential setting in which adult day care, prevocational, adult day habilitation, or group supported employment services are provided must be in compliance with 42 C.F.R. § 441.301(c)(4) before the MCO can use the setting; or

b. For State Plan services in Addendum VII.B and C:

i. Are certified as providers under Wis. Admin. Code § DHS 105 to provide acute, primary or long term care services specified in Wis. Admin. Code § DHS 107,

ii. Meet all required licensure and/or certification standards applicable to the service provided, and

iii. Are enrolled with the Department; or

c. Meet the MCO's provider standards that have been approved by the Department.

*Members residing in an existing residential setting that has been determined to not be in compliance with the home and community based setting requirements under 42 C.F.R. § 441.301(c)(4) may continue to reside in that setting pursuant to the Department approved MCO member transition plan.

2. *Laboratory Providers for Partnership*

For laboratory providers, the MCO will use only laboratories that have a valid Clinical Laboratory Improvement Amendments (CLIA) certification or a certificate along with a CLIA identification number and that comply with the CLIA regulations as specified by 42 C.F.R. Wis. Stats. § 493D. Those laboratories with certificates will provide only the types of tests permitted under the terms of 42 C.F.R. Wis. Stats. § 493.

3. *Emergency and Non-Clinical Services*

Exceptions to provider certification standards may include emergency medical services and non-clinical services or as otherwise requested by the MCO and approved by the Department.

4. *Excluded Providers*

All providers utilized by the MCO must not be excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. Except for emergency services, Medicaid payment is not available for excluded providers.

H. Cultural Competency

1. *Cultural Competency and Values*

The MCO shall encourage and foster cultural competency among MCO staff and providers.

The MCO shall incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs, being sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity, and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds.

The MCO shall have specific policy statements on these topics and communicate them to subcontractors and providers.

2. *Cultural Preference and Choice*

The MCO shall permit members to choose providers from among the MCO's network of providers based on cultural preference, including the choice of Indian members to choose to receive services from any Indian health care provider in the network as long as that provider has capacity to provide the services.

3. *Appeals and Grievances*

The MCO shall accept appeals and grievances from members related to a lack of access to culturally appropriate care. Culturally appropriate care is care delivered with sensitivity, understanding, and respect for the member's culture.

I. Access to Providers

1. *Access Standards*

The MCO shall demonstrate to the Department that all services and all service providers comply with access standards provided in Article VII, Services, and the access standards in this article.

2. *Assuring Member Access to Care and Services*

   The MCO must do the following to assure access:

   a. Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.

   b. Ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service members, if the provider serves only Medicaid members.

   c. Make benefit package services that are necessary to support outcomes or that are medically necessary, available twenty-four (24) hours a day, seven (7) days a week, as appropriate.

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

3. *Assuring Network Capacity*

   The MCO shall demonstrate to the Department an adequate internal staff and provider capacity to provide the projected membership in the service area with:

   a. The appropriate range of services to make all services in the benefit package readily available to all members, including those with limited English proficiency or physical or mental disabilities;

   b. A sufficient number, mix, and geographic distribution of providers of all services;

   c. Access to prevention and wellness services;

   d. Specialized expertise with the target population(s) served by the MCO;

   e. Culturally competent providers (see Section H. of this article) including Indian health care providers; and

   f. Services that are physically accessible and available on a timely basis.

4. *Frequency of Documentation of Network Capacity*

   a. The MCO must provide documentation to the Department, in a format specified by the Department, that it satisfies Article VIII.I.3.a. and b. at the following times:

      i. By the effective date of this contract;

      ii. Annually; and

iii. At any time there has been a significant change (as defined by the Department) in the MCO's operations that would affect the adequacy of capacity and services, including:

a) An increase or reduction of twenty-five (25) percent or more in the number of members in the MCO's service area as compared to the number of members reported in the most recent documentation provided to the Department;

b) A reduction of five (5) percent or more in the number of providers in the service area as compared to the number of providers reported in the most recent documentation provided to the Department;

c) Changes in MCO services, benefits, geographic service area, composition of, or payments to its provider network; or

d) Enrollment of new population in the MCO.

b. The MCO must provide documentation to the Department, in a format specified by the Department, that it satisfies Article VIII.I.3.c. through f. at the following times:

i. By the effective date of this contract; and

ii. Annually.

5. *Assuring Network Adequacy*

The MCO shall demonstrate that its provider network complies with the state developed network adequacy standards (time and distance and non-time and distance) as specified in the MCO Provider Adequacy Policy: https://www.dhs.wisconsin.gov/publications/p02542.pdf.

DHS may grant an exception to these standards if the MCO requests an exception and provides all of the following to the Department:

a. Conclusive evidence that there is an insufficient number of providers for a service in a given county;

b. An explanation of the factors beyond the MCO's control contributing to the inadequate supply; and

c. The MCO's strategy to provide a similar service to support member outcomes or other alternatives.

6. *Verification of MCO Network Adequacy and Access*

The MCO shall annually submit to the Department, in a format specified by the Department, the following information:

a. Actual and projected enrollment by target group for each county served by the MCO;

b. A description of how the MCO projects the needs for each target group;

c. A current listing* of all contracted providers that includes, but is not limited to, the following:

   i. Provider or facility name;

   ii. Provider or facility address(es) including satellite or remote office locations that are contracted with the MCO;

   iii. Services being provided (e.g. home health or respite);

   iv. For Partnership, whether or not physicians and hospitals are accepting new MCO members;

   v. Whether or not other network providers are accepting new MCO members; and

   vi. Verification that providers are credentialed, when appropriate.

d. For residential care facilities, identification of the availability of residential providers offering private rooms, and a process for moving an individual to a private room when one becomes available that is consistent with the member's preferences.

e. As applicable, evidence of compliance with the Mental Health Parity and Addiction Equity Act.

f. Current policies with supporting procedures* for assuring compliance with the state developed network adequacy standards as specified in the MCO Provider Adequacy Policy.

g. Current policies with supporting procedures for provider selection and retention; and

h. Other information the Department determines to be necessary for certification of the MCO provider network.

*For items c. and f., the MCO must additionally provide this information when there is a significant change to the MCO's operations as described under Article VIII.I.4.a.iii. above.

7. *Monitoring Access to Services*

The MCO shall:

a. Continuously monitor and report to the Department the extent to which it maintains an adequate capacity; and

b. Take corrective action if the MCO or the Department discovers deficiencies in its capacity to meet the requirements of Article VII, Services.

This shall include MCO policies and procedures for interdisciplinary teams to notify the MCO network developers when they experience problems in accessing services for members.

8. *Full Enrollment*

Any MCO that will, at any time during the term of this contract, operate the MCO in a service area where the Family Care benefit is available to all entitled persons in the service area shall demonstrate capacity to provide services to all entitled persons who seek enrollment in the MCO. The entitlement period is specified in Wis. Stat. § 46.286(3)(c).

J. Change in Providers

1. *Required Notifications*

a. Notice to Department

The MCO is required to notify the Department at dhsbmc@dhs.wisconsin.gov within seven (7) calendar days when:

i. Any notice is given by the MCO to a provider, or any notice given to the MCO from a provider, of a provider agreement termination, a pending provider agreement termination, or a pending modification in provider agreement terms that have potential to limit member access or compromise the MCO's ability to provide necessary rights.

ii. A community residential care provider reports to the MCO that an MCO member has or will be involuntarily discharged

b. Notice to members and Resource Centers

i. The MCO must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) business days after receipt or issuance of the termination notice, to each member who received his/her primary care from, or was seen on a regular basis by, the terminated provider.

ii. When the Department determines that a change is significant, the MCO shall provide each member and the resource centers in the service area affected by the change, written notice of the change at least thirty (30) calendar days before the effective date of the change. Notices about significant changes in providers that are to be sent to members and shared with the resource center must be submitted to the Department prior to delivery.

2. *Certification of Provider Agreements Related to the Change*

At any time the Department determines there has been a significant change in the MCO's capacity to offer services in the benefit package or in the MCO's

projected membership or in the service area, the Department may, at its discretion, require recertification of the MCO network.

3. *Invoking Remedies*

If the Department determines that a pending provider agreement termination or pending modification in provider agreement terms will jeopardize member access to care, the Department may invoke the remedies provided for in Article XVI.E., Sanctions for Violation, Breach, or Non-Performance. These remedies include contract termination (with notice to the MCO and an opportunity to correct provided for), and suspension of new enrollment.

K. Health Information System

1. *Accurate and Complete Data*

The MCO must ensure that data received from providers is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data;

b. Screening the data for completeness, logic, and consistency; and

c. Collecting service information in standardized formats to the extent feasible and appropriate.

The MCO must ensure that providers follow the data requirements in Article XII, Quality Management (QM) and Article XIV, Reports and Data.

2. *Unique Identifier*

The MCO must require each physician and other eligible provider to have a unique identifier to the extent required under the Health Insurance Portability and Accountability Act (HIPAA).

L. Payment

1. *Payment for Services Provided to Members*

The MCO shall be responsible for payment of all services in the benefit package provided to members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage. Additionally, the MCO agrees to provide or authorize provision of services to all Medicaid members with valid Medicaid ID (identification) cards indicating MCO enrollment without regard to disputes about enrollment status and without regard to any other identification requirements.

Any discrepancies between the cards and the reports will be reported to the Department for resolution. The MCO shall continue to provide and authorize provision of all contract services until the discrepancy is resolved. This includes recipients who were PENDING on the Initial Report and held a valid Medicaid

identification card indicating MCO enrollment, but did not appear as an ADD or CONTINUE on the Final Report.

2. *Federally Qualified Health Centers (FQHCs)*

   a. Payment

      If the MCO contracts with a facility or program, which has been certified as an FQHC, for the provision of services to its members, the MCO must:

      i. Provide payment that is not less than the level and amount of payment which the MCO would make for the services if the services were furnished by a provider which is not an FQHC; and

      ii. Increase the FQHC's payment in direct proportion to any annual increase the MCO receives from the Department for any type of provider.

   b. Reporting

      If the MCO contracts with a FQHC, it must report to the Department within forty-five (45) calendar days of the end of each quarter the total amount paid to each FQHC, per month as reported on the 1099 forms prepared by the MCO for each FQHC. FQHC payments include direct payments to a medical provider who is employed by the FQHC.

3. *Rural Health Clinics (RHCs)*

   If the MCO contracts with a facility or program, which has been certified as a RHC, for the provision of services to its members, the MCO must provide payment that is not less than the level and amount of payment which the MCO would make for the services, if the services were furnished by a provider which is not a RHC

4. *Allowable Cost Policy Not Applicable*

   The MCO is not subject to Wis. Stat. §§ 46.036(3) and (5m) which refer to allowable costs in establishing provider agreements and payment rates (see s.46.284(5)(a) at: http://docs.legis.wisconsin.gov/document/statutes/46.284(5)(a).

5. *Subcapitation*

   The MCO may expend funds from its capitation payments on a subcapitated basis.

6. *Home and Community Based Waiver Services Rates*

   a. The MCO may negotiate the rates it pays to providers of the Home and Community-Based Waiver Services in Addendum XII.A.

   b. The MCO must follow all of the procedures specified in Department memo #10-06, if a current community-based residential provider declines to continue providing services to the member at the rate offered by the MCO and the action results in a member move

(https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta10-06.pdf).

7. *Medicaid Rates*

a. Negotiated Rates

Except as provided in sub.b., if the MCO can negotiate such agreements with providers, the MCO may pay providers less than Medicaid fee-for-service rates.

b. Payment Rates for Nursing Home Services

In determining the payment rate for the purchase of nursing home services, the MCO must employ the Medicaid fee-for-service nursing home rate methodology applied solely to the MCO's residents in that nursing facility. MCOs may use either the acuity of the MCO's nursing home residents as of a specific date or each individual member's daily acuity. The Medicaid fee-for-service nursing home rate methodology includes any retroactive adjustments to the Medicaid fee-for-service rates for the nursing home. MCOs must apply nursing home retroactive rate adjustments within 90 days of DHS posting an updated rate for the nursing home, utilizing provider submitted member acuity information. DHS will periodically provide MCOs with member-specific acuity rosters, which MCOs have the option to use to further reconcile provider-submitted acuity levels. There is no timeframe for this optional reconciliation.

c. Medicaid Fee-For-Service Rates

The MCO shall not pay itself or its providers more than the Medicaid fee-for-service rates for Medicaid covered services in the benefit package except when it determines on an individualized basis, that it is unable or impractical to otherwise obtain the service. Paying above the Medicaid fee-for-service rate includes paying more than Medicaid fee-for-service would pay when coordinating benefits with other payers.

A listing of the specific fee-for-service Medicaid services exempt from the requirements in this section can be found in the Care Management Organization (CMO) Pricing Administration Guide on the ForwardHealth website.

d. MCO Notification of Payment Above the Medicaid Fee-For Service Rate

In the event that an MCO contracts at a rate above the Medicaid fee-for-service rate, the MCO will document and track each situation. The MCO must submit a single comprehensive report to the Department at DHSDMSBRS@dhs.wisconsin.gov in February and August of each year (see https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf for the specific due dates) as a component of the Quarterly Report required under Article XIV.C.3. The information will be reported to the

Department on a form provided by the Department. The MCO will identify expenditures on the services paid for above the Medicaid Fee-For-Service Rate within the LTCare IES.

8. *Payments for Court-Ordered Services*

The MCO will pay for covered court-ordered services that are in the benefit package in accordance with Article VII.M., Court-Ordered Services. Pursuant to a court order for treatment the MCO will pay for covered services provided by a provider that is not in the MCO's provider network to any member.

Coverage of a service is effective upon receipt of a written request for a referral from the non-network provider, and extends until the MCO issues a written denial of the referral. This requirement does not apply if the MCO issues a written denial of the referral within five (5) business days of receiving the request for the referral.

9. Direct Care Workforce Payment

To comply with Wis. Stat. § 49.45(47m), the Department may make payments to the MCO, which the MCO shall distribute to direct care workforce providers, under the following terms and conditions:

a. For purposes of this section, "direct care workforce provider" means providers of adult day care services, daily living skills training, habilitation services, residential care (adult family homes of 1-2 beds, adult family homes of 3-4 beds, community-based residential facilities, residential care apartment complexes), individual and group supported employment, prevocational employment, vocational futures planning, respite care services provided outside of a nursing home, and supportive home care. Providers of self-directed services are not eligible for direct care workforce payments for self-directed services. Nursing homes, personal care agencies, and MCOs are not direct care workforce providers under this section.

b. The Department will divide the total funds allocated under Wis. Stat. §49.45(47m) into amounts per claims period.

c. The dates by which the Department will make Direct Care Workforce payments to each MCO and the dates of service of the encounters used to calculate each payment will be communicated by the Department.

d. Encounters submitted after the Department's data pull for the payment calculation in one claims period will be included in the data pull for the payment calculation in a subsequent claims period, as appropriate.

e. As requested by the Department, the MCO shall also submit to the Department a list of the providers and encounters it believes should be included in the Direct Care Workforce funding calculations.

f. The MCO shall provide the Department a final list of all the direct care workforce providers the MCO contracts with and the providers' encounters. The MCO shall attest that the information they provide is complete and accurate.

g. To calculate the amount that each MCO needs to pay each provider each claims period, the Department will:

   i. Calculate the Direct Care Workforce percentage increase by dividing the Direct Care Workforce funding allocated to the claims period in Article VIII.L.9.b. by the sum of the cost of all direct care workforce encounters within the dates of service for the claims period and, as appropriate, any encounters not included in prior payment calculations. As necessary, the costs from encounters that span more than one claims period will be allocated between periods based on the number of days of service which occurred in each period.

   ii. Multiply the Direct Care Workforce percentage increase calculated in Article VIII.L.9.g.i. by the sum of all payments the MCO made to the provider.

   iii. If any provider would receive a Direct Care Workforce payment of less than $25, the Department shall exclude expenditures from those providers and recalculate the amounts in Article VIII.L.9.g.i. and ii.

h. The MCO shall distribute to each direct care workforce provider the amount determined by the Department by deadlines established by the Department. The Direct Care Workforce payment will be in addition to the provider's negotiated payment rate. The MCO shall return any direct care workforce payments for providers who have not returned a signed provider agreement according to deadlines established by the Department.

i. The MCO shall only distribute direct care workforce payments to those providers from whom the MCO has received a signed provider agreement and whom:

   i. The MCO still contracts for provision of services to Family Care or Family Care Partnership members in Wisconsin; or

   ii. If an MCO discontinues operations in a geographic service region, the MCO had a contract with the provider to provide the specified Family Care or Family Care Partnership services 30 days prior to the MCO discontinuing operations in the geographic service region in which the provider is located. This provision applies to any successor organization that assumed the financial or legal obligations of the MCO that discontinued operations in the geographic service region.

j. The Department will specify information unique to each provider to calculate the amount of direct care workforce funding for each provider. The MCO shall not distribute direct care workforce funding to providers that change or discontinue their unique identifying information until the MCO receives the Department's written approval. Providers that change their unique identifying information are required to submit documentation to the MCO that the old and new information belong to the same provider. The MCO is required to submit this documentation to the Department.

k. The MCO shall return to the Department any payments to providers that are not accepted by or recouped from providers and notify the Department of the amounts and reason the payments were not accepted or recouped. The Department will include funds returned to the Department in subsequent direct care workforce payment calculations.

l. The Department will use funds returned to the Department under Article VIII.L.9.k. for future direct care workforce payments.

m. The MCO shall assist the Department in obtaining the survey responses and attestation required in Article VIII.D.31., from direct care workforce providers who receive payments under this subsection. If directed by the Department, the MCO shall distribute and collect from providers the survey and attestations developed by the Department.

n. The MCO shall provide to the Department the following items by deadlines established by the Department:

   i. A print out from the MCO accounting system demonstrating the provider payments were made within the required distribution timeline and that the total payments equal the direct care workforce funding the MCO received from the Department. The MCO will include provider-specific explanations for any direct care workforce funding the MCO did not distribute to a provider.

   ii. A signed attestation that all direct care workforce providers received the funding paid to the MCO by the Department for this purpose.

o. The MCO shall send all documents they are required to submit to the Department under this section to DHSLTCFiscalOversight@dhs.wisconsin.gov with "Attention: Direct Care Workforce MCO Submission" in the subject line.

10. *Health Professional Shortage Area (HPSA) Payments*

The MCO must pay the HPSA enhanced rates outlined under Medicaid FFS policy or the equivalent for MCO covered primary care and emergency care services provided to a member living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA. Specified MCO-covered obstetric or gynecological services (see Wisconsin Health Care Programs Online

Handbooks) provided to a member living in a HPSA or by a provider practicing in a HPSA must also be paid at the HPSA enhanced rates as outlined under Medicaid FFS policy or the equivalent. However, this does not require the MCO to pay more than the enhanced FFS rate or the actual amount billed for these services.

M. Appeals to the MCO and Department for Payment/Denial of Providers Claims

1. *Provider Appeal to the MCO*

All providers must appeal first to the MCO if they disagree with the MCO's payment, nonpayment, partial payment, late payment or denial of a claim. To enable a provider to appeal, the MCO shall:

a. Provide written notification to providers of the MCO payment, nonpayment, partial payment, or denial determinations. These notifications will include:

i. A specific explanation of the payment amount or a specific reason for the nonpayment, partial payment or denial;

ii. A statement explaining the appeal process and the provider's rights and responsibilities in appealing the MCO's determination by submitting a separate letter or form which:

a) Is clearly marked "appeal";

b) Contains the provider's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration for each appeal; and

c) Is submitted to the person and/or unit at the MCO that handles Provider Appeals within sixty (60) calendar days of the initial denial or partial payment.

iii. The name of the person and/or unit at the MCO to whom provider appeals should be submitted.

iv. A statement advising the provider of the provider's right to appeal to the Department if the MCO fails to respond to the appeal within forty-five (45) calendar days or if the provider is not satisfied with the MCO's appeal decision. The statement must include the timeframe within which the provider must submit the appeal and the address to which the appeal must be sent.

b. Accept written appeals from providers who disagree with the MCO's payment, nonpayment, partial payment or denial determination, if the provider submits the dispute in writing within sixty (60) calendar days of the initial payment/denial notice.

c. Respond in writing to the provider within forty-five (45) calendar days from the date of receipt of the request for reconsideration. If the MCO

fails to respond within that time frame, or if the provider is not satisfied with the MCO's response, the provider may seek a final determination from the Department.

2. *Provider Appeals to the Department*

a. The Department will review appeals and make final determinations in cases where;

i. The provider has requested a reconsideration by the MCO according to the terms described above; and

ii. The provider continues to dispute the MCO's appeal determination; or

iii. The MCO or provider fails to respond within forty-five (45) calendar days from the date of receipt of the provider's request for reconsideration.

b. Appeals must be submitted to the Department within:

i. Sixty (60) calendar days of the date of written notification of the MCO's final decision resulting from a request for reconsideration; or

ii. Sixty (60) calendar days after the MCO's failure to respond within forty-five (45) calendar days to the provider's request for reconsideration.

c. Appeals to the Department are submitted by:

Fax: (608) 266 - 5629
Or
Mail: Provider Appeals Investigator
Division of Medicaid Services
1 West Wilson Street, Room 518
P.O. Box 309
Madison, WI 53701-0309

d. The Department will notify the MCO when a provider appeal is received and will share pertinent information so the MCO has an opportunity to respond.

e. The Department will accept written comments from all parties to the dispute prior to making the decision.

f. The Department can make a decision based on the information that it has even if it might not have all of the information that it has requested because the MCO or provider has failed to respond to a request from the Department for information by the deadline set by the Department.

g. The Department has forty-five (45) calendar days from the date of receipt of all written comments to respond to a provider's appeals.

h. The Department determinations may include the override of the MCO's time limit for submission of claims and appeals in exceptional cases.

i. The Department determinations may include the override of the time limit for submission of appeals to the Department in exceptional cases.

j. The MCO shall accept the Department's determinations regarding appeals of disputed claims. The MCO shall pay provider(s) within forty-five (45) calendar days of receipt of the Department's final determination.

3. *Provider Appeal Log and Summary*

The MCO shall submit to the Department a provider appeal log with data summary as specified in Article XIV.C.2. The log with summary will include the:

a. Name of the provider;

b. Type of service;

c. Date of service;

d. Amount of the claim;

e. Date of receipt of the appeal;

f. Appeal decision by the MCO;

g. Reason for the decision;

h. Total number of appeals denied for the reporting period;

i. Total number of appeals upheld for the reporting period;

j. Total number of appeals received year start to date of report;

k. Percent of appeals denied year start to date of report as percent of total appeals received; and

l. Percent of appeals upheld year start to date of report as percent of total appeals received.

N. Standards for MCO Staff

1. *Competency Standards*

The MCO shall set competency standards for MCO staff that provide services in the benefit package. The MCO shall provide or arrange for training to assure that MCO employees meet competency standards.

The MCO shall establish a system for monitoring MCO staff who deliver services in the benefit package to assure the provision of quality services. Refer to paragraph 5, Caregiver Background Checks, below for related employee standards.

2. *Relatives and Legal Guardians*

For the purpose of this section, a relative is defined as a person related, of any degree, by blood, adoption or marriage, to the member. Legal guardian is defined in state statute.

The member care plan identifies all services and supports needed by the member, including those which will be provided by natural supports. Natural supports are unpaid supports that are provided to a member voluntarily in lieu of waiver or State Plan services. Natural supports can, and should, be used when they are available.

Relatives and legal guardians may be paid to perform or provide only the following services: personal care, supportive home care, specialized transportation, certified 1-2 bed adult family home services, education (daily living skills training), respite care, skilled nursing, and supported employment.

The MCO shall have policies addressing the circumstances in which a relative or legal guardian may be paid by the MCO for these services. Those policies must reflect the goal of supporting and maintaining natural supports and may allow for relatives or legal guardians to be paid only if all the following apply:

a. The service is identified in the MCP;

b. The member's preference is for the relative or legal guardian to provide the service;

c. The interdisciplinary team ensures that:

   i. The service meets identified needs and outcomes in the MCP and assures the health, safety and welfare of the member;

   ii. The purchase of services from the relative or legal guardian is cost-effective in comparison to the purchase of services from another provider;

d. The interdisciplinary team monitors and manages any real or potential conflict of interest situation that may occur as a result of the relative or legal guardian providing services;

e. The relative or legal guardian meets the MCO's qualifications and standards for its providers or employees providing the same service;

f. There is a properly executed provider agreement between the MCO and the relative or legal guardian;

g. The service performed by the relative or legal guardian does not benefit the relative, legal guardian, or other individuals residing in the household with the member (for example, lawn mowing, snow shoveling, family meal preparation, grocery shopping, emptying trash cans, etc.). The service may be of incidental benefit to the relative or legal guardian as long as the service is clearly identified as intended to support the member

and is clearly identified as such in the MCP (for example, occasional grocery shopping conducted as a community integration outing for the member); and,

h. For spouses, the individual will either:

i. Provide an amount of service that exceeds the normal spousal care-giving responsibilities for a spouse who does not have a disability; or

ii. Find it necessary to forego paid employment in order to provide the service.

3. *Intimate Care Services*

If the MCO is the employer of attendants for the purposes of supportive home care, personal care or home health aide services the following conditions shall be met:

a. Members are offered the opportunity to participate with the MCO in choice and assignment of attendant(s) that provide the service;

b. Members are involved with training the MCO attendant(s) (if desired by the member);

c. Members are involved in negotiating hours of services;

d. Members regularly participate in the evaluation of services provided by their MCO attendant(s); and

e. Members are involved in the supervision of MCO attendant(s) along with the MCO attendant supervisor (if desired by the member and to the extent of his/her abilities).

4. *Federal Department of Labor*

The MCO shall implement and adhere to rules and regulations prescribed by the United States Department of Labor and in accordance with 41 C.F.R. § 60.

5. *Caregiver Background Checks*

The MCO shall comply with Wis. Admin. Code Chapters DHS 12 and 13 related to caregiver background and other checks, including:

a. The MCO shall establish and implement a policy consistent with Wis. Admin. Code Chapters DHS 12 and 13 to appropriately respond to an MCO employee who is paid to provide services to a member when the employee has a caregiver conviction that is substantially related to the care of a member;

b. The MCO shall perform, or require providers to perform, background checks on caregivers in compliance with Wis. Stat. § 50.065 and Wis. Admin. Code Chapter DHS 12;

c. If the MCO requires providers to perform background checks on caregivers, the MCO shall ensure that the providers perform the background checks in compliance with Wis. Stat. § 50.065 and Wis. Admin. Code Chapter DHS 12;

d. The MCO maintains the ability to not pay or contract with any provider if the MCO deems it is unsafe based on the findings of past criminal convictions stated in the caregiver background check.

The MCO shall require co-employment agencies and fiscal employer agents to perform background checks that are substantially similar to the background checks required under Wis. Stat. § 50.065 and Wis. Admin. Code Chapter DHS 12 on individuals providing services to self-directing members who have, or are expected to have, regular, direct contact with the member. Regular contact means scheduled, planned, expected or otherwise periodic contact. Direct means face-to-face physical proximity to a member that may afford the opportunity to commit abuse or neglect or misappropriate property.

The MCO shall take all appropriate steps the MCO deems necessary to assure the health and safety of the MCO's members.

O. Network, Coverage and Payment Provisions Applicable to Indian Health Care Providers and Indian Members

1. *Network and Coverage Requirements*

a. Adequate Indian Health Care Provider (IHCP) Network Capacity

i. As part its demonstration of network adequacy under Article VIII.K.3, the MCO shall document that its provider network includes sufficient participating Indian health care providers to ensure timely access to covered services in the benefit package from such providers for its Indian members.

ii. If an MCO cannot ensure such timely access due to few or no Indian health care providers in the geographic service region, it will be considered to have met the requirement for timely access if it permits Indian members to access out-of-region and/or out-of-State Indian health care providers.

b. Out-of-Network Indian Health Care Providers

The MCO shall permit Indian members to obtain covered services in the benefit package from out-of-network Indian health care providers that meet the state's provider qualifications except for having a provider contract with the MCO.

c. Choice to Receive Primary Care Services from IHCPs

Indian members enrolled in the Partnership program shall be allowed to choose to receive primary care services from an Indian health care

provider in the MCO's provider network, as long as that provider has the capacity to provide the services.

d. Referrals from Non-Network IHCPs

The MCO shall permit a non-network Indian health care provider to refer an Indian member to an MCO network provider and an otherwise coverable service may not be denied because the referral was from a non-network provider.

2. *Payment Requirements*

a. Payment Requirements for IHCPs - In General

The MCO shall pay Indian health care providers, whether or not they are part of the MCO's provider network, for services in the benefit package provided to Indian members who are eligible to receive services from such providers, either:

i. At a rate negotiated between the MCO and the provider, or

ii. If there is no negotiated rate, at a rate not less than the level and amount of payment that would be made to an in-network provider that is not an Indian health care provider.

b. Timely Payment

The MCO shall pay Indian health care providers promptly in accordance with this section and Article XIII MCO Administration, D.2 Claims Processing Payment Requirement, which incorporates the timely payment requirements under 42 C.F.R. § 447.45 and § 447.46.

c. Payment Rates for Non-Network IHCP FQHCs

When an Indian health care provider is enrolled in the Medicaid program as a FQHC but is not a network provider of the MCO, the MCO shall pay the provider for covered services provided to Indian members at the rate it would pay a FQHC that is a network provider but not an Indian health care provider. Notwithstanding Article VII.O.2.a.i, this rate may not be less than the fee-for-service rate the Indian health care provider FQHC would receive under the State plan's payment methodology.

d. Payment Rates for IHCPs That Are Not FQHCs

When an Indian health care provider is not enrolled in the Medicaid program as a FQHC, whether or not it is a network provider for the MCO, the MCO shall pay it for covered services provided to Indian members at the applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the rate it would receive under the State plan's fee-for-service payment methodology.

P. Non-risk Provisions for Members Receiving Care Management from an Indian Health Care Provider (IHCP)

1. *Interim Payments*

   a. The Department shall pay the MCO a monthly interim payment for each Indian member receiving care management from an IHCP as part of a three party agreement between the Department, the IHCP, and the MCO.

   b. The amount of the interim payments the MCO receives under this section will equal the MCO's capitation rate for the level of care and geographic service region of the member. No additional capitation payment will be made to the MCO for that member.

   c. The interim payments the Department makes to the MCO under this section are not actuarially sound.

   d. All other provisions in this contract concerning the capitation payments the Department pays to the MCO apply to the interim payment the Department pays to the MCO under this section.

2. *MCO Cost Settlement*

   a. The Department will complete an annual cost settlement of the MCO's costs of providing services to Indian members for whom the MCO received an interim payment under (1).

   b. The Department may complete one interim cost settlement if requested by the MCO.

   c. The cost settlement amount that the Department will pay or recoup from the MCO will be determined as follows:

      i. The Department will calculate the total amount the MCO paid for all services provided to Indian Family Care members based on the MCO's submitted encounter records. Indian Family Care members will be identified using a list of members the IHCP will provide to the Department.

      ii. The Department will subtract from the amounts in i. the total non-administrative portion of the interim payments the Department paid the MCO before the member's cost share was deducted as well as any other revenues the MCO received towards the cost of the member's care.

   d. The Department will complete the annual cost settlement within eighteen months of the calendar year in which the member received services.

3. *Encounter* Data Reporting

   a. The MCO shall submit encounter data for services provided to members receiving care management from an IHCP in accordance with all provisions of this contract.

b. Encounter data for members for whom the MCO received an interim payment under (1) will be removed from the data used for development of actuarially sound capitation rates.

Q. Physician Incentive Plans for Partnership

1. *Federal Requirements*

If the MCO implements a physician incentive plan then the MCO must meet the following requirements:

a. 42 C.F.R. § 422.208, 417.479 PIP: Requirements and Limitations;

b. Stark Laws I & II;

c. SOCIAL SECURITY ACT1903(m)(2)(A)(viii) & SSA1903(m)(4) Disclosure of Ownership and Report Transactions;

d. 42 C.F.R. § 438.6(h) Physician Incentive Plans;

e. 42 C.F.R. § 438.210(e) State Requirements;

f. 1903(m)(2)(A)(x) Prohibition;

g. 42 C.F.R. § 422.210 Disclosure of PIP;

h. 42 C.F.R. § 438.6(h) PIP Requirements; and

i. 42 C.F.R. § 434.70(a)(3) Conditions for FFP (Federal Financial Participation).

2. *Stark Laws I and II*

If the MCO implements a physician incentive plan, then the MCO must meet the Stark Laws I & II, 42 C.F.R. § 422.208, 417.479, Social Security Act Physician Incentive Plan 1903(m)(2)(A)(viii) and Social Security Act1903(m)(4) that require:

a. No specific payment of any kind be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or to limit medically necessary services. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

b. If the MCO places a physician or physician group at substantial financial risk (as determined by the Secretary of the Department) for services not provided by the physician or physician group, the MCO shall provide stop-loss protection for the physician or physician group that is adequate and appropriate based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group.

3. *Conduct Surveys*

   If the MCO implements a physician incentive plan, then the MCO must conduct surveys that:

   a. Include either all current Medicare/Medicaid members and individuals previously enrolled who have disenrolled during the past 12 months, or a sample of these same enrollees and disenrollees.

   b. Are designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis.

   c. Address consumer satisfaction with the quality of services provided and the degree of access to the services.

   d. Begin no later than one year after the effective date of the incentive plan. Thereafter, surveys must be conducted at least every two years.

4. *Information Concerning the Plans*

   If the MCO implements a physician incentive plan, then the MCO must provide CMS and the Department information concerning the plans, sufficient to permit the Secretary to determine whether the plan is in compliance. Disclosure must be made upon application for a contract or for a service area expansion, and upon request by CMS or the Department. The disclosure must contain the following information:

   a. Whether the incentive plan covers services not furnished by the physician or physician groups. If the plan covers only the services furnished by the physician or physician group, disclosure of other aspects of the plan is not needed.

   b. The type of incentive arrangement; for example, withhold, bonus, capitation.

   c. If withhold or bonus, the percent of the withhold or bonus.

   d. The amount and type of stop-loss protection.

   e. The panel size and, if patients are pooled according to one of the following permitted methods, the method used.

   f. Commercial, Medicare and/or Medicaid members in the calculation of the panel size.

   g. Pooling together of several physician groups into a single panel.

   h. Capitation payments, if any, paid to primary care physicians for the most recent year broken down by percent of primary care services, referral services to specialists, and hospital and other types of provider (for example, nursing home and home health agency) services.

   i. The results of surveys.

5. *Informing Members*

If the MCO implements a physician incentive plan, then the MCO must inform any Medicare/Medicaid beneficiaries whether they use a physician incentive plan that affects the use of referral services, the type of incentive arrangement, and, if available, the results of surveys.

IX. Marketing and Member Materials

A. Marketing/Outreach Plans and Materials

The MCO agrees to engage only in marketing/outreach activities and distribute only those marketing/outreach materials that are pre-approved in writing, as outlined in this section.

Marketing/outreach materials are defined in Article I, Definitions. The Department will determine what marketing/outreach materials and activities are subject to the requirements of this contract. The requirements of the contract are specific to the Medicaid plan being offered.

1. *Marketing/Outreach Plan Approval*

   If the MCO engages in marketing/outreach activities, a plan describing those activities must be approved in writing by the Department before the plan is implemented.

2. *Marketing/Outreach Material Approval*

   a. The MCO must ensure that members and potential members receive accurate oral and written information sufficient to make informed choices.

   b. The MCO shall submit to the Department for approval all marketing/outreach materials that describe the program or the benefit package, prior to disseminating the materials.

   c. For Family Care, all marketing/outreach materials must be approved by the Department prior to distribution. For Partnership, all marketing/outreach materials must be approved by the Department and CMS prior to distribution.

      i. The Department will review all marketing/outreach plans and materials in a manner which does not unduly restrict or inhibit the MCO's marketing/outreach plans and materials, and which considers the entire content and use of the marketing/outreach materials and activities.

      ii. Issues identified by the Department will be reviewed with the MCO. The MCO will be asked to make the appropriate revisions and resubmit the document for approval. The Department will not approve any materials it deems confusing, fraudulent, or misleading, or that do not accurately reflect the scope, philosophy, or covered benefits of the Program.

      iii. For Partnership, the Department will assist the MCO when issues arise in obtaining CMS approval for materials.

   d. This requirement applies to marketing/outreach materials specific to MCO services that are produced by providers or subcontractors who have

entered a provider agreement or subcontract with the MCO or are owned by the MCO in whole or in part.

3. *Timeline for Department's Approval*

   The Department will review marketing/outreach materials within thirty (30) calendar days of receipt.

4. *MCO Agreement to Abide by Marketing/Outreach and Distribution Criteria*

   a. The MCO agrees to engage only in marketing/outreach activities and distribute only those marketing/outreach materials that are pre-approved in writing.

   b. Any marketing/outreach activities must occur in its entire service area in a county. All marketing/outreach materials must be distributed to potentially eligible members in an entire service area, as defined in MCO's marketing/outreach plan, and must be equitably available to all consumers eligible for enrollment in the MCO's service area.

   c. The MCO must provide one electronic or hard copy of all marketing/outreach materials to the resource centers in the service area at the same time these materials are first used. If a hard copy is provided, the MCO must provide additional copies to the resource center upon request.

5. *Prohibited Practices*

   The following marketing/outreach practices are prohibited:

   a. Practices that are discriminatory;

   b. Practices that seek to influence enrollment in conjunction with the sale or offering of any other insurance product;

   c. Direct and indirect cold calls, either door-to-door, email, telephone, text or other cold call marketing activity;

   d. Offer of material or financial gain to potential members as an inducement to enroll;

   e. Activities and materials that could mislead, confuse or defraud members or potential members or otherwise misrepresent the MCO, its marketing representatives, the Department, or CMS. Statements that would be considered inaccurate, false, or misleading include, but are not limited to any assertion or statement (whether written or oral) that:

      i. The recipient must enroll in the MCO in order to obtain benefits or in order to not lose benefits; or

      ii. The MCO is endorsed by CMS, the federal or state government, or other similar entity.

   f. Practices that are reasonably expected to have the effect of denying or discouraging enrollment;

g. Practices to influence the recipient to either not enroll in or to disenroll from another MCO plan; and

h. Marketing/outreach activities that have not received written approval from the Department.

6. *Sanctions*

The MCO that fails to abide by these marketing/outreach requirements may be subject to any and all sanctions available under Article XVI.E., Sanctions for Violation, Breach, or Non-Performance. In determining any sanctions, the Department will take into consideration any past unfair marketing/outreach practices, the nature of the current problem and the specific implications on the health and well-being of the enrolled member.

In the event that the MCO's provider or subcontractor fails to abide by these requirements, the Department will evaluate whether the MCO should have had knowledge of the marketing/outreach issue and the MCO's ability to adequately monitor ongoing future marketing/outreach activities of the provider/subcontractor(s).

B. Member Materials – General Requirements

Member materials are defined in Article I, Definitions.

1. Member materials shall be accurate, readily accessible, appropriate for, and easily understood by the MCO target population and in accordance with accessibility of language requirements in this article Section E, Accessible Formats and Languages and Cultural Sensitivity.

2. Member materials shall be available to members in paper form, unless electronic materials are available, the member or member's legal decision maker prefers electronic materials, and the electronic materials meet the requirements in section 3 below. Alternatives for other languages are addressed in Section E.3, of this Article.

3. The MCO may provide members with materials using electronic media only if all of the following requirements are met:

   a. The format is readily accessible;

   b. The information is placed in a location on the MCO's website that is prominent and readily accessible;

   c. The information is provided in an electronic form which can be electronically retained and printed;

   d. The information is consistent with the content and language requirements in Section E, of this Article;

e. The member is informed that the information is available in paper form without charge upon request and the MCO provides it upon request within five (5) business days;

f. The MCO has obtained member consent to receive materials electronically; and

g. The MCO has safeguards in place to ensure delivery of electronic materials as follows:

i. The member must be able to opt out of receiving electronic communications upon request.

ii. The MCO must ensure that member contact information is current, materials are sent timely, and important materials are identified in a way that members understand their importance.

iii. The MCO must have a process for mailing of hard copies when electronic communications are undeliverable (e.g., an expired e-mail account).

iv. The MCO must ensure that it is in compliance with confidentiality laws.

4. The MCO shall have all member materials approved by the Department before distribution. The Department will review member materials within thirty (30) calendar days of receipt. The MCO is not required to submit model materials required by CMS to the Department for review and approval, but must provide a copy of such materials upon request.

5. For Partnership, the Department will assist the MCO when issues arise in obtaining CMS approval for materials.

6. Within ten (10) business days of initial enrollment notification, the MCO shall provide new members or their legal decision makers a member handbook and information about how to obtain an electronic copy of the provider network directory. A paper copy of the provider network directory must be provided upon request within five (5) business days.

7. MCOs are responsible for disseminating the materials to new members:

a. Member handbooks;

b. Provider network directories;

c. Self-directed supports guidebook; and

d. Partnership summary of benefits.

If a potential member requests member materials prior to enrollment, the resource center can refer the potential member to the MCO website or directly to the MCO.

8. For consistency in the information provided to members, the MCO shall use the Department's standard definitions of managed care terminology

(https://www.dhs.wisconsin.gov/familycare/mcos/standard-terminology.htm) in member materials.

9. For the Family Care program, the MCO shall use the standard member handbook template developed by the Department and submit plan-specific changes for Department approval prior to distribution.

10. For the Partnership program, the member handbook, summary of benefits, and annual notice of change templates will be developed cooperatively with all the Partnership plans and approved by the Department. Subsequently each plan will submit plan-specific publications, noting the changes, for Department and, if required, CMS approval prior to distribution.

11. Educational materials (e.g., health, safety, fall prevention, etc.) prepared by the MCO or by their contracted providers and sent to the MCO's other membership do not require the Department's approval, unless there is specific mention of Partnership and/or Medicaid. Educational materials prepared by outside entities do not require Department approval.

12. The MCO must provide all enrollment notices, informational materials, and instructional materials related to the enrollee and potential enrollees in a manner and format that may be easily understood and is readily accessible.

    All materials produced and/or used by the MCO must be understandable and readable for the average consumer and reflect sensitivity to the diverse cultures served. The MCO must make all reasonable efforts to locate and use culturally appropriate material. Materials shall take into account individuals who are visually limited or who are limited English proficient.

13. Model member notices and templates developed by DHS shall be used by the MCO.

14. The MCO must have in place mechanisms to help enrollees understand the requirements and benefits of the plan.

C. Member Handbook

1. The MCO must develop and maintain an up-to-date member handbook:

    a. Text must be in easily understood language and format in a font no smaller than 12 point.

    b. An electronic version of the MCO's member handbook must be maintained with complete and current information, readily accessible, and posted in a prominent location on the MCO's website.

    c. The paper version of the member handbook must be updated when significant changes occur and, at minimum, annually.

    d. The handbook must be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that

takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

e. The handbook must include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

2. The MCO must provide members a complete up-to-date member handbook upon initial enrollment and upon request within five (5) business days. The handbook will be considered to be provided if the MCO:

   a. Mails a printed copy of the information to the member's mailing address;

   b. Provides the information by email after obtaining the member's agreement to receive the information by email;

   c. Posts the information on the MCO's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

   d. Provides the information by any other method agreed to by the member that can reasonably be expected to result in the member receiving that information.

3. When significant changes occur, the MCO must distribute to its members a full member handbook, an addendum to the member handbook or other written notification at least thirty (30) calendar days in advance of the effective date.

4. Annually, the MCO must distribute to its members either the member handbook or notify members of their right to request and obtain the information listed below in C.5.

5. The Member Handbook, at a minimum, will include information about:

   a. Membership in the MCO. This information shall include the nature of membership in a Managed Care Organization as compared to fee-for-service;

   b. How to access auxiliary aids and services, including how to obtain information in alternate formats and the appropriate language, and how to access translation/interpreter services;

   c. Available assistance for members with cognitive impairments to review materials about membership in the MCO;

   d. The location(s) of the MCO facility or facilities;

   e. The hours of service;

   f. The services covered in the benefit package, including:

i. A list of services in the benefit package and information about the benefits available in sufficient detail to ensure that members understand the benefits to which they are entitled in the benefit package;

ii. The MCO's ability to provide an alternative support or service that is not specified in the benefit package;

iii. The services the MCO does not cover because of moral or religious objections and how the member can obtain information from the Department on how to access these services;

iv. Each member's right to select from the MCO's network of providers, and any restrictions on member rights in selecting providers;

v. A member's ability to change providers;

vi. Any cost sharing related to these services; and

vii. A member's liability for unauthorized services.

g. Medicaid covered services not in the benefit package that remain fee-for-service and procedures for obtaining these services, including:

i. A list of these services;

ii. How and where to obtain these services; and

iii. A statement on copayment.

h. Electing and maximizing Medicare benefits including:

i. For Family Care members:

a) The expectation that Medicare benefits will be elected by members who are currently enrolled in Medicare Parts A and/or B and that the Medicare benefit is maximized; and

b) That if the member is currently enrolled in Medicare Parts A and/or B and chooses not to use his/her Medicare benefits, the MCO may refuse to pay for costs that Medicare would otherwise cover.

ii. Partnership members must:

a) Enroll in and remain enrolled in all parts of Medicare for which they are eligible (Medicare Part A, Part B and/or Part D); and

b) Enroll in the MCO's Special Needs Plan if the member is eligible.

i. The right to receive services from culturally competent providers, and information about specific capacities of providers, such as languages spoken by staff;

j. Self-Directed Supports and how and where members can get more information;

k. The extent to which members may obtain services, including family planning services for Partnership members, outside of the provider network;

l. Obtaining benefits and advance authorization of services, and on the member's ability to obtain services necessary to support outcomes;

m. Using after hours services and obtaining services out of the MCO's service area;

n. The use of emergency and urgent care facilities for Partnership including:

   i. What constitutes emergency medical condition, emergency services, and post-stabilization services, as defined in Article VII, Services;

   ii. The fact that prior authorization is not required for emergency services;

   iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; and

   iv. The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care.

o. The telephone numbers including:

   i. The 24 hour a day toll free telephone number that can be used for assistance in obtaining urgent and emergency care; and

   ii. A toll free telephone number where members can acquire information about the requirements and benefits of the program;

p. The post-stabilization care services rules set forth at Article VII, Services, and 42 C.F.R. § 422.113(c) for Partnership members;

q. The process of selecting and changing the member's primary provider for Partnership members;

r. The policy on referrals for specialist care and for other benefits not furnished by the member's primary care provider for Partnership members;

s. Voluntary enrollment, voluntary disenrollment, and involuntary disenrollment;

t. Members' rights, responsibilities and protections as defined by the Department and specified in 42 C.F.R. § 438.100;

u. Abuse, neglect and financial exploitation including:

   i. What constitutes abuse, neglect and financial exploitation; and

   ii. Information on how to report suspected fraud and abuse, including the resources that exist for reporting and assistance, including emergency twenty-four (24) hour phone numbers.

v. Ombudsman and independent advocacy services available as sources of advice, assistance and advocacy in obtaining services;

w. The appeal and grievance process, including:

   i. What constitutes an appeal, grievance, or fair hearing request;

   ii. The right to file appeals or grievances, and the right to request a fair hearing after the MCO has made a determination on the member's appeal that is adverse to the member;;

   iii. How to file appeals, grievances, fair hearing requests and expedited review, including the timeframes, the rules that govern representation at the hearing and the member's ability to appear in person before the MCO personnel assigned to resolve appeals and grievances;

   iv. Information about the availability of assistance with the appeal and grievance process, and fair hearings;

   v. The toll-free numbers that the member can use to register a grievance or an appeal orally and request that the MCO put the grievance or appeal into writing;

   vi. The specific titles and telephone numbers of the MCO staff who have responsibility for the proper functioning of the process, and who have the authority to take or order corrective action;

   vii. The assurance that filing an appeal or grievance or requesting a fair hearing process will not negatively impact the way the MCO, its providers, or the Department treat the member; and

   viii. How to obtain services during the appeal and fair hearing process, including the fact that, when requested by the member:

      a) The benefits may continue if the member files an appeal or a request for State Fair Hearing and requests continuation of services within the timeframes specified for filing; and

      b) The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

x. Obtaining second medical opinions;

y. Policies and procedures for advance directives, as set forth in 42 C.F.R. § 438.3(j);

z. How members and their legal decision makers can have input on changes in the MCO's policies and services;

aa. The right to obtain results of member surveys;

bb. Estate recovery provisions applying to MCO membership;

cc. The notification that members may be asked to voluntarily participate in the quality review process;

dd. The additional information that is available upon request, including the following:

i. Structure and operation of the MCO; and

ii. Any physician incentive plans as set forth in 42 C.F.R. § 438.6(h) for Partnership members.

D. Provider Network Directory and Information

1. The MCO must develop and maintain up-to-date provider network directories and information.

a. An electronic version of the MCO's provider network directory must be maintained with complete and current information on the MCO's website. To be considered current, electronic versions of provider network directories, including internet directories, must be updated no later than thirty (30) calendar days after the MCO receives updated provider information.

b. The paper version of the provider network directory must be updated at least monthly.

c. The MCO must make the updated provider directories available to members upon initial enrollment and upon request.

d. When significant changes occur in the provider network, the MCO must provide members a revised directory, an addendum to the directory or other written notification of the change.

2. Provider directories must be made available on the MCO's website in a machine readable file and format as specified by the Department.

3. The MCO must make current information on the MCO's provider network available to IDT staff for care planning and appropriate authorization of services.

4. The MCO must provide all ADRCs in its service area with electronic access to complete and up-to-date provider network information, so that ADRCs can access the information at any time for the purpose of enrollment counseling.

5. The provider directory shall include providers that are under contract with the MCO, including physicians, hospitals, pharmacies, behavioral health providers, and long-term care providers. The directory will include the following information for providers under contract with the MCO:

   a. Provider name as well as any group affiliation (individual practitioner, clinic or agency as appropriate) including primary care physicians, specialists and hospitals for Partnership;

   b. Provider street address(es)telephone number(s), website URL, (as appropriate), and for in-home service providers, the service area;

   c. Services furnished by the provider;

   d. Provider specialty (as appropriate);

   e. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract;

   f. For Partnership, whether the provider is accepting new MCO members. If a preferred provider is not accepting new members, the MCO will assist the member in obtaining an alternate provider;

   g. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and

   h. Accessibility of the provider's premises (if the member will be receiving services at the provider's premises), including offices, exam rooms and equipment.

E. Accessible Formats and Languages and Cultural Sensitivity

The MCO shall provide member and marketing/outreach materials in a manner and format that may be easily understood and is readily accessible. Materials shall be understandable in language and format based on the following:

1. *Accessible Language*

   a. All written materials for potential members must include taglines in the prevalent non-English languages in the State, as well as large print (no smaller than 18 point font), explaining the availability of written translations or oral translation to understand the information, the toll free number of the resource center providing choice counseling, and the toll free and TTY/TDY telephone number of the MCO's member/customer service unit. DHS shall determine the prevalent non-English languages in each MCO service area.

b. Material directed at a specific member shall be in the language understood by the individual or oral interpretation shall be provided to the individual free of charge.

c. Written materials that are critical to obtaining services, including provider directories, handbooks, appeal and grievance notices, and denial and termination notices shall include taglines and be available in prevalent non-English languages in the MCO's service area.

2. *Materials Easily Understood and Accessible*

All materials produced and/or used by the MCO must:

a. Use easily understood language and format.

b. Use a font size no smaller than 12 point.

c. Be available in alternative formats and through the provision of auxiliary aids and services upon request and at no cost.

d. Include large print (font size no smaller than 18 point) tagline and information on how to request auxiliary aids and services, including the provision of materials in alternative formats and the toll free and TTY/TDY telephone number of the MCO's member/customer service unit.

3. *Cultural Sensitivity*

Materials for marketing/outreach and for health-promotion or wellness information produced by the MCO must be appropriate for its target population and reflect sensitivity to the diverse cultures served.

If the MCO uses material produced by other entities, the MCO must review these materials for appropriateness to its target population and for sensitivity to the diverse cultures served.

F. Reproduction and Distribution of Materials

The MCO shall reproduce and distribute at the MCO's expense, according to a reasonable Department timetable, information or documents sent to the MCO from the Department that contains information the MCO members and/or the MCO-affiliated providers must have in order to implement fully this contract.

G. MCO Identification (ID) Cards

The MCO may issue its own MCO ID cards. The ForwardHealth and Forward cards will always determine the MCO enrollment, even where the MCO issues MCO ID cards.

X. Member Rights and Responsibilities

A. Protection of Member Rights

The MCO shall have in effect written safeguards of the rights of enrolled participants, including a member bill of rights, in accordance with regulations and with other requirements of 42 C.F.R. § 438.100, Enrollee Rights and Protections, and of federal and state laws that are designed for the protection of members.

The language and practices of the MCO shall recognize each member as an individual and emphasize each member's capabilities. MCO staff and affiliated providers shall demonstrate dignity and respect in all of their interactions with members and take members' rights into account when furnishing services to members.

The MCO must have written policies regarding the enrollee rights specified in this section, including but not limited to:

1. Being treated with respect and with due consideration for his/her dignity and privacy.
2. Receiving information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
3. Participating in decisions regarding health and long-term care, including the right to refuse treatment and the right to request a second opinion.
4. Being free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
5. Being able to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. § 164.

B. Member Rights

Members have the right to all of the following:

1. Freedom from unlawful discrimination in applying for or receiving the benefit.
2. Accuracy and confidentiality of member information.
3. Prompt eligibility, entitlement and cost-sharing decisions and assistance.
4. Access to personal, program and service system information.
5. Choice to enroll in an MCO, if eligible, and to disenroll at any time.
6. Information about and access to all services of the Department, Resource Centers and MCOs to the extent that the member is eligible for such services.
7. Support in understanding member rights and responsibilities related to Family Care or Partnership.
8. Support from the MCO in all of the following:
    a. Self-identifying outcomes and long-term care needs.

b. Securing information regarding all services and supports potentially available to the member through the benefit.

c. Actively participating in planning individualized services and making reasonable service and provider choices for supporting identified outcomes.

d. Identifying, eliminating or monitoring and managing situations where a conflict of interest may exist due to a person or entity having an interest in, or the potential to benefit from, a particular decision, outcome or expenditure.

9. Services identified in the member's member-centered plan.

10. Support in the exercise of any rights and available grievance and appeal procedures beyond those specified elsewhere in this article.

11. Exercise rights, and to be assured that the exercise of those rights does not adversely affect the way the MCO and its providers or any state agency treat the enrollee.

C. Member Responsibilities

The MCO shall encourage and support members to carry out the following responsibilities.

1. *Responsibilities Related to Individual Outcomes*

   Members are responsible to participate in the comprehensive assessment of their strengths and needs, in the identification of the outcomes important to them and in the development of a member-centered plan designed to support their identified outcomes and meet their identified needs. In addition, members are expected to utilize the available grievance and appeal processes to improve the quality of their own services and supports.

2. *Responsibilities Related to Overall MCO Quality Improvement*

   Members are responsible to participate in evaluating the overall quality of the MCO through member surveys, member interviews conducted by the Department or its external quality review organization and other evaluations conducted by the MCO or the Department. In addition, members' participation in the available

   grievance and appeal processes will provide valuable information to the MCO and the Department about the quality of the services and supports delivered by the MCO.

D. Member Rights and Responsibilities Education

The MCO shall provide education to members on the grievance and appeal process within ninety (90) calendar days of enrollment. Responsibility for member education may be delegated to the member's lead/primary care manager.

At a minimum, this education process shall include reviewing the MCO grievance and appeal process described in the member handbook, including information about the availability of the MCO Member Rights Specialist. The MCO shall work proactively with the membership to encourage the use of the internal appeal and grievance process as the first step in the resolution of issues.

E. Member Rights Specialist and MCO Advocacy Services

The MCO shall designate a Member Rights Specialist to serve as a member advocate within the agency.

1. *Member Rights Specialist*

   The Member Rights Specialist shall provide support for all members in understanding their rights and responsibilities related to Family Care or Partnership, including due process procedures available to them in a grievance or appeal and other opportunities that may be available to express opinions and concerns about the Resource Center, providers with which the MCO contracts and services received by the member.

   The Member Rights Specialist shall also assist members to identify all rights to which they are entitled. If multiple grievance, review or fair hearing processes are available to the member, the Member Rights Specialist shall also offer advice about which process might best meet the member needs.

2. *MCO Advocacy Services*

   a. The MCO Member Rights Specialist shall have direct access to top level management of the MCO, and shall perform the following functions at a minimum:

      i. Assist individual members with issues and concerns that relate to the care management or the services provided through the MCO; and

      ii. Assist in assuring quality services throughout the MCO.

   b. The MCO shall assure that, within 90 calendar days after enrollment, members have had a face-to-face contact to make certain they are aware of the advocacy services available to them. This contact may be done by the interdisciplinary team.

F. Legal Decision Makers

The MCO shall determine the identity of any and all legal decision makers for the member and the nature and extent of each legal decision maker's authority. The MCO shall include any legal decision maker in decisions relating to the member only to the extent consistent with the scope of the legal decision maker's authority.

G. Informal Resolution

Members shall obtain a prompt resolution, through established procedures, of issues raised by the members, including grievances and appeals. Members shall have the option to be represented by an advocate, peer or other person designated by the member in these processes. Whenever possible, the MCO shall attempt to resolve appeals and grievances through internal review, negotiation or mediation. Such attempts do not, however, relieve the MCO of any responsibility to comply with all requirements of the grievance and appeals process including timely resolution and prompt notice of any decisions.

H. Advance Directives

1. The MCO shall comply with requirements of federal and state law with respect to advance directives (e.g., living wills, durable power of attorney for health care).
2. The MCO shall not base the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. This provision shall not be construed as requiring the provision of care that conflicts with an advance directive.
3. The MCO shall:
   a. Provide written information at time of MCO enrollment to all adults receiving medical care through the MCO regarding:
      i. The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
      ii. The individual's right to file a grievance with the Department of Health Services, Division of Quality Assurance, regarding noncompliance with advance directive requirements. If requested, assist the member in filing a grievance with the Division of Quality Assurance regarding noncompliance with advance directive requirements, and
      iii. The MCO's written policies respecting the implementation of such rights, including a statement on any limitation regarding implementation of advance directives as a matter of conscience.
   b. Document in the member record whether or not the member has executed an advance directive.
   c. Provide education for staff and the community on issues concerning advance directives including information and/or training about ways to recognize and minimize or eliminate any potential conflicts of interest associated with providing counseling and assistance to members in executing advance directives.

d. Provide referral to appropriate community resources, for any member or individual seeking assistance in the preparation of advance directives.

e. Have written policies and procedures regarding advance directives for all members that include all requirements listed in this section.

4. The written information must reflect changes in State law related to advance directives as soon as possible, but no later than ninety (90) calendar days after the effective date of change.

5. The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider who, as a matter of conscience, cannot implement an advance directive.

I. Provision of Interpreters

The MCO shall provide interpreter services for members, as necessary, to ensure availability of effective communication regarding treatment, medical history, health education and information provided to members. The MCO must offer an interpreter, such as a foreign language or a sign language interpreter or a transcriber, in all crucial situations requiring language assistance as soon as it is determined that the member is of limited English proficiency or needs other interpreter services. (For related information, refer to Article IX.E., Accessible Formats and Languages and Cultural Sensitivity. The MCO shall meet the following requirements in the provision of interpreter services.

1. *Availability*

   The MCO must provide for twenty-four (24) hour a day, seven (7) days a week access to interpreters conversant in languages spoken by the members in the MCO. In a specific situation when a member needs care from the benefit package and requests interpreter services, the MCO shall make all reasonable efforts to acquire an interpreter in time to assist adequately with all necessary care.

2. *Professional Interpreters*

   Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed.

3. *Family Members as Interpreters*

   Family members, especially children, may not be used as interpreters for discussion of technical, medical or treatment information or in assessments, therapy and other situations where impartiality is critical.

4. *Civil Rights Act of 1964*

   Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act.

XI. Grievances and Appeals

A. Purpose and Philosophy

Members have the right to appeal MCO adverse benefit determinations and to grieve any action or inaction of an MCO that the member perceives as negatively impacting the member. Members are encouraged to attempt to informally resolve their issues before filing a grievance or an appeal.

1. The member's interdisciplinary team is usually in the best position to deal with issues directly and expeditiously. The Member Rights Specialist within the MCO is the next most direct source of information and assistance.
2. When a concern cannot be resolved through internal review, negotiation, or mediation with the assistance of these individuals, the MCO's grievance and appeal process is the next step for resolving differences. It is described in more detail in Section F of this article.
3. Department Review is the final process in resolving members' grievances. For more information about the Department Review process see Section G of this article.
4. The State Fair Hearing process is the final administrative review process for the Department in resolving members' appeals of adverse benefit determinations. It is described in Section H of this article.
5. Other remedies available to members, depending on the circumstances or issue, may include Wis. Admin. § DHS 94, Patient Rights and Resolution of Patient Grievances or seeking resolution in Circuit Court.

B. Definitions

As used in this article, the following terms have the indicated meanings:

1. *Adverse benefit determination*
   a. An "adverse benefit determination" is any of the following:
      i. The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of the MCO's administration of the long-term care functional screen, including a change from nursing home level of care to non-nursing home level of care.
      ii. The denial or limited authorization of a requested service that falls within the benefit package specified in Addendum VII, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
      iii. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of time or duration and that amount or duration has been completed.

iv. The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VII.

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

vi. The denial of a member's request to obtain services outside the MCO's network when the member is a resident of a rural area with only one managed care entity.

vii. The failure to provide services and support items included in the member's MCP in a timely manner, as defined by the Department.

viii. The development of a member-centered plan that is unacceptable to the member because any of the following apply.

a) The plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member.

b) The plan does not provide sufficient care, treatment, or support to meet the member's needs and support the member's identified outcomes.

c) The plan requires the member to accept care, treatment, or support items that are unnecessarily restrictive or unwanted by the member.

ix. The involuntary disenrollment of the member from the MCO at the MCO's request.

x. The failure of the MCO to act within the timeframes of this article for resolution of grievances or appeals.

b. An "adverse benefit determination" is not:

i. A change in provider;

ii. A change in the rate the MCO pays a provider;

iii. A termination of a service that was authorized for a limited number of units of service or duration of a service as defined in Article V.K.3.a. and b.; or

iv. An adverse benefit determination that is the result of a change in state or federal law; however, a member does have the right to a State Fair Hearing in regard to whether he/she is a member of the group impacted by the change.

v. The denial of authorization or payment for a service or item that is not inside of the benefit package specified in Addendum VII.

2. *Appeal*

An "appeal" is a request for MCO review of an "adverse benefit determination." If a member is dissatisfied with the MCO's appeal decision, he or she can request a State Fair Hearing.

3. *Grievance*

"Grievance" is an expression of a member's dissatisfaction about any matter other than an "adverse benefit determination." If a member is dissatisfied with the MCO's grievance decision, he or she can request DHS Review of the decision.

When a member expresses dissatisfaction about any matter other than an adverse benefit determination, the member is expressing a grievance. As indicated under section F, the IDT staff will first attempt to resolve this grievance informally unless the member objects. If the IDT staff is unable to resolve the issue to the member's satisfaction (or if the member objects) then IDT staff will refer the member to the Member Rights Specialist. The Member Rights Specialist will then assist the member in filing a formal grievance while simultaneously attempting to resolve the issue informally unless the member objects.

4. *Grievance and Appeal System*

The term "Grievance and Appeal System" refers to the overall system the MCO implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

5. *Fair Hearing*

A "fair hearing" means a de novo review under Ch. HA 3, Wis. Admin. Code, before an impartial administrative law judge of an action by the Department, a county agency, a resource center, or an MCO.

C. Overall Policies and Procedures for Grievances and Appeals

1. *General MCO Requirement*

The governing board of the MCO is responsible to assure that the MCO has a grievance and appeal system that is responsive to concerns raised by members. This function may be delegated in writing to a grievance and appeal committee.

The MCO must resolve each grievance and appeal, and provide notice of a final decision, as expeditiously as the member's health condition requires, within timeframes that may not exceed the Department-established timeframes specified in this article.

Only the MCO adverse benefit determinations set forth in Article XI.B.1.a.i.- ix. can be reviewed by the internal MCO appeal process. Financial eligibility decisions and cost share calculations cannot be reviewed by the MCO's internal appeal system. The only means by which members may contest those decisions is through the State Fair Hearing process.

The policies and procedures used by the MCO to resolve grievances and appeals shall be approved by the Department in initial certification and when any significant change in the MCO's policies and procedures is made.

2. *One Level of Appeal*

   The MCO must only have one level of appeal and a member must exhaust this level of appeal before he or she can request a State Fair Hearing.

3. *Opportunity to Present Evidence*

   A member shall have a reasonable opportunity, in person and in writing, to present evidence testimony and legal and factual arguments, in an MCO grievance, MCO appeal, or State Fair Hearing. In an expedited review, the MCO must inform the member sufficiently in advance of the expedited appeal resolution timeframe described in Article XI.F.5.f. of the limited time available to present evidence and testimony and make legal and factual arguments.

4. *Provision of Case File*

   The MCO must ensure that the member is aware that he or she has the right to access his or her case file, free of charge, and to be provided with a free copy of his or her case file. "Case file" in this context means all documents, records, and other information relevant to the MCO's adverse benefit determination and the member's appeal of that adverse benefit determination. This includes, but is not limited to, medical necessity criteria, functional screen results, any processes, strategies, or evidentiary standards used by the MCO in setting coverage limits and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination. This information must be provided to the member sufficiently in advance of the appeal resolution timeframes described in Article XI.F.5.e and f.

5. *Cooperation with Advocates*

   MCOs must make reasonable efforts to cooperate with all advocates a member has chosen to assist him or her in a grievance or appeal.

   a. As used here "advocate" means an individual whom or organization that a member has chosen to assist in articulating his or her preferences, needs, and decisions.

   b. "Cooperate" means:

      i. To provide any information related to the member's eligibility, entitlement, cost sharing, care planning, care management, services, or service providers to the extent that the information is pertinent to matters in which the member has requested the advocate's assistance.

      ii. To assure that a member who requests assistance from an advocate is not subject to any form of retribution for doing so.

c. Nothing in this section allows the unauthorized release of member information or abridges a member's right to confidentiality.

6. *Reversed Appeal Decisions*

If the MCO appeal process or State Fair Hearing process reverses a decision to deny, limit, or delay services that were not furnished during the appeal, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision.

If the MCO appeal process or State Fair Hearing process reverses a decision to deny authorization of services, and the member received the disputed services during the appeal, the MCO must pay for those services.

7. *Continuation of Benefits While an MCO Appeal or State Fair Hearing are Pending*

a. Services shall be continued by the MCO throughout the local MCO appeal process and State Fair Hearing process in relation to the initial adverse benefit determination if all of the following criteria are met:

i. The member files the request for an appeal timely in accordance with Section F.5.b of this article;

ii. The appeal involves the termination, suspension, or reduction of previously authorized services;

iii. The period covered by the original authorization has not expired;

iv. The member makes a timely request for continuation of benefits. A request for continuing benefits is timely if it is submitted on or before the effective date in a notice of adverse benefit determination or MCO appeal decision. If the member makes a timely request for continuation of benefits, the MCO must continue the benefits even if a previously authorized time period or service limit is reached during the course of the appeal process.

b. If, at the member's request, the MCO continues or reinstates the member's services while the appeal or State Fair Hearing is pending, the services must be continued until one of the following occurs:

i. The member elects to withdraw the appeal or request for State Fair Hearing;

ii. The member fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after the day the MCO sends the notice of an adverse resolution to the member's appeal. In this context, sends means putting a hard copy notice in the mail or transmitting the notice to the member electronically.

iii. A State Fair Hearing decision is issued upholding the MCO's reduction, suspension, or termination of services.

c. A member does not have a right to continuation of benefits:

i. When grieving a change in provider that is the result of a change in the MCO's provider network due to contracting changes; however, in such a situation the member does have a right to appeal on the basis of dissatisfaction with her/his MCP.

ii. When grieving adverse benefit determinations that are the result of a change in state or federal law; however, in such a situation a member does have the right to appeal whether he/she is a member of the group impacted by the change.

d. If the final resolution of the appeal or State Fair Hearing, excluding eligibility appeals, is adverse to the member (i.e. upholds the MCO's adverse benefit determination), the MCO may recover the cost of services continued solely because of the requirements of this section. The Department or the MCO may waive or reduce the member's liability if the Department or the MCO determines that the person would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided.

8. *Information to Providers*

In its subcontracts with providers, the MCO shall furnish providers with information regarding the grievance and appeal processes as specified in this article and require subcontractors to cooperate in grievance and appeal investigations.

D. Notice of Adverse Benefit Determination

1. *Requirement to Provide Notice of an Adverse Benefit Determination*

The MCO must provide written notice of an adverse benefit determination in the situations listed below.

The MCO must use the Department and/or CMS issued notice of adverse benefit determination form for the Family Care and Partnership Programs: https://www.dhs.wisconsin.gov/library/f-00232.htm. The notice of adverse benefit determination may be mailed or hand delivered. An oral or e-mail notice or reference to information in the member handbook or other materials does not meet the requirement to provide notice of adverse benefit determination.

a. Denial in Whole or in Part of a Request for Service

The MCO must mail or hand deliver written notice of adverse benefit determination https://www.dhs.wisconsin.gov/library/f-00232.htm to an affected member when the MCO intends to deny in whole or in part a request for a service included in the benefit package.

Although the MCO may cover a service that is outside of the benefit package under the circumstances set forth in Article VII, Section A.5., an MCO is not required to provide a notice of adverse benefit determination when it denies a member's request for such a service. The MCO is however required to inform members in writing when a request for a service outside the benefit package is denied. The MCO must utilize DHS' Notification of Non Covered Benefit template (https://www.dhs.wisconsin.gov/library/f-01283.htm) and must maintain a copy of the completed form in the member's file.

Denial of a request for an item meeting the definition of medical equipment or appliances (Article I.86) or medical supplies (Article I.87) shall be treated by the MCO as a denial of a benefit package service regardless of whether the item is on the Forward Health Durable Medical Equipment Index or the Wisconsin Medicaid Index of Disposable Medical Supplies or other indices of coverable medical equipment and supplies used by the MCO.

b. Reduction, Suspension, or Termination of a Previously Authorized Service

The MCO must mail or hand deliver advance written notice of adverse benefit determination https://www.dhs.wisconsin.gov/library/f-00232.htm to an affected member when the MCO intends to reduce, suspend or terminate any service regardless of whether that service is included in the benefit package.

c. Denial of Payment for a Service

The MCO must mail or hand deliver written notice of adverse benefit determination https://www.dhs.wisconsin.gov/library/f-00232.htm to an affected member when the MCO intends to deny a member's request for payment of a service included in the benefit package.

Although the MCO may pay for a service that is outside of the benefit package under the circumstances set forth in Article VII, Section A.5., an MCO is not required to provide a notice of adverse benefit determination when it denies a member's request for payment of such a service. The MCO is however required to inform members in writing when a request for payment of a service outside of the benefit package is denied. The MCO must utilize DHS' Notification of Non Covered Benefit template (https://www.dhs.wisconsin.gov/library/f-01283.htm) and must maintain a copy of this completed form in the member's file.

Denial of payment for an item meeting the definition of medical equipment or appliances (Article I.86) or medical supplies (Article I.87) shall be treated by the MCO as a denial of a benefit package service regardless of whether the item is on the Forward Health Durable Medical Equipment Index or the Wisconsin Medicaid Index of Disposable Medical

Supplies or other indices of coverable medical equipment and supplies used by the MCO.

2. *Documentation of Notice of Adverse Benefit Determination*

The MCO is required to maintain a copy of any notice of adverse benefit determination required in Article XI.D.1. in the member's paper or electronic record.

3. *Language and Format Requirements for Notice of Adverse Benefit Determination*

A notice of adverse benefit determination required in Article XI.D.1. must be in writing. A notice of adverse benefit determination must use easily understood language and format. It must include a statement that written or oral interpretation is available for individuals who speak non-English languages and indicate how such interpretation can be obtained. A notice of adverse benefit determination must meet the language and format requirements of 42 C.F.R. § 438.10(d) and 42 C.F.R. § 438.404 to ensure ease of understanding.

4. *Content of Notice of Adverse Benefit Determination*

The MCO will use the DHS issued notice of adverse benefit determination form (https://www.dhs.wisconsin.gov/library/f-00232.htm) required in Article XI.D.1.

The notice must include the date the notice is mailed or hand delivered and explain the following:

a. The adverse benefit determination the MCO or its contractor has taken or intends to take, including the effective date of the adverse benefit determination.

b. The reason(s) for the adverse benefit determination.

c. Any laws that support the adverse benefit determination.

d. The right of the member or any other legal decision maker to request an appeal with the MCO of the adverse benefit determination.

e. The right of the member or any other legal decision maker to request a State Fair Hearing after the member appeals the MCO's adverse benefit determination and receives written notice that the adverse benefit determination has been upheld by the MCO or the MCO fails to adhere to the notice and timing requirements described in Article XI.F.5.e and f (i.e. the member is deemed to have exhausted the MCO's appeal process).

f. The procedures for exercising the rights specified in this paragraph, including appropriate phone numbers and addresses.

g. The member's right to appear in person before the MCO grievance and appeal committee.

h. The circumstances under which expedited resolution is available and how to request it.

i. The availability of independent advocacy services and other local organizations that might assist the member in an MCO grievance, or appeal, Department grievance review or State Fair Hearing.

j. The right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination and how to obtain copies. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.

k. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to re-pay the costs of these continued services.

5. *Timing of Notice of Adverse Benefit Determination*

The MCO must mail or hand deliver the notice of adverse benefit determination required in Article XI.D.1. as expeditiously as the member's condition requires and within the following timeframes:

a. Service Authorization Decisions in Response to a Request for Service

i. Standard Service Authorization Denials or Limitations: For standard service authorization decisions that deny or limit a requested service included in the benefit package, the MCO must mail or hand deliver a notice of adverse benefit determination within fourteen (14) calendar days of the request unless the MCO extends the timeframe. The MCO may extend the timeframe by up to fourteen (14) additional calendar days (for a total timeframe of twenty-eight (28) calendar days) if the member or provider requests the extension or the MCO justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest

If the timeframe is extended, the MCO must mail or hand deliver a written notification of extension to the member no later than the fourteenth calendar day after the original request. The notification of extension must inform the member:

a) Of the reason for the extension;

b) That the member may file a grievance if dissatisfied with the extension, in which case the extension will be considered a denial, and

c) That the member may contact the Member Rights Specialist for assistance.

If the MCO denies a member's request for an alternate service, as described in Article VII. Section A.5., the MCO must mail or hand deliver a Notification of Non Covered Benefit (https://www.dhs.wisconsin.gov/library/f-01283.htm) within fourteen (14) calendar days of the request.

ii. Expedited Service Authorizations: A member or provider may request an expedited service authorization decision. For cases in which an expedited decision is needed because a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or physical or mental health or ability to attain, maintain, or regain maximum function, the MCO must make the service authorization decision and mail or hand deliver notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after the request unless the timeframe has been extended.

In the case of an expedited decision, the timeline for a decision may be extended by an additional fourteen (14) calendar days up to a total of seventeen (17) calendar days if the member or provider requests the extension or the MCO justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest.

If the timeframe is extended, the MCO must:

a) Mail or hand deliver to the member written notice of the reason for the decision to extend the timeframe and the member's right to file a grievance if he/she disagrees with that decision; and

b) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

iii. A standard or expedited service authorization decision that is not reached within the timeframes specified in paragraphs i. or ii. constitutes a denial. In such situations, the MCO must send a notice of adverse benefit determination as soon as the timeframes have expired.

b. Termination, Suspension Or Reduction of Services

For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must mail or hand deliver a notice of adverse benefit determination https://www.dhs.wisconsin.gov/library/f-00232.htm with an effective date of implementation not less than fifteen (15) calendar days from the date of the notice of adverse benefit determination. This includes five (5) mailing days to ensure that member

receives the notice of adverse benefit determination ten (10) days before the effective date of the adverse benefit determination.

In the following circumstances the fifteen (15) calendar day advance notice of adverse benefit determination is not required:

i. Notice of adverse benefit determination is required five (5) calendar days in advance

The period of advance notice is shortened to five (5) calendar days if probable member fraud has been reported to the county, DHS, or DOJ Medicaid Fraud Unit.

ii. No advance notice of adverse benefit determination is required

In the following circumstances, the MCO may take action to immediately reduce or terminate a member's service. The MCO shall mail or hand deliver a notice of adverse benefit determination to the member at the same time it takes such an adverse benefit determination in the following circumstances.

a) The member has requested, in writing, the termination or reduction of service(s). The written request and termination or reduction must be documented in the member's record.

b) The member has provided information that will require termination or reduction of services and has indicated in writing that s/he understands that will be the result of supplying that information.

c) An immediate change in the plan of care, including the reduction or termination of a service, is necessary to assure the safety or health of the member or other individuals.

iii. No notice of adverse benefit determination is required

The MCO is not required to provide notice of adverse benefit determination when terminating services when a member is disenrolled.

c. Denial of Payment

For denial of payment, the MCO must mail or hand-deliver a notice of adverse benefit determination on the date of the denial.

E. Notification of Appeal Rights in Other Situations

1. *Requirement to Provide Notification of Appeal Rights*

The MCO must provide members with written notification of appeal and grievance rights in the following circumstances.

a. Change in Level of Care from Nursing Home to Non-Nursing Home

Members whose level of care changes from the nursing home level of care to the non-nursing home level of care must receive a written notice that clearly explains the potential impact of the change, the member's right to request a functional eligibility re-screening, the member's right to appeal with the MCO and the member's right to request a State Fair Hearing following the MCO's appeal decision or the MCO's failure to issue a decision within the timeframes specified in Article XI.F.5.e and f. The MCO shall provide for functional eligibility re-screening by a different screener within ten (10) calendar days of a request by a member or member's legal decision maker. The MCO shall provide for functional eligibility re-screening by a different screener within ten (10) calendar days of a request by a member or a member's legal decision maker. The MCO must mail or hand deliver the Department issued notice of change in level of care form https://www.dhs.wisconsin.gov/library/f-01590.htm when the MCO administers a long-term care functional screen that results in a reduction of the member's level of care from "nursing home" to "non-nursing home," as identified in Article XI.B.1.a.i.

The MCO does not need to provide notification of change in level of care if the member is found to no longer meet any level of care because the ForwardHealth interChange system will automatically issue a Notice of Loss of Functional Eligibility to the member which includes an explanation of the member's appeal rights.

b. Adverse MCO Grievance or Appeal Decision

When the MCO makes a decision in response to a member's grievance or appeal that is entirely or partially adverse to the member it must on the date of the decision mail or hand deliver a written notification to the member of the reason for the decision and any further grievance or appeal rights. For appeal decisions, the MCO shall use the following Department mandated templates:

i. MCO decision is upheld:

https://www.dhs.wisconsin.gov/library/f-00232e.htm

ii. MCO decision is reversed:
https://www.dhs.wisconsin.gov/library/f-00232d.htm

iii. MCO notification of extension for decision:
https://www.dhs.wisconsin.gov/forms/f02619.docx

c. Involuntary Disenrollment of the Member from the MCO at the MCO's Request

MCO requested disenrollments must be approved by the Department (see Article IV.B.3.c). When the Department approves an MCO requested

disenrollment, the ForwardHealth interChange system will automatically issue a Notice of Disenrollment to the member which includes an explanation of the member's appeal rights.

d. Other Adverse Benefit Determinations

A member has the right to appeal the other adverse benefit determinations identified in Article XI.B.1.a.v.-viii The MCO shall mail or hand deliver to the member a written notification of the right to appeal these adverse benefit determinations with the MCO and the right to request a State Fair Hearing following the MCO's appeal decision or the MCO's failure to issue a decision within the timeframes specified in Article XI.F.5.e and f.

2. *Documentation of Notification of Appeal Rights*

The MCO is required to maintain a copy of any notification of appeal rights required in Article XI.E.1. in the member's paper or electronic record.

3. *Timing of Notification of Appeal Rights*

a. Loss or Change of Functional Eligibility

When administration of the long-term care functional screen results in a loss or change in functional eligibility under Wis. Stat. § 46.286(1)(a), the screener shall verify the results and then immediately transfer the screen results to CARES. The screen results will also be automatically updated in ForwardHealth interChange. In addition:

i. If the functional screen results in a complete loss of functional eligibility for the program, the member will be automatically disenrolled in ForwardHealth interChange and the interChange system will automatically issue a Notice of Loss of Functional Eligibility to the member. The MCO must continue to provide services until the date of disenrollment.

ii. For Family Care only, if the functional screen results in a change in level of care from the nursing home level of care to the non-nursing home level of care, the MCO shall verify the result and mail or hand deliver a notice of change in level of care which includes notification of appeal rights informing the member of the change in level of care. The effective date included in the notification shall be not less than fifteen (15) calendar days from the date the screen is calculated, and the notification shall be mailed or hand delivered to the member on the date the screen is calculated. If the member remains enrolled at the non-nursing home level of care and the MCO will reduce or terminate any service as a result of the change in level of care, the MCO must provide an additional notice of adverse benefit determination in accordance with Article XI.D.5.b.

b. Adverse MCO Grievance or Appeal Decision

i. Grievances

The MCO must mail or hand-deliver a written decision regarding a grievance to the member and the member's legal decision maker, if applicable, within the timeframes specified in Article XI.F.4.e. When the MCO's decision is entirely or partially adverse to the member, the decision must include the reason for the decision and the member's right to request DHS Review of the MCO's grievance decision.

ii. Appeals

The MCO must mail or hand-deliver a written decision regarding an appeal to the member and the member's legal decision maker, if applicable, within the timeframes specified in Article XI. F.5.e. and f. When the MCO's decision is entirely or partially adverse to the member, the decision must include notice of the member's right to request a State Fair Hearing. The notification shall establish the effective date of the implementation of the decision not less than fifteen (15) calendar days from the date of the notification.

c. Other Adverse Benefit Determinations

A member has the right to appeal the other adverse benefit determinations identified in Article XI.B.1.a.vii.-viii. On the date it becomes aware of any such adverse benefit determination, the MCO shall mail or hand deliver to the member a written notification of the right to appeal these adverse benefit determinations.

F. MCO Grievance and Appeal Process

The MCO grievance and appeal process must meet the following requirements.

1. *Assistance in Filing a Grievance or Appeal*

The MCO must designate a "Member Rights Specialist" (see Article X.E.) who is responsible for assisting members when they are dissatisfied. The MCO Member Rights Specialist must offer assistance to members in submitting grievances or appeals.

The Member Rights Specialist assigned to assist a member in a specific circumstance may be responsible for scheduling and facilitating meetings, but may not be a member of the MCO grievance and appeal committee that considers that specific circumstance. The Member Rights Specialist may not represent the MCO at a hearing of the MCO grievance and appeal committee or at a State Fair Hearing.

The MCO should attempt to resolve issues and concerns without formal hearings or reviews whenever possible. When a member presents a grievance or appeal, the interdisciplinary team and the Member Rights Specialist must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible.

a. The interdisciplinary team is the first level of support when a member is dissatisfied. Unless contrary to the expressed desire of the member, the IDT will attempt to resolve the issue through internal review, negotiation, or mediation, if possible. If the IDT cannot resolve the issue, it will refer the member to the Member Rights Specialist or offer assistance to the member or legal decision maker who wishes to file a grievance or appeal.

b. The Member Rights Specialist will assist the member or legal decision maker to understand the grievance or appeal options and help to complete any required paperwork to file the grievance or appeal. At the same time, unless contrary to the expressed desire of the member, the Member Rights Specialist will attempt to resolve issues through internal review, negotiation, or mediation.

c. The MCO must provide members with any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, assistance with committing an oral grievance or appeal to writing and providing auxiliary aids and services upon request (such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability).

d. The MCO must allow members to involve anyone the member chooses to assist in any part of the grievance and appeal process, including informal negotiations.

2. *Grievance and Appeal Decision Makers*

The MCO must ensure that the MCO grievance and appeal committee is comprised of:

a. Individuals who were not involved in any previous level of review or decision making. A subordinate of an individual who was involved in a previous level of review or decision making may not be included in the MCO grievance and appeal committee;

b. At least one member or guardian, or one person or guardian of a person, who meets the functional eligibility for one of the target populations served by the MCO. This person must be free from conflict of interest regarding his/her participation in the governing board/committee;

c. Individuals who, if deciding any of the following, are health care professionals possessing the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease:

i. An appeal of an adverse benefit determination that is based on lack of medical necessity.

ii. A grievance regarding denial of expedited resolution of an appeal.

iii. A grievance or appeal that involves clinical issues.

d. Individuals who will take into account all comments, documents, records, and other information submitted by the member or the member's legal representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

3. *Confidentiality*

The MCO shall assure the confidentiality of any member who uses the grievance and appeal process is maintained, including:

a. Assuring that all members of the grievance and appeal committee have agreed to respect the privacy of members who bring a grievance or appeal before the committee and have received appropriate training in maintaining confidentiality and;

b. Offering a member the choice to exclude any consumer representatives under Article XI.F.2.b. from participation in a hearing on a matter the member is bringing before the grievance and appeal committee.

4. *MCO Process for Medicaid Grievances*

a. Authority to File

A member or a member's legal decision maker or anyone acting on the member's behalf with the member's written permission may file a grievance with the MCO.

b. Timing of Filing

A grievance can be filed with the MCO at any time.

c. Acknowledgement of Grievance Receipt

The MCO must acknowledge in writing receipt of each grievance. The MCO's written acknowledgment must include Department issued template language providing the date by which the MCO will make a decision on the member's grievance and explaining that the member can request Department Review of the grievance if the MCO does not provide the member with its decision by that date. The acknowledgement must be provided to the member, person acting on the member's behalf, or the member's legal decision maker if applicable and must be mailed or hand delivered within five (5) business days of the date of receipt of the grievance. (See Article XI.F.4.a. for a description of individuals who may be authorized to submit a grievance.)

d. Procedures

i. A grievance may be filed either orally or in writing with the MCO. In order to establish the earliest possible filing date for the grievance, the MCO must document all grievances whether received orally or in writing.

ii. Unless contrary to the expressed desire of the member, the MCO must attempt to resolve all grievances through internal review, negotiation, or mediation.

iii. A grievance that cannot be resolved through internal review, negotiation, or mediation, must be reviewed by the MCO grievance and appeal committee.

iv. A member who files a grievance must be given the right to appear in person before the MCO grievance and appeal committee or its designee.

e. Grievance Resolution Timeframe

i. The MCO grievance and appeal committee must mail or hand-deliver a written decision on a grievance to the member and the member's legal decision maker, if applicable, as expeditiously as the member's situation and health condition require, but no later than ninety (90) calendar days after the date of receipt of the grievance. This timeframe for resolution may be extended by up to fourteen (14) calendar days, up to a total of one hundred and four (104) calendar days if:

a) The member requests the extension; or

b) The MCO demonstrates (to the satisfaction of the Department, upon the Department's request) that there is a need for additional information and how the delay is in the member's interest.

ii. For an extension not requested by the member, the MCO must:

a) Make reasonable efforts to give the member prompt oral notice of the delay; and

b) Within two (2) calendar days mail or hand deliver to the member (and the Department if requested) written notice which includes: the reason for the decision to extend the timeframe, the member's right to file a grievance if he/she disagrees with that decision, Department issued template language providing the date by which the MCO will make a decision on the member's appeal and an explanation that the member can request a Department Review if the MCO

does not provide the member with its decision by the date; and

c) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

f. Content of Grievance Resolution Decision

The written decision must include the results and date of the decision. For decisions not wholly in the member's favor the notice must include the right to request a Department Review and how to do so.

5. *MCO Process for Medicaid Appeals*

a. Authority to File

i. A member or a member's legal decision maker or anyone acting on the member's behalf with the member's written permission may file an appeal with the MCO regarding any MCO adverse benefit determination, with the exception of the adverse benefit determination specified in Article XI.F.5.a.iii.

ii. There is no MCO level appeal of loss of financial eligibility under Wis. Stat. § 46.286(1)(a) or calculation of cost share under Wis. Stat. § 46.286(2).

A member or member's legal decision maker or anyone acting on the member's behalf with the member's written permission may request a State Fair Hearing regarding loss of financial eligibility or calculation of cost share.

iii. There is no right to an MCO level appeal of a decision that has been issued by the MCO grievance and appeal committee or an administrative law judge as the result of a State Fair Hearing.

b. Timing of Filing

An appeal must be filed within sixty (60) calendar days of the date on the adverse benefit determination notice.

c. Acknowledgement of Appeal Receipt

The MCO must acknowledge in writing receipt of each appeal. The MCO's written acknowledgement must include Department issued template language providing the date by which the MCO will make a decision on the member's appeal and explaining that the member can request a State Fair Hearing if the MCO does not provide the member with its decision by that date. The acknowledgement must be provided to the member, person acting on the member's behalf or the member's legal decision maker, if applicable, and must be mailed or hand delivered within five (5) business days of the date of receipt of the appeal. See Article

XI.F.5.a.i. for a description of individuals who may be authorized to submit an appeal.

d. Procedures

i. An appeal may be filed either orally or in writing with the MCO. However, for standard appeals, the individual must follow an oral filing with a written, signed appeal. In order to establish the earliest possible filing date for the appeal, the MCO must document all appeals whether received orally or in writing. The MCO will process oral requests for expedited appeals without requiring further action of the member.

ii. Unless contrary to the expressed desire of the member, the MCO must attempt to resolve all appeals through internal review, negotiation, or mediation.

iii. An appeal that cannot be resolved through internal review, negotiation, or mediation, must be reviewed by the MCO grievance and appeal committee.

iv. A member who files an appeal must be given the right to appear in person before the grievance and appeal committee.

v. The MCO grievance and appeal committee will make its determinations related to authorization of services based on whether services are necessary to support outcomes as defined in Article I, Definitions.

vi. The MCO grievance and appeal committee must make a decision on an appeal as expeditiously as the member's situation and health condition requires. The MCO must mail or hand deliver notification of the decision with an effective date of implementation of the decision not less than fifteen (15) calendar days from the date of the decision.

e. Standard Appeal Resolution Timeframe

i. Unless the member requests expedited resolution, for Family Care and Partnership the MCO must mail or hand-deliver a written decision on the appeal no later than thirty (30) calendar days after the date of receipt of the appeal. This timeframe for resolution may be extended by up to fourteen (14) calendar days, up to a total of forty-four (44) calendar days if:

a) The member requests the extension; or

b) The MCO demonstrates (to the satisfaction of the Department, upon the Department's request) that there is need for additional information and how the delay is in the member's interest.

ii. For an extension not requested by the member, the MCO must:

a) Make reasonable efforts to give the member prompt oral notice of the delay; and

b) Within two (2) calendar days, mail or hand deliver to the member (and the Department, if requested) written notice which includes: the reason for the decision to extend the timeframe, the member's right to file a grievance if he/she disagrees with that decision, Department issued template language providing the date by which the MCO will make a decision on the member's appeal and an explanation that the member can request a State Fair Hearing if the MCO does not provide the member with its decision by that date; and

c) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

f. Expedited Appeal Resolution Timeframe

i. Members may request an expedited resolution if the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The MCO must make reasonable efforts to give the member prompt oral notice of approval or denial of the request for expedited resolution and a written notice within two (2) calendar days.

If the MCO denies a request for expedited resolution this written notice must inform the member of his/her right to file a grievance if he or she disagrees with the MCO's decision. When the MCO denies a request for expedited resolution, it must reach a decision on the appeal within the standard timeframe.

If the request for expedited resolution meets the criteria in this subsection, the MCO must make reasonable efforts to orally communicate its decision resolving the appeal to the member and mail or hand-deliver its decision as expeditiously as the member's health condition requires, but not more than seventy-two (72) hours after the date of receipt of the appeal. The timeframe for an expedited appeal may be extended by an additional fourteen (14) calendar days, up to a total of seventeen (17) calendar days if:

a) The member requests the extension; or

b) The MCO demonstrates (to the satisfaction of the Department, upon the Department's request) that there is

need for additional information and how the delay is in the member's interest.

ii. For an extension not requested by the member, the MCO must:

a) Make reasonable efforts to give the member prompt oral notice of the delay; and

b) Within 2 calendar days, mail or hand deliver to the member (and the Department, if requested) written notice of the reason for the decision to extend the timeframe and the member's right to file a grievance if he/she disagrees with that decision; and

c) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

iii. In an expedited review, the MCO must inform the member sufficiently in advance of the expedited resolution timeframes of the limited time available to present evidence and testimony and make legal and factual arguments. The MCO must ensure that punitive action is not taken against a member or provider who either requests an expedited resolution or supports a member's request for an expedited resolution.

g. Content of Appeal Resolution Decision

The MCO grievance and appeal committee must mail or hand deliver written notice of its appeal decision to the member and, if applicable, the member's legal decision maker. The written decision must include the results and date of the decision. For decisions not wholly in the member's favor the notice must include the right to request a State Fair Hearing and how to do so and the right to continue to receive benefits pending a hearing and how to request the continuation of benefits, and that the member may be liable for the cost of any continued benefits if the MCO's decision is upheld in the State Fair Hearing.

h. Deemed Exhaustion of Appeals Process

If the MCO fails to issue a written decision within the timeframes described in Article XI.F.5.e and f or according to the notice content requirements described in Article XI.F.5.g, the member is deemed to have exhausted the MCO's internal appeals process and may request a State Fair Hearing.

6. *Parties to the Appeal*

The parties to the MCO appeal shall include, as applicable:

a. The member and his/her legal decision maker; or

b. The legal representative of a deceased member's estate.

G. The Department Review Process

The Department Review process consists of two components: The formal review of MCO grievance decisions when requested by a member and the informal review of all State Fair Hearing requests made by members. The MCO will participate in the Department Review Process.

1. *Grievance Review Process*

a. If a member files a grievance with the MCO and is dissatisfied with the MCO's decision regarding the grievance (or the MCO fails to make a grievance decision within the required timeframe), the member may request that the Department review the MCO's grievance decision.

b. The Department shall complete a timely review, investigation, and analysis of the facts surrounding the member grievance and issue a written, binding decision.

c. Unless the member and the Department agree to an extension for a specified period of time, the Department has thirty (30) calendar days from the date of receipt of a request for review from a member in which to issue its written, binding grievance decision.

d. If the Department determines that it needs more than thirty (30) calendar days to issue a decision then it must send the member a written notice which includes:

i. The reason for the need for additional time;

ii. The amount of additional time needed;

iii. The right of the member to deny the Department's request for an extension, in which case the MCO's grievance decision is the final decision.

e. If, during the course of its grievance review, the Department determines that the MCO failed to act within the requirements of this contract, the Department may order the MCO to take corrective action. The MCO shall comply with any corrective action required within the timeframes established by the Department.

f. The MCO shall provide the Department or its delegate with all requested documentation to support the review process within five (5) calendar days of the date of receipt of the request.

g. The member must file the request for grievance review within forty-five (45) calendar days of the receipt of the MCO's written decision regarding the member's grievance or, if the MCO fails to adhere to the timing requirements described in Article XI.F.4.e, within forty-five (45) calendar days from the date the applicable timeframe expires.

h. The Department will mail or hand deliver to the member and the MCO it's written, binding decision within seven (7) calendar days of the completion of the grievance review.

2. *Informal Review of State Fair Hearing Requests*

a. Whenever the Department receives notice from the Department of Administration's Division of Hearings and Appeals that it has received a State Fair Hearing request, the Department will conduct an informal review of the request.

b. The purpose of informal review is to identify, and, as appropriate, intervene in, appeals related to member health and safety, DHS-MCO contract non-compliance and complex situations, if it appears to the Department that informal resolution of the matter may be appropriate.

c. If, during the course of its informal review, the Department determines that the MCO failed to act within the requirements of this contract, the Department may order the MCO to take corrective action. The MCO shall comply with any corrective action required within the timeframes established by the Department.

H. The State Fair Hearing Process

The MCO will participate in the State Fair Hearing Process.

1. *Request for State Fair Hearing*

A member, immediate family member, or someone with legal authority to act on the member's behalf (as specified in s. HA 3.05(2), Wis. Admin. Code) can file a request for a State Fair Hearing in response to the adverse benefit determinations listed under Article XI.B.1.a. after the member has received written notice under Article XI.E.1.b. that the MCO is upholding its adverse benefit determination or after the MCO has failed to issue a decision within the applicable timeframe specified under Article XI.F.5.e or f. (i.e. the member is deemed to have exhausted the MCO internal appeals process).

2. *Time Limits for Requesting a State Fair Hearing*

For the adverse benefit determinations described above, the member must file the request for a State Fair Hearing within ninety (90) calendar days of the date of receipt of written notice from the MCO that the adverse benefit determination is upheld or, if the MCO fails to adhere to the notice and timing requirements described in Article XI.F.5.e-g., within ninety (90) calendar days from the date the applicable timeframe expires.

3. *MCO Response*

When it is notified by the Wisconsin Department of Administration, Division of Hearings and Appeals (DHA) that a member has requested a State Fair Hearing, the MCO must submit an explanation of its actions within ten (10) calendar days

to DHA. A copy of this explanation must also be sent to the member, the member's legal decision maker if known, and to the Department if requested by the Department.

4. *Participation of MCO Representative at State Fair Hearing*

The MCO will assure that a representative of the MCO participates in State Fair Hearings if:

a. Any MCO adverse benefit determination described in Article XI.B.1. is being appealed; or

b. The MCO has knowledge that the issue being appealed concerns the member's cost share and the MCO has relevant information likely to help the Administrative Law Judge reach a decision.

c. The MCO representative will be prepared to

i. Represent the MCO's position;

i. Explain the rationale and authority for the MCO adverse benefit determination that is being appealed;

ii. Accurately reference and characterize any policies and procedures in this contract related to the adverse benefit determination that is being appealed; and

iii. Accurately reference and characterize any specific MCO policies and procedures related to the adverse benefit determination that is being appealed.

5. *Timeline for Resolution of State Fair Hearing*

The Wisconsin Department of Administration, Division of Hearings and Appeals (DHA) is required to make a decision through the State Fair Hearing process within ninety (90) calendar days of the date a member files a request for the hearing.

6. *Parties to the State Fair Hearing*

The parties to the State Fair Hearing include, as applicable:

a. The member and his/her legal decision maker;

b. The legal representative of a deceased member's estate;

c. The Department; and

d. The MCO.

7. *State Fair Hearing Decision*

Any formal decision made through the State Fair Hearing process under this section, shall be subject to member appeal rights as provided by State and federal

laws and rules. The State Fair Hearing process will include receiving input from the member and the MCO in considering the appeal.

8. *Access to Services*

If the MCO's decision to deny or limit a service is reversed through the State Fair Hearing process, the MCO shall authorize or provide the service promptly and as expeditiously as the member's situation or health condition requires, but no later than 72 hours from the date it receives the State Fair H earing decision reversing the determination.

I. Documentation and Reporting

The MCO must maintain records of member grievances and appeals. Each record must be adequately maintained in an accessible manner and be made available upon request to the State and CMS. The documentation and reporting required in this article regarding grievances and appeals provide the basis for monitoring by the MCO and the Department. The MCO and the Department shall review grievance and appeal information as part of its ongoing monitoring procedures and overall quality management strategies.

1. *Content of Grievance and Appeal Records*

The record of each grievance or appeal must contain, at a minimum, all of the following information:

a. Whether the issue is a grievance or an appeal;

b. A general description of the reason for the appeal or grievance;

c. The date the appeal or grievance was received by the MCO;

d. The date receipt of the appeal or grievance was acknowledged by the MCO;

e. The date(s) of any formal or informal reviews or meetings;

f. The date on which the grievance or appeal was resolved through internal review, negotiation, or mediation or the date a decision was issued by the local grievance and appeal committee;

g. A summary of the internal review, negotiation or mediation resolution or local grievance and appeal committee decision;

h. Whether the member's request was upheld by a local committee decision, whether the member's request was partially upheld or whether the committee agreed with the MCO decision or response to a grievance or appeal;

i. Whether a disenrollment occurred during the course of the grievance or appeal or within fourteen (14) calendar days of receipt of a committee decision, and if so, the reason for the disenrollment; and

j. Name of the member for whom the appeal or grievance was filed.

2. *Confidentiality of Grievance and Appeal Records*

   The MCO shall keep grievance and appeal records confidential in accordance with Article XIII.A., Member Records.

3. *Retention of Grievance and Appeal Records*

   The MCO shall retain the documents related to each grievance and appeal in accordance with Article XIV.F., Records Retention.

4. *Notice of Adverse Decisions to the Department*

   a. Applicability

      The notice of adverse decision requirements described in paragraph b. apply only to the following MCOs:

      i. Any MCO that is in its first year of operation.

      ii. Any MCO, after the first year of operation, that has been identified by the Department as needing to comply with the requirements described in paragraph b. The Department will make this determination based on the MCO's quality review, quarterly reports, and other factors.

   b. Required Submission

      If the MCO makes a decision on a grievance or appeal that is entirely or partially adverse to the member, the MCO shall submit the decision to the Department no later than twenty (20) business days after the MCO mails or hand-delivers the written decision. Supporting documentation shall include:

      i. Any transcript and minutes of the MCO Appeal and Grievance Committee related to the grievance or appeal, including a list of committee members;

      ii. List of the attendees at the hearing;

      iii. Documentation of Resource Allocation Decision (RAD) or other Department approved authorization process, relating to the decision being grieved or appealed;

      iv. Any notices of adverse benefit determination related to the decision;

      v. Any case notes that are pertinent to the grievance and its decision;

      vi. Any other documents, such as physical therapy notes, that would support the team decision; and

      vii. Copies of evidence presented by the member/ representative.

5. *Quarterly Grievance and Appeal Reports*

The MCO shall submit to the Department a quarterly grievance and appeal report as specified in Article XIV.C.3., consisting of a summary and a log, as follows:

a. Summary

The summary shall be an analysis of the trends the MCO has experienced regarding types of issues appealed and grieved through the local MCO process, the DHS process, and the State Fair Hearing process. In addition, the summary should identify whether specific providers are the subject of grievances or appeals. If the summary reveals undesirable trends, the MCO shall conduct an in-depth review, report the results to DHS, and take appropriate corrective action.

b. Log

MCOs must use the Department approved appeal log: https://www.dhs.wisconsin.gov/library/f-02466.htm.

XII. Quality Management (QM)

A. Leadership and Organization of the QM Program

1. *Responsibility for the QM Program*

   The MCO's quality management (QM) program shall be administered through clear and appropriate administrative structures, such that:

   a. The governing board oversees and is accountable for the QM program;

   b. The manager responsible for implementation of the QM plan has direct authority to deploy the resources committed to it;

   c. Responsibility for each aspect of the QM program shall be clearly identified and assigned;

   d. A quality management committee or other coordinating structure that includes both administrative and clinical personnel shall exist to facilitate communication and coordination among all aspects of the QM program and between other functional areas of the organization that affect the quality of service delivery and clinical care (e.g., utilization management, risk management, appeals and grievances, etc.).

2. *Member Participation*

   a. The MCO's Member Advisory Committee in Article II.C shall be a means for members to participate in the QM program and the MCO shall actively encourage and support the participation of members and other community individuals who represent the MCO's target population(s).

   b. The MCO shall keep documentation, e.g., minutes of attendance at QM committee meetings or correspondence, that documents the level of member and community participation in the QM program, and make this documentation available to the Department upon request.

3. *Staff and Provider Participation*

   a. The MCO shall create a means for MCO staff and providers, including attendants, informal caregivers, and long-term care and health care providers with appropriate professional expertise to participate in the QM program and shall actively encourage that participation.

   b. The MCO shall keep documentation, e.g., minutes of attendance at QM committee meetings or correspondence, that documents the level of staff and provider participation in the QM program, and make this documentation available to the Department upon request.

4. *Accreditation*

   a. An MCO must inform the Department before each calendar year whether it has been accredited by a private independent accrediting entity. The

following validation documentation must be submitted to: DHSBMC@wisconsin.gov:

i. Accreditation status;

ii. Accrediting entity, as applicable;

iii. Survey type, and level, as applicable;

iv. Accreditation results, that include: recommended actions or improvements, corrective action plans, and summaries of findings and expiration date of accreditation.

b. As required by 42 C.F.R. § 438.332(c), the Department shall publish on its website the accreditation status of each MCO, and if applicable, the name of the accrediting entity, accreditation program and accreditation level.

B. QM Annual Workplan and Evaluation

1. *Creation and Approval of an Annual QM Workplan*

Each year, the MCO's governing board or its designee shall approve a written QM workplan that outlines the scope of activity and the goals, objectives, timelines, and responsible person for the QM workplan for the contract period, and contains evidence of the MCO's commitment of adequate resources to carry out the program. The MCO's annual QM plan shall be based on findings from quality assurance and improvement activities included in the QM program.

2. *Annual Evaluation and Revision*

The MCO shall evaluate the overall effectiveness, including the impact, of its QM program annually to determine whether the program has achieved significant improvement, where needed, in the quality of service provided to its members.

3. *Special Needs Plan (SNP) Reports*

For those MCOs that operate special needs plans (SNPs), the MCO shall submit to the Department any quality reports that it submits to CMS pursuant to Medicare regulations for SNPs.

C. Activities of the QM Program

Explanatory Material: The QM program will assess and improve the quality of care and services provided through MCO staff and through its contracted providers. The purposes of this program include:

- Potential problem identification through ongoing monitoring efforts;
- Identification of quality-related problems and causes;
- Evaluation of problems to determine severity and whether or not further study is warranted by audit or other means;
- Evaluation of care management practice of members identified as vulnerable/high risk members by audit or other means;

- Design of activities to address deficiencies;
- Development and implementation of corrective action plans; and
- Conducting follow-up activities to determine whether identified quality issues have been corrected and whether care meets acceptable standards.

1. *Documentation of QM Activities, Findings, and Results*

   The MCO shall maintain documentation of the following activities of the QM program and have that documentation available for Department review upon request:

   a. The annual QM workplan and its approval by the governing board or its designee;

   b. Monitoring the quality of assessments and member-centered care plans;

   c. Monitoring the completeness and accuracy of completed functional screens;

   d. Monitoring the member's long term care and personal experience outcomes to ensure the setting in which the member resides supports integration into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community;

   e. Monitoring the results of care management practice related to the support provided to vulnerable/high risk members;

   f. Member satisfaction surveys;

   g. Provider surveys;

   h. Incident Management Systems;

   i. Appeals and grievances that were resolved as requested by the members;

   j. Monitoring of access to providers and verifying that the services were actually provided;

   k. Performance improvement projects;

   l. Results of the annual evaluation of the quality management program; and

   m. Monitoring the quality of sub-contractor services as noted in Article XVI.G.5., Contractual Relationship.

2. *Obtaining Member Feedback*

   Annually, the Department or its designee shall survey each MCO's membership or a representative sample of its enrolled members to identify their level of satisfaction with the MCO's services. The MCO shall cooperate with the Department or its designee to respond timely to requests for member information that is not available through state-level data systems (e.g., current mailing

address) or verify information provided by the Department. The Department or its designee shall compile the survey results for publication and distribution.

3. *Monitoring the Quality of Care Management*

The MCO will conduct an ongoing program of reviews that collects evidence that:

a. Appropriate risk assessments are performed on a timely basis;

b. Members and legal decision makers when appropriate participate in the preparation of the care plan and are provided opportunities to review and accept it;

c. Member-centered plans (MCP) address all participants' assessed needs (including health and safety risk factors) and outcomes;

d. MCPs are updated and revised in accordance with the applicable standards for timeliness and when warranted by changes in the members' needs and outcomes;

e. Services are delivered in accordance with the type, scope, amount, and frequency specified in the member-centered plan;

f. Members are afforded choice among covered services and providers; and

g. Overall member risk, including risk for VHRMs, identified through assessment; appropriate interventions are documented on the MCP to mitigate risk.

4. *Monitoring the Quality of Services Provided by MCO Staff*

a. The MCO shall operate a system for monitoring the quality of services provided by MCO staff.

b. The MCO shall adopt written standards and procedures to govern quality management for its functional screening activities and will upon request submit those that describe:

i. The MCO methods employed to monitor the accuracy, completeness, and timeliness of annual and change-in-condition screens submitted by the MCO or an MCO contractor;

ii. The criteria employed to evaluate the accuracy, completeness, and timeliness of annual and change-in-condition screens submitted by the MCO or an MCO contractor;

iii. The process by which changes in condition are communicated by IDT staff to screeners who are not members of IDT staff; and

iv. The most recent results of the quality management monitoring of functional screen activities.

5. *Monitoring the Quality of Purchased Services*

   a. The MCO shall monitor the performance of providers and collect evidence that both licensed/certified providers and non-licensed/non-certified providers continuously meet required licensure, certification, or other standards and expectations, including those for:

      i. Caregiver background checks;

      ii. Education or skills training for individuals who provide specific services; and

      iii. Reporting of member incidents to the MCO.

      If the MCO identifies deficiencies or areas for improvement, the MCO and the provider(s) shall take corrective action.

   b. For MCOs that include primary and acute medical services in the benefit package, the scope of activities of the QM program must also include review of the provision of health services by appropriate health professionals.

6. *Monitoring Restrictive Measures*

   The MCO shall have policies and procedures to ensure:.

   a. Review and decision on all requests for restrictive measures respective to its members prior to submission of the request to the designated state level approving entity unless the request is a concurrent review in which requests are submitted prior to the MCO making a decision (see Article V.J.4.).

   b. Maintenance of data related to all restrictive measures requests and decisions respective to its members regardless of the state level entity utilized for restrictive measures review and approval.

   c. Education of all individuals involved in the administration of restrictive measures by the Department, designated restrictive measures expert(s), and/or designated competent MCO staff.

   d. MCO report of member restrictive measures data to the Department in accordance with the Department's restrictive measures report specifications. Member restrictive measures data is submitted to the Department on a quarterly basis as described in Article XIV.C.3. The report shall be submitted electronically as specified by the Department.

7. *Performance Improvement Projects*

   Performance improvement projects (PIP) shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on member outcomes or satisfaction.

a. For the purposes of this section: "Active progress" is defined as the point of having implemented at least one intervention and measured its effects on at least one indicator. "Significant improvement" is defined either as reaching a specific performance improvement target or as improving performance in the project focus area by a percentage defined by the MCO or the Department.

b. Annually, each MCO shall make active progress on at least one clinical and one non-clinical PIP relevant to long-term care.

   i. A dual Family Care and Family Care Partnership MCO may fulfill this PIP requirement by conducting one or both of the required PIPs with both Family Care and Family Care Partnership members. If the MCO chooses to combine programs in a single PIP, the baseline and outcome data must be separated by program enrollment.

   ii. A Partnership MCO may use a CMS-required Chronic Care Improvement Project (CCIP) to meet Department requirements. The MCO must receive Department approval prior to utilizing this option and may submit the request to the Department using the CMS improvement project template.

c. Each clinical and non-clinical PIP must have a clearly defined topic relevant to MCO member characteristics and member care quality improvement needs as identified through the MCO's needs assessment.

d. During the PIP planning phase, the MCO shall submit the proposed study questions, project aims or goals and project indicators for each clinical and non-clinical PIP to the Department for review and approval as specified by the Department. The Department will review the plans for the following:

   i. A sufficient needs assessment, which demonstrates that the proposed project topic is relevant to the needs of the MCO's population;

   ii. Whether the project aims or goals provide a good basis for demonstrable significant improvement; and

   iii. Whether the project indicators indicate a baseline measure and are objective, clearly defined, measurable, and time-specific in accordance with the current CMS PIP validation protocol included in Addendum IV, Performance Improvement Projects.

e. The Department may require specific topics for PIPs and may require specific performance measures.

f. An MCO may conduct a PIP at any time for any purpose. All PIPs that are submitted in fulfillment of contract requirements must be approved by the Department before initial project interventions are implemented.

g. An MCO may submit a PIP proposal which covers the two year contract period. If an MCO plans and submits, for DHS approval, a clinical or non-clinical PIP which covers the two year contract period, the MCO shall submit a report for EQRO validation at the end of the first year. Upon review and consideration of the first-year EQRO validation recommendations, the MCO shall submit an update to DHS specifying the MCO's proposed second year plan. This update must address each of the EQRO validation recommendations and does not require DHS approval before the MCO can proceed with the second year PIP implementation.

h. If an MCO plans and conducts a one-year PIP and determines a rationale for a continuing PIP to meet the contract requirement, the MCO must annually submit a PIP proposal for approval. The proposal must include the justification for continuing the PIP.

i. As specified by the Department, the MCO shall submit an annual report to the Department regarding the status and results of any approved PIP. In addition, the Department may request results of any PIP at any time.

j. Collaborative Performance Improvement Project

   i. The MCO may satisfy its PIP requirement by actively participating in a collaborative performance improvement project in conjunction with one or more MCOs.

   ii. The topic for a collaborative improvement project may be specified by the Department or by consensus agreement of the MCO participants. The topic must be founded on a sufficient needs assessment reflective of each participating MCO's membership.

   iii. If a project topic is determined by the Department, project performance measures may also be specified.

   iv. MCO participants shall establish the parameters of the project design, implementation, data analysis, evaluation, and sustainability of improvements as achieved. The project plan shall be submitted to the Department for approval prior to project implementation.

   v. If the MCO is participating in a collaborative PIP, each MCO shall <u>provide a separate annual report to the Department as required in 7.i. above</u>.

k. The MCO may request technical assistance from the Department or the EQRO for any performance improvement project at any time. Additional performance improvement project guidance is included in Addendum IV, Performance Improvement Projects.

8. *Compiling and Using Quality and Performance Indicators*

   a. The MCO shall maintain a health information system that collects, analyzes, integrates, and reports data that can support the objectives of the MCO's QM program. The system must:

      i. Provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility;

      ii. Include systematic data collection relating to achievement of member outcomes;

      iii. Produce performance indicators for internal use that are relevant and timely for quality-management purposes; and

      iv. Provide for presentation and interpretation of the indicators to care managers and providers.

   b. The MCO shall submit performance indicators as specified in Addendum III, MCO Quality Indicators.

9. *Utilization Review*

   a. The QM program shall include processes to:

      i. Monitor and detect underutilization and overutilization of services.

      ii. Assess the quality and appropriateness of care furnished to members.

   b. For medical services in the benefit package, the documented policies and procedures for medical record content and utilization review of medical services shall reflect current standards of medical practice in processing requests for initial or continued authorization of services, and shall:

      i. Be consistent with the utilization control requirement of 42 C.F.R. § 456, Utilization Control including:

         a) Safeguards to prevent unnecessary or inappropriate use of Medicaid services available under this plan, and guard against excess payments;

         b) Under-utilization and over-utilization of services to assure that members receive and have access to services that promote health and safety; and

         c) Medical record content for hospitals and mental hospitals is consistent with the utilization control requirements of 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211.

      ii. Have appropriate health professionals reviewing the provision of health services;

iii. Provide for systematic data collection of performance and results; and

iv. Provide for making needed changes.

D. Cooperation with the Department QM Program

1. *Cooperation with Department Review*

The MCO is subject to, at a minimum, an annual external independent review of quality outcomes, timeliness of, and access to, the services covered in the benefit package.

The MCO must assist the Department and the external quality review organization (EQRO) in identifying and collecting information required to carry out on-site or off-site reviews and interviews with MCO staff, providers, and members.

2. *Response to Department Findings*

In the event that a review by the Department or the EQRO results in findings that concern the Department, the MCO will cooperate in further investigation or remediation, which may include:

a. Revision of a care plan or any of its elements for correction, if found to be incomplete or unsatisfactory;

b. Corrective action within a time frame to be specified in the notice, if the effect on the member is determined to be serious;

c. Additional review by the Department or by the MCO to determine the extent and causes of the noted problems; or

d. Action to correct systemic problems that are found to be affecting additional members.

XIII. MCO Administration

A. Member Records

The MCO shall have a system for maintaining member records and for monitoring compliance with their policies and procedures.

1. *Confidentiality of Records and HIPAA Requirements*

The MCO shall implement specific procedures to assure the security and confidentiality of health and medical records and of other personal information about members, in accordance with Wis. Stats. Chapter 49, Subchapter IV; Wis. Admin. Code § DHS 108.01; 42 C.F.R. 431, Subpart F; 42 C.F.R. 438; 45 C.F.R. 160; 45 C.F.R. 162; and 45 C.F.R. 164 and any other confidentiality law to the extent applicable.

a. Duty of Non-Disclosure and Security Precautions

The MCO shall protect and secure all confidential information and shall not use any confidential information for any purpose other than to meet its obligations under this contract. The MCO shall hold all confidential information in confidence, and not disclose such confidential information to any persons other than those directors, officers, employees, agents, subcontractors and providers who require such confidential information to fulfill the MCO's obligations under this contract. The MCO shall institute and maintain procedures, including the use of any necessary information technology, which are necessary to maintain the confidentiality of all confidential information. The MCO shall be responsible for the breach of this contract in the event any of the MCO's directors, officers, employees, or agents fail to properly maintain any confidential information.

b. Limitations on Obligations

The MCO's obligation to maintain the confidentiality of confidential information shall not apply to the extent the MCO can demonstrate that such information:

i. Is required to be disclosed pursuant to a legal obligation in any administrative, regulatory, or judicial proceeding. In this event, the MCO shall promptly notify the Department of its obligation to disclose the confidential information (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, the MCO shall furnish only that portion of the confidential information that is legally required and shall disclose it in a manner designed to preserve its confidential nature to the extent possible.

ii. Is part of the public domain without any breach of this contract by the MCO;

iii. Is or becomes generally known on a non-confidential basis, through no wrongful act of the MCO;

iv. Was known by the MCO prior to disclosure hereunder without any obligation to keep it confidential;

v. Was disclosed to it by a third party which, to the best of the MCO's knowledge, is not required to maintain its confidentiality;

vi. Was independently developed by the MCO;

vii. Is the subject of a written agreement whereby the Department consents to the disclosure of such confidential information by the MCO on a non-confidential basis; or

viii. Was a permitted use or disclosure, in accordance with Wis. Stats. Chapter 49, Subchapter IV; Wis. Admin. Code § DHS 108.01; 42 C.F.R. 431, Subpart F; 42 C.F.R. 438; 45 C.F.R. 160; 45 C.FR. 162; and 45 C.F.R. 164 or other applicable confidentiality laws.

c. Unauthorized Use, Disclosure, or Loss

If the MCO becomes aware of any threatened or actual use or disclosure of any confidential information that is not specifically authorized by this contract, or if any confidential information is lost or cannot be accounted for, the MCO shall notify the Privacy Officer in the Department's Office of Legal Counsel within one day of the MCO becoming aware of such use, disclosure, or loss. The notice shall include, to the best of the MCO's understanding, the persons affected, their identities, and the confidential information that was disclosed.

The MCO shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The MCO shall reasonably cooperate with the Department's efforts, if any, to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its confidential information, including complying with the following measures, which may be directed by the Department, at its sole discretion:

i. Notifying the affected individuals by mail or the method previously used by the Department to communicate with the individual. If the MCO cannot with reasonable diligence determine the mailing address of the affected individual and the Department has not previously contacted that individual, the MCO shall provide notice by a method reasonably calculated to provide actual notice;

ii. Notify consumer reporting agencies of the unauthorized release;

iii. Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the

Department for one year from the date the individual enrolls in credit monitoring;

iv. Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as determined by the Department; and

v. Adequately staff customer service telephone lines to ensure an actual wait time of less than five (5) minutes for callers.

d. Indemnification

In the event of an unauthorized use, disclosure, or loss of confidential information, the MCO shall indemnify and hold harmless the Department and any of its officers, employees, or agents from any claims arising from the acts or omissions of the MCO, and its subcontractors, providers, employees, and agents, in violation of this section, including but not limited to costs of monitoring the credit of all persons whose confidential information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the Department in the enforcement of this section. In addition, notwithstanding anything to the contrary herein, the MCO shall compensate the Department for its actual staff time and other costs associated with the Department's response to the unauthorized use, disclosure, or loss of confidential information.

e. Equitable Relief

The MCO acknowledges and agrees that the unauthorized use, disclosure, or loss of confidential information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the Department, which injury will not be compensable by money damages and for which there is not an adequate remedy at law. Accordingly, the MCO agrees that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this contract or under applicable law.

f. Sanctions

In the event of an unauthorized use, disclosure, or loss of confidential information, the Department may impose sanctions, in the form of civil monetary penalties, pursuant to the terms described in Article XVI.E.2.a.xiii. and Article XVI.E.2.e.v.

g. Compliance Reviews

The Department may conduct a compliance review of the MCO's security procedures to protect confidential information.

2. *Member Access and Disclosure*

Members shall have access to their records in accordance with applicable state or federal law. The MCO shall use best efforts to assist a member, his/her legal decision maker, and others designated by the member to obtain records within ten (10) business days of the request. The MCO shall identify an individual who can assist the member and his/her legal decision maker in obtaining records. Members have the right to approve or refuse the release of confidential information, except when such release is authorized by law.

3. *Medical Information Available to MCOs*

The MCO is a Contractor of the State and is therefore entitled to obtain records according to Wis. Admin. Code § DHS 104.01(3). The Department requires Medicaid-certified providers to release relevant records to the MCO to assist in compliance with this section. Where the MCO has not specifically addressed photocopying expenses in their provider agreements or other arrangements, the MCO is liable for charges for copying records only to the extent that the Department would reimburse on a fee-for-service basis.

4. *Maintain Complete Records*

Documentation in member records must reflect all aspects of care, including documentation of assistance with transitional care in the event of a disenrollment. Member records must be readily available for member encounters (encounter data via the LTCare IES), and for administrative purposes.

5. *Professional Standards*

The MCO shall maintain, or require the MCO's providers to maintain, individual member records in accordance with any applicable professional and legal standards.

6. *Provision of Records*

The MCO shall make all pertinent information relating to the management of each member's medical and long-term care readily available to the Department. The MCO shall provide this information to the Department at no charge. The MCO shall have procedures to provide copies of records promptly to other providers for the management of the member's medical and long-term care, and the appropriate exchange of information among the MCO and other providers receiving referrals.

7. *Records Available for Quality Management (QM) and Utilization Review*

Member records shall be readily available for MCO-wide QM and utilization review activities. The member records shall provide adequate medical and long-

term care service information, and other clinical data needed for QM and utilization review purposes, and for investigating member appeals and grievances.

8. *Record Retention*

Records must be retained in accordance with the requirements in Article XIV.F., Records Retention.

9. *Continuity of Records*

The MCO shall have adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

10. *Contents of Member Records*

A member record shall contain at least the following items:

a. Face sheet of demographic information;

b. Consent forms;

c. Comprehensive health assessment;

d. Comprehensive social assessment;

e. Documentation of re-assessment(s);

f. Member-centered plan;

g. Copy of advance directive document (if applicable);

h. Copy of signed guardianship order (if applicable);

i. Copy of activated power of attorney document (if applicable);

j. Case notes by MCO interdisciplinary team members;

k. Cost share forms/documentation (if applicable);

l. Notice of change forms (if applicable);

m. Signed enrollment request;

n. Reports of consultations;

o. Notification of the results or outcomes of an investigation described by Article V.J.5.b.xiii; and

p. Copy or documentation of member's most up to date DVR coordination plan (if applicable).

Minimum member record documentation per chart entry or encounter must conform to the applicable provisions of Wis. Admin. Code § DHS 106.02(9).

B. Civil Rights Compliance/Affirmative Action Plan Requirements

1. *MCO*

a. Compliance Requirements

All MCOs must comply with the Department's Affirmative Action/Civil Rights Compliance requirements at https://www.dhs.wisconsin.gov/civil-rights/index.htm.

b. Affirmative Action Plan

As required by Wisconsin's Contract Compliance Law, Wis. Stat. § 16.765, the MCO must agree to equal employment and affirmative action policies and practices in its employment programs:

The MCO agrees to make every reasonable effort to develop a balance in either its total workforce or in the project-related workforce that is based on a ratio of work hours performed by handicapped persons, minorities, and women except that, if the department finds that the MCO is allocating its workforce in a manner which circumvents the intent of this chapter, the department may require the MCO to attempt to create a balance in its total workforce. The balance shall be at least proportional to the percentage of minorities and women present in the relevant labor markets based on data prepared by the department of industry, labor and human relations, the office of federal contract compliance programs or by another appropriate governmental entity. In the absence of any reliable data, the percentage for qualified handicapped persons shall be at least 2% for whom the MCO must make a reasonable accommodation.

The MCO must submit an Affirmative Action Plan within fifteen (15) working days of the signed contract. Exemptions exist, and are noted in the Instructions for Contractors posted on the following website: http://vendornet.state.wi.us/vendornet/contract/contcom.asp.

The MCO must submit its Affirmative Action Plan or request for exemption from filing an Affirmative Action Plan to:

Department of Health Services
Division of Enterprise Services
Bureau of Strategic Sourcing
Affirmative Action Plan/CRC Coordinator
1 West Wilson Street, Room 655
P.O. Box 7850
Madison, WI 53707
dhscontractcompliance@dhs.wisconsin.gov

c. Civil Rights Compliance (CRC)

As required by Wis. Stat. § 16.765, in connection with the performance of work under this contract, the MCO agrees not to discriminate against any

employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the MCO further agrees to take affirmative action to ensure equal employment opportunities. The MCO agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

In accordance with the provisions of Title VI of the Civil Rights Act of 1964 (nondiscrimination on the basis of race, color, national origin), Section 504 of the Rehabilitation Act of 1973 (nondiscrimination on the basis of disability), the Age Discrimination Act of 1975 (nondiscrimination on the basis of age), regulations of the U.S. Department of Health and Human Services issued pursuant to these three statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91, the MCO shall not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by the MCO directly or through a sub-contractor or any other entity with which the MCO arranges to carry out its programs and activities.

Additionally, in accordance with Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, and rules promulgated to implement Section 1557 (81 Fed. Reg. 31376 et seq. (May 18, 2016) (amending 45 C.F.R. Part 92 to implement Section 1557)), the MCO shall not exclude, deny benefits to, or otherwise discriminate against any person on the basis of sex in admission to, participation in, or receipt of the services and benefits under any of its health programs and activities, and in staff and employee assignments, whether carried out by the MCO directly or through a sub-contractor or any other entity with which the MCO arranges to carry out its programs and activities.

i. Civil Rights Compliance Plan

The MCO must file a Civil Rights Compliance Letter of Assurance (CRC LOA) for the compliance period of January 1, 2014 through December 31, 2017, within fifteen (15) working days of the effective date of the contract. If the MCO employs fifty (50) or more employees and receives at least $50,000 in funding, the MCO must complete a Civil Rights Compliance Plan (CRC Plan). The

CRC Plan must be kept on file by the MCO and made available upon request to any representative of DHS. The Civil Rights Compliance Requirements are published by the Department of Health Services, either on its own or in conjunction with other state agencies, and includes the Civil Rights Compliance Requirements and all appendices thereto. The current Civil Rights Compliance Requirements and all appendices for the Civil Rights Compliance period of January 1, 2014 to December 31, 2017 is hereby incorporated by reference into this Agreement and is enforceable as if restated herein in its entirety. The Civil Rights Compliance Requirements, including the template and instructions, for the CRC Plan can be found at https://www.dhs.wisconsin.gov/civil-rights/requirements.htm or by contacting:

Department of Health Services
Civil Rights Compliance Officer
Attn: Attorney Laura Varriale
1 West Wilson Street, Room 651
P.O. Box 7850
Madison, WI 53707-7850
Telephone: (608) 266-1258 (Voice)
711 or 1-800-947-3529 (TTY)
Fax: (608) 267-1434
Email: dhscrc@dhs.wisconsin.gov

If the MCO subcontracts/enters into a provider agreement to administer its federally-funded (through the Department of Health Services) programs, services and/or activities, it must require its subcontractor or provider to provide the MCO a CRC LOA within fifteen (15) working days of the effective date of the subcontract or provider agreement. If the subcontractor or provider employs fifty (50) or more employees and receives at least $50,000 in funding, the Contractor must require its subcontractor or provider to complete a Civil Rights Compliance Plan (CRC Plan) as a term of its sub-contract or provider agreement. The CRC Plan must be kept on file by the subcontractor or provider and made available upon request to any representative of Department of Health Services.

ii. Civil Rights Compliance Letters of Assurances should be sent to:

Department of Health Services
DES/BSS – AA/CRC Coordinator
1 West Wilson Street, Room 672
P.O. Box 7850
Madison, WI 53707-7850

dhscontractcompliance@dhs.wisconsin.gov

iii. The Contractor agrees to all of the following:

a) Design and implement an effective limited English proficiency (LEP) plan to ensure meaningful access to LEP persons at no cost to the LEP persons, in compliance with Title VI of the Civil Rights Act of 1964, and Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, and rules promulgated to implement Section 1557 (81 Fed. Reg. 31376 et seq. (May 18, 2016) (amending 45 C.F.R. Part 92 to implement Section 1557)). The LEP plan will identify individuals who need LEP language assistance, describe language assistance measures that may be provided, require training staff to implement the plan, provide a mechanism for notice to LEP persons who are in need of the services, provide accurate and timely language assistance to LEP persons at no cost to themselves, and provide for monitoring and updating the LEP Plan.

b) Design and implement a plan to ensure that the MCO communicates effectively with people who have vision, hearing, or speech disabilities, in compliance with Title II of the Americans with Disabilities Act and Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, and rules promulgated to implement Section 1557 (81 Fed. Reg. 31376 et seq. (May 18, 2016) (amending 45 C.F.R. Part 92 to implement Section 1557)). The plan must require that the MCO shall provide auxiliary aid and services when needed to communicate effectively with people who have communication disabilities to ensure that a person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the MCO at no cost to the person with a disability.

c) The MCO agrees to cooperate with DHS in any complaint investigations, monitoring or enforcement related to civil rights compliance of the MCO or its sub-contractor under this Agreement.

d. Failure to Comply

Failure to comply with Article XIII.B.1.b.-c. may result in the following consequences:

i. Termination of this Contract after a 30-day notice to cure deficiencies;

ii. Designation of the MCO as "ineligible" for future consideration as a responsible qualified bidder or proposer for state contracts; or

iii. Withholding of payment(s) due under the Contract until the MCO is in compliance

2. *MCO Subcontracts and Provider Agreements*

a. All MCO subcontracts and provider agreements must contain a statement that the subcontractor is required to comply with all applicable affirmative action and civil rights compliance laws and regulations.

b. A vendor that subcontracts or enters into a provider agreement with an MCO is required to develop and provide a copy of a civil rights compliance/affirmative action plan to the MCO, except:

i. A vendor that provides only services in the benefit package; or

ii. A vendor that:

a) Is under a contract with the MCO of less than $25,000; or

b) Has less than twenty-five (25) employees regardless of the amount of the contract; or

c) Is a foreign company with a work force of less than twenty-five (25) employees in the United States; or

d) Is a federal government agency or a Wisconsin municipality; or

e) Has a balanced work force.

C. Subcontracting and Entering Provider Agreements

1. *Ability to Subcontract and Enter Provider Agreements*

The MCO may subcontract or enter a provider agreement for any or all functions covered by this contract, subject to the requirements of this contract.

2. *MCO Responsibility and Accountability for Subcontracts and Provider Agreements*

The MCO retains responsibility for fulfillment of all terms and conditions of this contract when it enters into a subcontract or provider agreement and will be subject to enforcement of the terms and conditions of this Subcontract or Provider Agreement including assurance of civil rights compliance. The MCO oversees and is held accountable for any functions and responsibilities that it delegates to any subcontractor or provider. In order to meet these requirements the MCO must assure that:

a. All subcontractors and providers agree to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance, and contract provisions.

b. The MCO evaluates the prospective subcontractor or provider's ability to perform the activities to be delegated; and

c. The MCO and the subcontractor or provider have a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

3. *Department's Discretion Regarding Subcontracts and Provider Agreements*

a. At any time, the Department may review, approve, approve with modification, impose conditions or limitations or deny any and all subcontracts or provider agreements under this contract at its sole discretion and without the need to demonstrate cause. The Department may consider factors to protect the interests of the State and members, including but not limited to, the subcontractor's or provider's past performance.

b. If as the result of a Department action under paragraph 3.a., the Department requires the MCO to find a new subcontractor or provider, the MCO shall secure a new subcontractor or provider in one hundred-twenty (120) calendar days, and allow sixty (60) calendar days to implement any other change required by the Department:

i. The MCO may request a waiver of this deadline for subcontracting or entering into a provider agreement and for any other change, justifying the reasons the extension is needed.

ii. The Department, at its own discretion, may extend the deadline if the MCO shows to the satisfaction of the Department that additional time is needed.

c. Any disapproval of subcontracts or provider agreements or failure of the MCO to comply with conditions or limitations imposed under paragraph 4.a. may result in the application by the Department of remedies pursuant to Article XVI.E., Sanctions for Violation, Breach, or Non-Performance.

4. *Notification of Procurement or Termination of Subcontracts*

The MCO will notify the Department when considering procurement of new contracts or termination of current contracts for:

a. Care management under Article V, Care Management;

b. Claims administration under Article XIII, MCO Administration, Section F, Claims Administration; or

c. Quality management under Article XII, Quality Management (QM).

5. *Department Approval for Subcontracts*

The MCO may subcontract part of the functions in Article XIII, MCO Administration, Section C.4., Notification of Procurement or Termination of

Subcontracts, only with the prior written approval of the Department. In addition, Department approval may be required prior to completing an award process, selection of a subcontractor or finalizing the terms and conditions of the subcontracts and the subcontractors selected.

Approval of a subcontractor, subcontract, provider or provider agreement will be withheld if the Department reasonably believes that the intended subcontractor or provider will not be responsible in terms of services provided and costs billed.

Approval is not required for renewal of existing subcontracts or provider agreements, unless the subcontract or provider agreement changes.

Failure to receive approval for a subcontract or provider agreement prior to execution of the subcontract or provider agreement may result in application by the Department of remedies pursuant to Article XVI.E., Sanctions for Violation, Breach, or Non-Performance.

D. Management of Subcontractors and Providers

1. *Establishing and Maintaining Subcontracts and Provider Agreements*

   The MCO must:

   a. Establish mechanisms to monitor the performance of subcontractors and providers to ensure compliance with provisions of the subcontract or provider agreement on an ongoing basis, including formal review according to a periodic schedule, consistent with industry standards or state laws and regulations.

   b. Identify deficiencies or areas for improvement.

   c. Take corrective action if there is a failure to comply.

2. *Quality Monitoring of Providers Regulated by the Division of Quality Assurance (DQA)*

   Each MCO shall have a system for monitoring the quality of subcontracted DQA-regulated provider services. The MCO must:

   a. Establish mechanisms to monitor the performance of DQA-regulated provider services to ensure member health and welfare and provider compliance with member-care-related provisions of the subcontract on an ongoing basis.

   b. Identify provider deficiencies or areas for improvement (inclusive of monitoring statements of deficiency (SOD) issued by the Department of Health Services, Division of Quality Assurance).

      i. The MCO shall have specific SOD review processes in place to address SODs with significant enforcement action, such as: directed plan of correction, no new admission orders, impending revocations, repeat citations, immediate jeopardy with unresolved

deficiencies, or situations of actual serious harm or risk for serious harm to members not already identified via the MCO's internal critical incident reporting system.

c. Take corrective action if a provider fails to comply, including proactive prevention activities.

i. Each MCO shall respond to SODs by taking reasonable and prudent actions to assure member health and safety.

ii. As available, each MCO shall review relevant provider plans of correction submitted to DQA and determine whether to require any additional plan of correction.

Each MCO shall monitor the quality improvement of any of its DQA-cited providers.

3. *Additional Requirements for Subcontracts*

Subcontracts are subject to additional review to assure that rates are reasonable:

a. Services and Compensation

Subcontracts must clearly describe the services to be provided and the compensation to be paid.

b. Bonuses, Profit Sharing

i. Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the MCO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the subcontract period.

ii. Any such bonus or profit sharing shall be reasonable compared to services performed. The MCO shall document reasonableness.

iii. A maximum dollar amount for such bonus or profit sharing shall be specified for the subcontract period.

4. *Additional Requirements for Provider Agreements*

Article VIII, Provider Network, provides additional Department requirements for provider agreements.

E. Memorandum of Understanding (MOU)

1. *Entering into an MOU*

An MCO may enter into an MOU with a business, provider or similar entity. Such an MOU may not violate any of the requirements found in this contract concerning contracts, subcontracts or provider agreements between the MCO and a business, provider or similar entity.

2. *Submission of Memoranda of Understanding (MOUs) to the Department*

The MCO shall submit MOUs referred to in this contract to the Department within fifteen (15) business days of the effective date of the MOU.

The MCO shall submit copies of changes in MOUs to the Department within fifteen (15) business days of the effective date of the MOU.

F. Claims Administration

The MCO must maintain a management information system that is in accordance with:

- The claims administration requirements in this section; and
- Article XIV, Reports and Data, Section A., Management Information System.

The MCO is responsible for ensuring claims administration for all services provided to members in compliance with the requirements enumerated in this contract.

1. *Claims Retrieval System*

The MCO shall maintain or contract for a claims retrieval system that can, on request, identify the date a service was received, action taken on all provider claims (e.g., paid, denied, other), and when action was taken. All provider claims shall be date stamped upon receipt.

2. *Claims Processing Payment Requirement*

a. Definitions

The following definitions apply in this section:

i. Authorized service means a service or item in the benefit that, if required, has been authorized by the MCO in accordance with Article V.K., Service Authorization.

ii. Claim means a single transaction submitted by a provider as a bill or other approved document or format for all authorized services for one member.

iii. Clean claim means a claim that can be processed without obtaining additional information from the provider of the service. A claim is still considered a clean claim if the only error(s) in the submitted information are the result of an error originating in the Department's system or with errors originating from an MCO's claims processing system problem, an MCO's internal claims or an MCO's business process problem. A clean claim does not include a claim that is under review for medical necessity or any claim from a provider who is under investigation for fraud or abuse.

iv. Date of receipt means the date the MCO or its third party administrator (TPA) receives the claim, as indicated by its date stamp on the claim.

v. The date of adjudicating and mailing or transmitting the remittance advice with payment, partial payment or denial of payment is the date on which the remittance advice with payment, partial payment or denial of payment is mailed or otherwise transmitted.

b. Except to the extent providers or subcontractors have agreed to later payment, the MCO shall adjudicate and mail or transmit the remittance advice with payment, partial payment or denial of payment as follows:

i. Ninety (90) percent of clean claims within thirty (30) calendar days of receipt; and

ii. Ninety-nine (99) percent of clean claims within ninety (90) calendar days of receipt; and

iii. One hundred (100) percent of clean claims within one hundred eighty (180) calendar days of receipt.

3. *Claims Inventory Reports*

If the Department has indications that the MCO's claims processing is not in compliance with Article XIII, MCO Administration, F. Claims Administration, the MCO will be required to submit claims inventory reports documenting its claims inventory status.

4. *Failure to Pay or Inappropriate Payment Denials*

a. The MCO must notify the Department immediately if it is unable to meet the standards in Article XIII, MCO Administration, Section F., Claims Administration.

b. An MCO must establish a Department-approved process to assure payment of at-risk providers if claims are delayed beyond 30 days.

At-risk providers are either:

i. All providers of home and community-based services as defined in Addendum VII, Benefit Package Service Definitions, Section A., Home and Community-Based Waiver Services; or

ii. Providers that are determined to be at-risk as defined by the MCO's Department-approved policies and procedures.

c. If the MCO inappropriately fails to provide timely payment or denies payment for services, the MCO may be subject to the following sanctions:

i. Article XVI.E., Sanctions for Violation, Breach, or Non-Performance;

ii. Limiting risk-sharing or enhanced payments;

iii. Reducing administrative funding;

iv. Requiring an increased amount in the MCO's reserves;

v. Requiring administrative actions necessary to assure timely and appropriate payment of claims under current funding levels.

These sanctions may be applied not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made.

5. *New Contracts, Renewal Contracts, and Contract Amendments for Claims Administration by a Third Party Administrator and New Purchases of a Claims Processing System or Software that Will be Developed Into an Internal MCO Claims Processing System*

a. Any new contracts, contract renewals, or contract amendments between the MCO and a third party administrator (TPA) for claims administration and any purchase of a new claims processing system or software that will be developed into an internal MCO claims processing system must meet standards established by the Department.

Any claims administration contract shall not include penalties or high fees that make it difficult to terminate a contract.

b. The MCO must receive Department approval prior to either finalizing an external contract with a TPA for claims administration services or finalizing a contract to purchase a claims processing system or software that will be developed into an internal MCO claims processing system. An MCO may request from the Department variances for pre-approval of specified types of contract amendments, as part of their submittal of the original contract for Department approval.

An MCO using TPA must submit the contract, along with all documentation identified by the Department to the Department at least sixty (60) calendar days prior to finalizing the contract. An MCO that has purchased a claims processing system or software to develop an internal claims processing system must submit all documentation identified by the Department at least sixty (60) calendar days prior to implementation.

The Department will complete its review within forty-five (45) calendar days of receipt.

G. Required Disclosures

1. *Disclosure of Ownership or Controlling Interest*

In accordance with 42 C.F.R. § 438.602(c), the MCO agrees to submit to the Department the Disclosure of Ownership or Controlling Interest. This form requires full and complete information as to the identity of each person or corporation with an ownership or controlling interest in the MCO, or any subcontractor or provider in which the MCO has a five percent (5%) or more ownership interest, at the following times:

- When the MCO submits a proposal in accordance with the procurement process;
- Within thirty (30) calendar days of contract signing;
- When the Department renews or extends the MCO contract; and
- Within thirty five (35) calendar days after any change in ownership of the MCO.

a. Definition of "Ownership or Controlling Interest"

A "person with an ownership or controlling interest" means a person or corporation that:

i. Owns, directly or indirectly, five percent (5%) or more of the MCO's capital or stock or receives five percent (5%) or more of its profits;

ii. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the MCO or by its property or assets, and that interest is equal to or exceeds five percent (5%) of the total property and assets of the MCO; or

iii. Is an officer, director (if the MCO is organized as a corporation), partner (if the MCO is organized as a partnership), or managing employee of the MCO. Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the MCO.

b. Calculation of Five Percent (5%) Ownership or Control

The percentage of direct ownership or control is the percentage interest in the capital, stock or profits. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns ten (10) percent of the stock in a corporation which owns eighty (80) percent of the stock of the MCO, the person owns eight (8) percent of the MCO. The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest which a person owns in that obligation by the percent of the MCO's assets used to secure the obligation. Thus, if a person owns ten (10) percent of a note secured by sixty (60) percent of the MCO's assets, the person owns six (6) percent of the MCO.

c. Information to be Disclosed

The following information must be disclosed:

i. The name and address of each person with an ownership or controlling interest of five percent (5%) or more in the MCO or in any subcontractor or provider in which the MCO has direct or indirect ownership of five percent (5%) or more;

ii. The date of birth and Social Security Number of each individual with an ownership or controlling interest of five percent (5%) or more in the MCO or in any subcontractor or provider in which the MCO has direct or indirect ownership of five percent or more;

iii. The other tax identification number of each corporation with an ownership or controlling interest of five percent (5%) or more in the MCO or in any subcontractor or provider in which the MCO has direct or indirect ownership of five percent or more;

iv. The name, address, date of birth and social security number of any managing officer, director, partner or managing employee of the MCO.

v. A statement as to whether any of the persons with ownership or controlling interest is related to any other of the persons with ownership or controlling interest as spouse, parent, child, or sibling; and

vi. The name of any other organization in which the person also has ownership or controlling interest. This is required to the extent that the MCO can obtain this information by requesting it in writing. The MCO must keep copies of all of these requests and responses to them, make them available upon request, and advise the Department when there is no response to a request.

d. Reporting Information on Disclosure

The MCO shall submit ownership and control information on the DHS designated form as required in sub. 1.

The Department must provide this information to CMS upon CMS's request. Failure to provide this required disclosure information puts the federal financial participation (FFP) portion of the capitation payments at risk, and the MCO shall be liable for any penalty or disallowance imposed by CMS resulting from the MCO's failure to report this information as required.

2. *Disclosure of Business Transactions*

a. Business Transactions with a Party-In-Interest. The MCO must disclose to the Department information on certain types of transactions that it has

with a "party in interest" as defined in the Public Health Service Act and 1903(m)(2)(A)(viii) and 1903(m)(4)(A) of the Social Security Act.

i. Definition of a Party in Interest. As defined in s. 1318(b) of the Public Health Service Act, a party in interest is:

a) Any director, officer, partner, or employee responsible for management or administration of the MCO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the MCO; any person who is the beneficial owner of more than five percent (5%) of the MCO; or, in the case of the MCO that is organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

b) Any organization in which a person described in subsection (a) directly above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the MCO; or, has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the MCO;

c) Any person directly or indirectly controlling, controlled by, or under common control with the MCO; or

d) Any spouse, child, or parent of an individual described in subsections (a-c) above.

ii. Types of Transactions That Must Be Disclosed. Business transactions which must be disclosed include:

a) Any sale, exchange, or lease of any real or personal property between the MCO and a party in interest;

b) Any lending of money or other extension of credit goods, services (including management services) or facilities between the MCO and the party in interest; and

c) Any furnishing for consideration of goods, services (including management services) or facilities between the MCO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

iii. The information which must be disclosed in the transactions listed in subsection ii. between the MCO and a party in interest includes:

a) The name of the party in interest for each transaction;

b) A description of each transaction and the quantity or units involved;

c) The accrued dollar value of each transaction during the fiscal year; and

d) Justification of the reasonableness of each transaction.

iv. If this contract is renewed or extended, the MCO must disclose information on these business transactions which occurred during the prior contract period within thirty (30) calendar days of contract signing. If the contract is an initial contract with Medicaid but the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these business transactions must be reported.

b. Business Transactions required under 42 C.F.R. § 455.105. In addition to the above described disclosures, the MCO must disclose, within 35 days of a request from the Department, full and complete information about:

i. The MCO's ownership of any subcontractor or provider with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and

ii. Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor or provider, during the five (5) year period ending on the date of the request. A significant business transaction is any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five (5) percent of the MCO's total operating expenses.

H. Ineligible Organizations and Individuals

In implementing this section the MCO shall check at least monthly the federal DHHS OIG List of Excluded Individuals /Entities (LEIE), the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the System for Award Management (SAM), and the federal General Services Administration Excluded Parties Listing Service (EPLS) as required by 42 C.F.R. § 455.436, as well as any other databases that may be required by the federal DHSS or the Department. Upon obtaining information from a database of excluded entities or individuals receiving information from the Department or from another verifiable source, the MCO shall disclose to the Department, and exclude from participation in the MCO, all individuals or organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. *Ineligibility*

Entities which could be excluded under Section 1128 (b) (8) of the Social Security Act are entities in which a person: (1) who is an officer, director, agent or managing employee of the entity; (2) who has a direct or indirect ownership or controlling interest of five percent or more in the entity; (3) who has beneficial ownership or controlling interest of five percent or more in the entity; or (4) who was described in (2) or (3) but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the household (as defined in 1128(j)(1) and 1128(j)(2)) in anticipation of (or following) a conviction, assessment, or exclusion has:

a. Been convicted of the following crimes:

i. Program related crimes, such as, any criminal offense related to the delivery of an item or service under title XVIII or under any State health care program (see Section 1128 (a) (1) of the Act);

ii. Patient abuse, such as, criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128 (a) (2) of the Act);

iii. Fraud, such as, a state or federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government (see Section 1128 (b) (1) of the Social Security Act);

iv. Obstruction of an investigation or audit, such as, conviction under state or federal law of interference or obstruction of any investigation or audit related to any criminal offense described directly above (see Section 1128 (b) (2) of the Act); or,

v. Offenses relating to controlled substances, such as, conviction of a state or federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128 (b) (3) of the Act).

b. Been excluded from participation in Medicare or a state health care program.

A state health care program means a Medicaid program or any state program receiving funds under Title V or Title XX of the Act. (See Section 1128 (h) of the Act.) Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person described in section H.1.a. above from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

c. Been assessed a civil monetary penalty under Section 1128A or 1129 of the Act.

Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the federal Department of Health and Human Services Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128 (b) (8) (B) (ii) of the Act.)

2. *Contractual Relations*

Entities which have a direct or indirect substantial contractual relationship with an individual or entity listed above in section H.1. Substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

a. The administration, management, or provision of medical or long-term care services;

b. The establishment of policies pertaining to the administration, management, or provision of medical or long-term care services; or

c. The provision of operational support for the administration, management, or provision of medical or long-term care services.

3. *Excluded from Participation in Medicaid*

Entities which employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A of the Act, for the provision (directly or indirectly) of health care, utilization review, medical social work or administrative services. For the services listed, the MCO shall exclude from contracting with any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

The MCO attests by signing this contract that it excludes from participation in the MCO all individuals and organizations which could be included in any of the above categories.

4. *Disclosure of Excluded Individuals or Entities*

The MCO shall disclose to the Department any relationship with an excluded individual or entity described under H.1 within ten (10) days of discovery of the individual or entity's excluded status. This disclosure will be made to DHSLTCFiscalOversight@dhs.wisconsin.gov and will contain the following information:

a. The name, address, phone number, Social Security number/Employer Identification number and operating status/ownership structure (sole proprietor, LLC, Inc., etc.) of the individual or organization;

b. The type of relationship and a description of the individual or entity's role (for example, provider and service type or employee and classification);

c. The initial date of the relationship, if existing;

d. The name of the database that was searched, the date on which the search was conducted and the findings of the search;

e. A description of the action(s) taken to exclude the individual or entity from participation in MCO contracted and business operations and the date(s) on which such action(s) occurred.

5. *Foreign Entity Exclusion*

a. Participation in Medicaid

Pursuant to 42 C.F.R. § 438.602(i), the State is prohibited from contracting with an MCO located outside of the United States. In the event an MCO moves outside of the United States, this contract will be terminated.

b. Capitation rate development

Pursuant to 42 C.F.R. § 438.602(i), no claims paid by an MCO to a network provider, out-of-network provider, subcontractor or financial institution outside of the United States will be considered in the development of actuarially sound capitation rates.

I. Compliance with Applicable Law and Cooperation with Investigations

The MCO shall observe and comply with all federal and state law in effect when this contract is signed or which may come into effect during the term of this contract, which in any manner affects the MCO's performance under this contract. These federal and state laws include all the provisions of 45 C.F.R. § 74 Appendix A, the Byrd Anti-Lobbying Amendment that specifies that federal funds must not be used for lobbying, the Clean Air Act and Federal Water Pollution Control Act, the rights of the federal government and MCO members to inventions in accordance with 37 C.F.R. § 401 and, for MCOs participating in the Partnership program, all federal Medicare requirements.

To the extent permitted by law, the MCO shall fully cooperate with any member-related investigation conducted by the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity.

The MCO must have conflict of interest safeguards in place at least equal to federal safeguards (41 USC 423, Section 27).

J. Access to Premises and Information

1. *Access to Premises*

The MCO shall allow duly authorized agents or representatives of the state or federal government, including CMS, the HHS Inspector General, the Comptroller General, or their designees or representatives, at any time, access to the MCO's premises, physical facilities, and equipment, the MCO providers' premises, physical facilities, and equipment or the MCO subcontractors' premises, physical facilities, and equipment to inspect, audit, monitor, examine, excerpt, transcribe, copy or otherwise evaluate the performance of the MCO's or subcontractors' contractual activities and shall forthwith produce all records or documents, including but not limited to financial, member or administrative records, books, contracts, and computer or other electronic systems requested as part of such review or audit.

The Department may inspect and audit any financial, care management, member, administrative or other records of the MCO, its providers, or its subcontractors. There shall be no restrictions on the right of the state or the federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and the reasonableness of their costs or for any purpose the Department deems necessary for administration or operation of the program. When requested by the Department or CMS, the MCO shall provide access to electronic records in any circumstance when the MCO uses electronic records.

In the event right of access is requested under this section, the MCO, provider, or subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The Department may perform off-site audits or inspections to ensure that the MCO is in compliance with contract requirements.

All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the MCO's, provider's, or subcontractor's activities. The MCO shall be given fifteen (15) business days to respond to any findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

2. *Access to and Audit of Contract Records*

Throughout the duration of this contract, and after termination of this contract, the MCO shall provide duly authorized agents of the state or federal government access to all records and material relating to the contract's provision of and reimbursement for activities contemplated under this contract. The rights of access in this paragraph are not limited to the required retention period, but shall

last as long as records are retained, if longer. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of this contract. All information so obtained will be accorded confidential treatment as provided under applicable law. The rights to access, inspect, and audit premises and contract records described in Article XIII.H.1.-2. exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, these access and audit rights may be exercised at any time.

K. Program Integrity Plan, Program and Coordination

The MCO must establish a Regulatory Compliance Committee on the MCO's governing board and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

The MCO must have administrative and management arrangements or procedures, and a Program Integrity Plan, that are designed to guard against fraud, waste, and abuse.

The MCO's governing board or its designee shall approve a written Program Integrity Plan that is developed by a designated MCO program integrity compliance officer and a compliance committee which is accountable to senior management. The plan will describe the MCO's commitment to operational initiatives designed to prevent, detect, and correct instances of fraud and abuse including details describing the scope of activity, goals, objectives and timelines associated with the monitoring program. The program integrity plan must be submitted to the Department and approved on an annual basis prior to the effective date of the new contract year. In this subsection, the term abuse means any practice that is inconsistent with sound fiscal, business or medical practices and results in unnecessary program costs.

1. *Procedures*

   The MCO's arrangements or procedures must include the following:

   a. Written policies, procedures, and standards of conduct that relate to the following:

      i. Articulating the organization's commitment to comply with all applicable federal and state standards, including occupational safety and health standards.

      ii. Conducting regular reviews and audits of operations.

      iii. Assessing and strengthening internal controls.

      iv. Educating employees, network providers and members about fraud and abuse and how to report it.

      v. Effectively organizing resources to respond to and process complaints of fraud and abuse.

vi. Rights of employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers

b. The designation of a compliance officer and compliance committee that are accountable to senior management.

c. Effective training and education for the compliance officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.

d. Effective lines of communication between the compliance officer and the organization's employees.

e. Enforcement of standards through well-publicized disciplinary guidelines.

f. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's contract with the Department.

g. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.

h. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

i. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

2. *Reporting*

a. The MCO shall report any suspected fraud, waste, or abuse involving the program to the Department as soon as possible, but within ten (10) business days.

All credible provider and member allegations must be reported through the fraud and financial abuse toll-free reporting hotline 1-877-865-3432 or the on-line reporting system at www.reportfraud.wisconsin.gov. In addition, the MCO must also send notification of the credible allegation of fraud to the BLTCF mailbox at DHSLTCFiscalOversight@dhs.wisconsin.gov.

Reporting details must include information required for the quarterly reporting listed in Article XIII.K.2.b.ii.a)-i) below.

b. Quarterly, as specified below, the MCO shall submit a Program Integrity report to the BLTCF mailbox at DHSLTCFiscalOversight@dhs.wisconsin.gov and to the BALTCS mailbox at DHSBMC@dhs.wisconsin.gov describing any instances of suspected fraud, waste, or abuse and OIG Provider suspensions for contracted providers that arose during the quarter, including the following:

i. Number of complaints of suspected fraud and abuse made to the MCO that warrant preliminary investigation.

ii. For each situation which warrants investigation, supply the:

a) Name and ID number;

b) Source of complaint;

c) Type of provider;

d) Nature of complaint;

e) The approximate range of dollars involved;

f) Timeline in which it was handled;

g) Outcome;

h) Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and

i) Description of any corrective action that was taken.

c. The MCO shall comply with any other federal, state or local requirements for reporting fraud, waste, and abuse.

3. *Suspension of Provider Payments*

a. The MCO shall suspend payments to a sub-contracted provider pursuant to 42 C.F.R. § 455.23 if the Department informs the MCO that the Department has suspended fee-for-service Medicaid payments to the provider because of a credible allegation of fraud, unless the MCO believes there is good cause for not suspending its payments. If the MCO believes based on the criteria under 42 C.F.R. § 455.23 (e) or (f) that there is good cause for not suspending its payments or for only suspending them in part, it shall submit written documentation to the Department describing the basis for such a good cause exception to suspending payment. The Department shall approve or disapprove the MCO's request for a good cause exception within ten (10) business days. If the Department disapproves the request the MCO shall suspend payments to the provider.

b. If the Department determines that a report by an MCO under Section 2.a. of suspected fraud by a provider is a credible allegation, the MCO shall suspend its payments to the provider unless the MCO believes there is good cause for not suspending its payments. If the MCO believes based on the criteria under 42 C.F.R. § 455.23 (e) or (f) that there is good cause for not suspending its payments or for only suspending them in part, it shall request and the Department shall approve or disapprove an exception to payment suspension as in Section 3.a. above.

c. If the MCO suspends its payments in whole or in part to a provider because the Department has determined that there is a credible allegation of fraud and there fails to be good cause to not suspend payments, the MCO shall:

i. Provide notice to the provider that meets the timeframe and content requirements of 42 C.F.R. § 455.23 (b).

ii. Terminate the suspension when the Department or a prosecutorial authority determines there is insufficient evidence of fraud by the provider or legal proceedings related to the alleged fraud are completed, or when the Department determines there is good cause under 42 C.F.R. § 455.23 (e).

iii. Maintain documentation for at least five (5) years of all payment suspensions, instances where a payment suspension was not imposed, imposed only in part or discontinued for good cause, as provided in 42 C.F.R. § 455.23 (g).

4. *Investigations*

The MCO shall cooperate with any investigation of fraud and abuse, including directly conducting investigations as needed. The MCO shall assist the Department and any other entity legally authorized to investigate fraud and abuse in determining any amounts to be repaid, and with other follow up as requested.

L. Business Continuity

The MCO shall have a Business Continuity Plan and a Disaster Recovery Plan on file with the Department which will be updated and submitted annually as part of the certification process.

1. *Business Continuity Plan*

Business Continuity Plans shall address, at a minimum, the following:

a. A description of the organization and the urgency with which activities and processes will need to be resumed in the event of a disruption.

b. Inclusion of a business impact analysis and risk assessment. This will address each continuity management strategy both at the corporate and key functional area separately and will identify, quantify and qualify areas

that will be used to continue the organization's business impacts of a disruption to determine at what point in time the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.

c. Inclusion of a risk assessment that reviews the probability and impact of various threats to the MCO's operations. This involves stress testing the MCO's business processes and business impact analysis assumptions with various threat scenarios. The results of the risk assessment should assist the MCO in refining its business impact analysis and in developing a business continuity strategy.

d. Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.

e. Criteria for executing the business continuity plan, including escalation procedures.

f. A detailed communication plan with members, employees, providers, the Department and other stakeholders.

g. Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event.

h. A description of the organization and the urgency with which activities and processes will need to be resumed in the event of a disruption.

i. Recovery time for each major business function, based on priority.

j. Business workflow and workaround procedures, including alternate processing methods and performance metrics.

k. Recording and updating business events information, files, data updates, once business processes have been restored.

l. Documentation of security procedures for protection of data.

m. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.

n. A description of an annual testing and evaluation plan.

o. A description of the MCO familiarity with and involvement in the emergency government plan of the counties in which they are providing services. The MCO will negotiate, or make a "good faith" effort to negotiate, an MOU with each county in their service area addressing the MCO's and county's role in emergency response.

p. A description of the steps that will be taken to ensure and preserve member safety and wellbeing in the event of a disruption or disaster.

2. *Disaster Recovery Plan*

The Disaster Recovery Plan shall address, at a minimum, the following:

a. Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.

b. Communication plan for critical personnel, key stakeholders and business partners.

c. Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system operations, and user documentation (e.g., electronic, non-electronic, incremental, full).

d. Full and complete back-up copies of all data and software.

e. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.

f. Policies and procedures for purging outdated backup data.

g. Plan that supports the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.

h. Identification of a back-up processing capability at a remote site(s) from the primary site(s) such that normal business processes and services can continue in the event of a disaster or major hardware problem at the primary site(s).

i. Policies and procedures to ensure and preserve member safety and wellbeing in the event of a disruption or disaster/

M. Resource Center Conflict of Interest Policies and Procedures

1. *Written Conflict of Interest Policies and Procedures*

The MCO shall have written conflict of interest policies and procedures that prohibit MCO employees and employees of subcontractors and providers from attempting to influence the independence of options counseling, enrollment counseling, disenrollment counseling and advocacy provided by resource center staff.

2. *Conflict of Interest Regarding Specific Care Management Services*

When the MCO subcontracts for care management services through a county or with the same agency that is responsible for the resource center, the MCO and the subcontracted care management agency shall comply with its policies and procedures regarding conflict of interest.

3. *Policies Regarding the MCO and Resource Center*

The MCO shall comply with all Department policies regarding MCO coordination and conflict of interest with resource centers.

N. Commercial Leases

1. If the MCO enters into leases of real property to support the administrative responsibilities of the MCO, at the time the MCO enters into a new lease or renews an existing lease the MCO shall include a termination clause in that lease allowing the MCO to terminate the lease on reasonable notice to the landlord, not to exceed 90 days, that the MCO will cease to operate as an MCO due to a discontinuation of this Contract with the Department. Such termination must not be considered a default of the lease, must occur without penalty and must limit any future rent liability.
2. The MCO is not required to negotiate such a clause into any existing lease.
3. If after a good faith attempt to negotiate, the MCO is unable to include such a clause in a lease of real property but determines that such a lease is essential to the operation of the MCO, the MCO may apply to the Department for a waiver of this requirement. Any such waiver shall be at the discretion of the Department.
4. If the MCO enters into leases of commercial property other than real property on a long-term basis, e.g., office equipment, the MCO shall attempt to include a termination without penalty clause in those leases, to the extent practicable.

O. MCO's Insurance Responsibility

The MCO shall maintain the following coverage for the organization(s) covered under this contract:

1. Worker's compensation, as required by Wisconsin Statutes for all MCO employees;
2. Commercial liability, bodily injury and property damage insurance against any claim(s), which might occur in carrying out this contract with a minimum coverage of one million dollars ($1,000,000) per occurrence liability for bodily injury and property damage including products liability and completed operations;
3. Motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract, with a minimum coverage of one million dollars ($1,000,000) per occurrence combined single limit of automobile liability and property damage;
4. Professional Liability (malpractice) or Managed Care Liability with a minimum coverage of one million dollars ($1,000,000) per occurrence;
5. Director and Officers liability or equivalent coverage specific to the entity structure;
6. Umbrella coverage; and
7. Employee Dishonesty or Fidelity Bond as a stand-alone policy or included under the entity's Commercial property coverage.

Entities operating under a subsidiary or related party organizational structure shall maintain required coverage at the subsidiary or related party level identified as the contracting MCO in this contract. The MCO shall submit a certificate of insurance to demonstrate coverage with the State of Wisconsin listed as a certificate holder annually with the required business plan submission or as otherwise indicated but prior to contract renewal with the Department.

P. Business Associate Agreement

Due to the MCO using and/or disclosing protected health information subject to HIPAA, the MCO shall review and execute a Business Associate Agreement (BAA) F-00759 with the Department as a mandatory and critical exhibit to the Contract. A BAA must be executed before the MCO performs any work of any kind for DHS as a result of this Contract.

XIV. Reports and Data

A. Management Information System Requirements

The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas that include, but are not limited to: utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

The MCO must collect, maintain and report data on member and provider characteristics and on services furnished to members through an encounter data system.

The MCO shall:

1. Meet all of the reporting requirements as specified in this contract in a timely way, assure, to the best of their knowledge and beliefs, the accuracy and completeness of the data, and submit the reports/data in a timely manner.
2. Support data submitted to the Department by having records available for inspection or audit by the Department.
3. Submit data and/or reports to the Department, and receive data and/or reports from the Department in a secure format.
4. Designate a primary contact person responsible for data reporting who is available to answer questions from the Department and resolve any issues regarding reporting requirements. At the same time, designate a back-up person who will be available to perform this function when needed.
5. Ensure that data, documentation or information is certified by either the MCO's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification provided by the individual described above attests that, based on best information, knowledge and beliefs, the data, documentation or information transmitted via the Data Certification Form (provided by the Department per 42 C.F.R. § 438.600) is accurate, complete and truthful. This certification must be submitted concurrently with the data, documentation or information it is certifying.
6. Ensure that its Management Information System (MIS) is sufficient to support quality assurance/quality improvement requirements described in Article XII, Quality Management (QM).

B. Encounter Data

1. *Encounter Data – Reports*

   The MCO shall report member-specific data on the LTCare IES as directed by the Department. MCO staff will participate in the planning and development of data

reporting requirements for implementation during the term of this contract consistent with all HIPAA requirements applicable to the MCO. This participation will include attending workgroup meetings, addressing necessary changes to local applications or databases, and cooperating with the Department on data submission protocol and testing.

Prior to the effective date of this contract, the MCO shall demonstrate it has the ability to:

a. Analyze, integrate and report data;

b. Process coordination of benefits as outlined in the LTCare IES Implementation Guide.

c. Capture and maintain a member level record of all services in the benefit package provided to members by the MCO and its providers, in a computerized data base adequate to meet the reporting requirements of the contract;

d. Monitor enrollment and disenrollment, in order to determine which members are enrolled or have disenrolled from the MCO on any specific day;

e. Collect and accurately produce data, reports, and member histories including, but not limited to, member and provider characteristics, encounter data, utilization, disenrollments, solvency, member and provider appeals and grievances as specified by the Department; and

f. Ensure that data received from providers, and reported to the Department and upon request to CMS, is timely, accurate and complete, by:

   i. Verifying the accuracy and timeliness of reported data;

   ii. Screening the data for completeness, logic, and consistency;

   iii. Collecting information on services in standardized HIPAA-compliant formats, such as the CMS 1500 or UB04 format, or other uniform format, to the extent possible; and

   iv. Recording and tracking all services with a unique member identification number.

2. *Encounter Data – Format*

The MCO shall assure member-specific data is reported to the Department in an encounter-data format (XML) specified by the Department and according to any HIPAA deadlines/standards/requirements applicable to the MCO. The specifications and HIPAA deadlines, standards and requirements are identified in documents found on the Department's website at: https://www.dhs.wisconsin.gov/ies/index.htm.

The MCO shall meet certification standards that demonstrate it has the ability to meet the Department's reporting requirements in the formats and timelines

prescribed by the Department. The MCO will provide data extracts, as necessary, for testing the reporting processes and will assist with and participate in the testing processes. The Department will provide MCOs with reasonable advance notice of required changes to encounter reporting standards, formats and MIS capacity necessary to meet federal and state requirements.

3. *Encounter Data – Submission Testing*

   The MCO shall test encounter record submissions with the Department prior to undertaking claims systems or claims processing vendor changes or prior to the addition of new DHS lines of business requiring encounter data reporting. Information can be found on the Department's website at: https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html.

4. *Encounter Data - Submission*

   The Encounter Reporting Submission is a monthly file submission. The file submission is due on the thirtieth day after the end of the month, or the first business day following the thirtieth day when the thirtieth day is not a business day. The Encounter Data Reporting Submission will be used to report member specific enrollment and disenrollment, utilization of services and expenditure in the benefit package, receipts for payments not received directly from the state, recoveries to include overpayments to subcontractors/providers when received or recovered by the MCO, and member characteristic/demographics. Other member specific data may be required by the Department in the future. The Encounter Reporting Submission shall be reported on-line through the LTCare IES application.

   Mandatory versus voluntary requirements for encounter data reconciliation and certification are currently defined by line of business. Changes to these requirements are likely during the course of this contract. The MCO agrees to accommodate the mandated requirements in the eLTCare IES implementation guide for waiver program encounter reporting in the event that they are enforced for the MCO's line(s) of business during the course of this contract, if they are not already accommodating reconciliation and certification requirements for their line(s) of business.

5. *Encounter Data - Non-Compliance Resolution Process*

   The Department shall have the right to audit any records of the MCO and to request any additional information. If at any time the Department determines that the MCO has not complied with any requirement in this section, the Department will issue a corrective action to the MCO. The MCO shall comply within the timeframe defined in the corrective action. If the MCO fails to comply, the Department may pursue action against the MCO as provided under Article XVI.E.2.i.

C. Reports: Regular Interval

1. *General*

The MCO agrees to furnish information from its records to the Department, and to the Department's authorized agents and upon request to CMS, which may be required to administer this contract. See https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf for a compilation of these and other reports/documents and due dates which are specified in this contract.

2. *Monthly Report*

The monthly member incident report is due on the thirtieth day after the end of the month, or the first business day following the thirtieth day when the thirtieth day is not a business day. The reports shall be submitted electronically through the Long Term Care Information Exchange System (see Article V.J.5.b.xii).

3. *Quarterly Restrictive Measures Reporting*

Approved restrictive measures reporting is due quarterly. The report shall be submitted no later than forty-five (45) calendar days after the end of the reporting period, as provided at https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf. The reporting shall be submitted electronically through the Restrictive Measures database: (https://ltcareies.forwardhealth.wi.gov/restrictiveMeasures/#/login).

4. *Quarterly Report*

The Quarterly Report is due forty-five (45) calendar days after the reporting period. The Department may from time to time revise elements to be included in the Quarterly Report and shall give the MCO notice of new elements to include in the Report prior to the commencement of the next reporting period. The Quarterly Report contains the following components:

a. Appeal and grievance summary and log as specified in Article XI, Grievances and Appeals, Section I..

b. Provider appeal log as specified in Article VIII.0.3., Provider Appeal Log.

c. Financial report as defined in Article XVII.B., Financial Reporting and required Financial Statement certification form(s), as shown in Addendum V, Data Certification.

d. Payments the MCO received for enhanced services and donations directly received by the MCO from members, the member's family or significant others as specified in Article VII.K.9.

e. Identified provider-preventable conditions, if any, as defined in Article I, Definitions.

f. The number of members who were forced to move from one community-based residential care facility to another, or from a community-based

residential care facility to a nursing home, due to the member's lack of financial resources sufficient to meet the room and board costs.

g. Total overpayments recovered, split out by those retained by the MCO, those returned to the Department because the MCO is not permitted to retain them, and those due to potential fraud.

h. Overpayments identified but not recovered.

i. Payments above the Medicaid fee-for-service rate as described in Article VIII.7.d. (2nd and 4th quarters only)

5. *Quarterly Employment Data Report*

The MCO shall report employment data for members working in Competitive Integrated employment (CIE) quarterly for members who do and do not have a vocational service provider. The MCO shall use a prepopulated Excel list of members provided by DHS and is required to add individuals who are working in CIE without supports. The MCO may choose to require employment services providers to report employment data to them; however, the MCO will be responsible for the uploading and certification of the employment data sent to DHS. The tool the MCO will use for employment data collection and submission of these reports will be the Integrated Exchange System (IES) through Business Objects.

D. Reports: As Needed

The MCO agrees to furnish reports which may be required to administer this contract, to the Department and the Department's authorized agents. Such reports include but are not limited to corporate restructuring or any other change affecting the continuing accuracy of information previously reported by the MCO to the Department.

The MCO shall report each such change in information as soon as possible, but not later than thirty (30) calendar days after the effective date of the change. Changes in information covered under this section include all of the following:

- Any change in information relevant to Article XIII.H, Ineligible Organizations.
- Article XIII, MCO Administration.

E. Disclosure of Financial Information

The MCO and any subcontractors or providers shall make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the MCO, subcontractors or providers which relate to the MCO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this contract. The MCO shall comply with applicable record-keeping requirements specified in Wis. Admin. Code §§ DHS 105.02(1)-(7), as amended.

F. Records Retention

The MCO shall retain, preserve and make available upon request all records or documents relating to the performance of its obligations under this contract, including paper and electronic claim forms, for not less than ten (10) years following the end of this contract period. Records and documents that must be retained include, but are not limited to, the following:

1. *Member grievance and appeal records, as described by Article XI.I.1.*
2. *As described by 42 C.F.R. §438.5(c), base data used for developing capitation rates, including:*
   a. Validated encounter data;
   b. Fee-for-service data; and
   c. Audited financial reports that demonstrate experience for the populations to be served by the MCO.
3. *As described by 42 C.F.R. §438.8(k), documents and data used to prepare annual MLR reports, including:*
   a. Total incurred claims to include care management expenses;
   b. Expenditures on quality improving activities;
   c. Expenditures related to program integrity requirements;
   d. Non-claims costs;
   e. Premium/capitation revenue;
   f. Taxes, licensing, and regulatory fees;
   g. Methodology(ies) for allocating expenditures;
   h. Any credibility adjustment applied;
   i. The calculated MLR;
   j. Any remittance owed to the State;
   k. A comparison of the information reported with the audited financial reports required under 42 C.F.R. § 438.3(m);
   l. A description of the aggregation method used to determine the total in a., above; and
   m. The number of member months.
4. *As described by 42 C.F.R. §§438.604 and 438.606, data, information, and documentation, including:*
   a. Encounter data;
   b. Data used to determine the actuarial soundness of the MCO's capitation rates;

c. Data used to determine the MCO's medical loss ratio requirements and compliance;

d. Data used to determine whether the MCO has made adequate provision against the risk of insolvency;

e. Documentation used to determine whether the MCO has complied with requirements regarding availability and accessibility of services, including the adequacy of its provider network;

f. Information on ownership and control of the MCO and its subcontractors;

g. The annual report of overpayment recoveries; and

h. Documentation certifying the data, information, or documentation referenced in Article XIV.F.4.a.-g.

5. *As described by 42 C.F.R. §§438.608 and 438.610, data, information, and documentation related to program integrity requirements, including:*

a. The detection and prevention of fraud, waste, and abuse;

b. Compliance with all requirements and standards under this contract, including all federal and state requirements;

c. The identification and recovery of overpayments, specifically including, but not limited to, recoveries of overpayments due to fraud, waste, or abuse;

d. Notifications regarding changes in members' circumstances which may impact eligibility;

e. Notifications regarding changes in a network provider's circumstances which may impact the provider's ability to provide services to members or to remain as a network provider;

f. Verification that services that were represented to have been delivered were actually received by members;

g. Compliance with the False Claims Act;

h. Compliance with requirements regarding the enrollment of providers with the state as Medicaid providers;

i. Disclosure of information regarding ownership and control of the MCO and its subcontractors;

j. Disclosure of any prohibited affiliations, including:

i. Individuals, entities, or their affiliates (as defined in 48 C.F.R. §2.101) acting as: a director, officer, partner, or subcontractor (as defined by 42 C.F.R. §438.230) of the MCO; a person with beneficial ownership of five percent or more of the MCO's equity; or a network provider or person with employment, consulting, or

other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's contractual obligations with the state if those individuals, entities, or affiliates are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under associated implementing guidelines;

ii. Individuals or entities excluded from participation in any federal health program under section 1128 or 1128A of the Social Security Act.

The MCO shall provide these records or documents to the Department at no charge. Records or documents involving matters that are the subject of any litigation, claim, financial management review or audit shall be retained for a period of not less than ten (10) years from the end of this contract period, following the termination or completion of the litigation, claim, financial management review or audit or disposition of real property and equipment acquired with Federal funds, whichever is later. The retention requirements described above shall include records or documents related to recoveries of all overpayments from the MCO, to a provider, including specifically recoveries of overpayments due to fraud, waste, or abuse.

G. MCO Data Integrity and Systems Assessments

Health and long-term care service information from each MCO is transmitted to the Department on a regular basis through the encounter reporting process, utilizing the LTCare IES application. This information is used for research, capitation rate calculations, and various other ad hoc applications. The accuracy of encounter data may be impacted by various systems maintained by the MCO.

The purpose of data integrity and system assessments is to assure the data that exist in the organizations' originating system are accurately reflected in the data existing in the encounter data repository, and that the repository accurately reflects the service records present in the MCO systems. The objectives of the data integrity and systems assessments are to verify that:

- Claims and encounter data exist in MCO systems;
- Data from MCO systems is presented to the State correctly;
- Data submitted to the State accurately reflects encounters; and
- Data that resides with the State is an accurate reflection of what exists in the MCO system.

MCO system and data integrity assessments will be scheduled and conducted on an as needed basis as determined by the Department. The MCO data integrity and system assessments are specific to the Family Care or Partnership processes. These assessments include processes or activities regarding the operation of specific managed care

programs, the operation of the LTCare IES application, or MCO financial systems and processes.

1. *MCO Responsibilities*

   When an assessment is scheduled, the MCO shall:

   a. Appoint a primary assessment contact person to be the Department audit team's contact for scheduling and reviewing assessment activities, and to provide acceptance of the final assessment report. At the same time, designate a back-up person who will be available to perform this function when needed;

   b. Supply ad hoc reconciliation reports as requested by the Department assessment team within 30 calendar days of the request, using date parameters specified by the Department's assessment team; and

   c. Comply with an onsite visit by the Department's assessment team to make available all relevant data in order to complete the assessment.

2. *Department Responsibilities*

   The Department assessment team shall:

   a. Contact the MCO regarding the scheduling of onsite visits at least thirty (30) calendar days prior to the visit;

   b. Develop, after completion of the assessment, an initial draft report of the findings of the assessment and share these findings with the MCO within thirty (30) calendar days of the visit;

   c. Schedule a phone conference (or meeting, as appropriate) to discuss the findings of the draft report within two weeks of the release of the report. Any issues regarding the report will be jointly resolved with the MCO assessment contact; and

   d. Provide a written final report to both the MCO and the Department's program managers within six weeks of the phone call. The assessment report shall identify areas of compliance as well as inconsistencies found, system or data integrity vulnerabilities, and process deficiencies that may put system or data integrity at risk.

H. Required Use of the Secure ForwardHealth Portal

All MCOs must use the secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions, and other business with the Department.

MCOs must assign and remove users roles/permissions within the secure ForwardHealth Portal account to ensure only authorized users have access to data and functions provided. MCOs must ensure all users log in to the secure Managed Care Organization Portal to submit or retrieve account or member information that may be sensitive and/or

fall under the requirements of the Health Insurance Portability and Accountability Act (HIPAA) regulations.

I. Access to CARES Data

The MCO is authorized to have access to, and make use of, data found in the Client Assistance for Reemployment and Economic Support system (CARES) operated for the Department so that the MCO will be able to help its members maintain their eligibility to receive Medicaid and remain enrolled in an MCO.

1. *Department Responsibility*

   a. The Department shall give the MCO query access to certain data in the CARES mainframe computer system and the CARES Worker Web system. The types of data to which the MCO shall have access in CARES are data used to determine a member's eligibility to receive Medicaid and remain enrolled in an MCO and data used to help a member understand and/or meet any financial or other type of obligation that he/she is required to meet in order to remain eligible to receive Medicaid. These types of data include:

      i. Data used to calculate a member's initial room and board expense when the member first enrolls in the MCO or data used to calculate any change in this expense after the member enrolls;

      ii. Data used to calculate a member's medical and remedial expenses, cost share, or any similar financial expense or obligation or data used to calculate any changes in these expenses or obligations; and

      iii. Data used to help a member complete his/her annual Medicaid eligibility review.

   b. The Department shall designate a data steward for providing the MCO with access to CARES data who shall be responsible for:

      i. Approving or denying requests from the MCO asking that staff be given access to CARES;

      ii. Working with staff in the Department's systems security unit to develop, implement, and/or monitor the procedures for providing MCO staff with access to data found in CARES; and

      iii. Coordinating any other CARES data exchange requests between the Department and the MCO for data that it is unable to obtain using the limited access to CARES under this contract. The Department has sole discretion as to whether to grant such requests. The MCO may be required to reimburse the Department for the costs incurred in obtaining this data for the MCO.

2. *MCO Responsibility*

a. The MCO shall identify an MCO security and data exchange coordinator who shall be responsible for:

i. Forwarding to the Department's data steward all requests from the MCO to give or delete CARES access for individual staff members;

ii. Working with the Department's data steward and, as necessary and appropriate, staff in the Department's systems security unit to develop, implement, and/or monitor the procedures for designating those MCO staff that will have access to data found in CARES; and

iii. Coordinating any other data exchange requests between the Department and the MCO in accordance with this agreement.

The MCO will use the Agency Data Security Staff User Agreement to notify the Department of new designations or changes to the primary or secondary MCO Security and Data Exchange Coordinator.

b. The MCO shall protect the confidentiality of data it obtains by exercising its right to access CARES. Protecting the confidentiality of this data includes, but is not limited to, protecting it from access by, or disclosure to, individuals who are not authorized to see it. The MCO shall:

i. Give access to CARES data only to authorized staff members;

ii. Use the data that it obtains under this agreement only for the purpose listed in this section;

iii. Store the data that it obtains under this agreement in a place that has been physically secured from access by unauthorized individuals in accordance with the Department's security rules and security system rules;

iv. Make sure that data that it obtains under this agreement that is in an electronic format, including but not limited to, magnetic tapes or discs, is stored and processed in such a way that unauthorized individuals cannot retrieve this information by using a computer or a remote terminal or by any other means;

v. Comply with federal and state laws, regulations, and policies that apply to and protect the confidentiality of CARES data that the MCO obtains;

vi. Provide information and/or training to all staff members who have access to CARES data to ensure they understand MCO policies and procedures to protect the confidentiality of this data, and the federal and state laws, regulations, and policies related to confidentiality; and

vii. By the signature of its representative on the Agency Data Security Staff User Agreement, the MCO attests that all of its staff members with access to any CARES data the MCO obtains shall be required to follow all of the policies and procedures of the Department and of the MCO that apply to and protect the confidentiality of this data.

c. The MCO shall not disclose any data that it obtains under this agreement to any third party other than an individual member without prior written approval from the Department unless federal or state law requires or authorizes such a disclosure. The MCO may, without prior written approval from the Department, disclose CARES data that it obtains about an individual member:

i. To the individual member;

ii. To the individual member's guardian;

iii. To any person who has an activated power of attorney for health care for the individual member; and

iv. To any person who has been designated as the individual member's authorized representative for the purpose of determining the individual's eligibility for Medicaid.

d. Provisions related to confidentiality and disclosure of CARES data shall survive the term of this contract.

The MCO shall permit authorized representatives of the Department or its agents as well as authorized representatives of federal oversight agencies and their agents to make on-site inspections of the MCO to make sure that the MCO is meeting the requirements of the federal and state laws, regulations, and policies applicable to access to CARES or to the use of CARES data.

3. *Suspension of Access to CARES for Default*

The Department shall suspend access to CARES in the event of any of the following:

a. The MCO uses any data that it obtains under this agreement for a purpose not specified in this article;

b. The MCO fails to protect the confidentiality of CARES data that it obtains or to protect it against unauthorized access or disclosure; or

c. The MCO fails to allow on-site inspections as required in this article.

Any suspension shall last until the Department is satisfied that the MCO is capable of complying with the responsibilities specified in this article.

J. Access to LTCare Data Warehouse

The MCO is authorized to have access to, and make use of, data found in the LTCare Data Warehouse operated for the Department. The MCO will be able to use the data for utilization management, network development and quality assurance and improvement.

1. *Department Responsibility*

   a. The Department shall give the MCO access to certain data in the LTCare Data Warehouse. These types of data include:

      i. Appropriate personally identifiable member data; and

      ii. Reference data.

   b. The Department shall designate a data steward and/or security processes for providing the MCO with access to the LTCare Data Warehouse data which shall be responsible for:

      i. Approving or denying requests from the MCO asking that staff be given access to the LTCare Data Warehouse; and

      ii. Working with staff in the Department's systems security unit to develop, implement, and/or monitor the procedures for providing MCO staff with access to data found in the LTCare Data Warehouse.

2. *MCO Responsibility*

   a. The MCO shall designate a data steward and/or security processes which shall be responsible for:

      i. Managing all requests from the MCO to give or delete LTCare Data Warehouse access for individual staff members; and

      ii. Working with the Department's data steward and/or security processes, as necessary and appropriate, to develop, implement, and/or monitor the procedures for designating those MCO staff that will have access to data found in the LTCare Data Warehouse.

   b. The MCO shall protect the confidentiality of data it obtains by exercising its right to access the LTCare Data Warehouse. Protecting the confidentiality of this data includes, but is not limited to, protecting it from access by, or disclosure to, individuals who are not authorized to see it. The MCO shall:

      i. Give access to LTCare Data Warehouse data only to authorized staff members;

      ii. Use the data that it obtains under this agreement only for the purpose listed in this section;

iii. Store the data that it obtains under this agreement in a place that has been physically secured from access by unauthorized individuals;

iv. Make sure that data that it obtains under this agreement that is in an electronic format, including but not limited to, magnetic tapes or discs, is stored and processed in such a way that unauthorized individuals cannot retrieve this information by using a computer or a remote terminal or by any other means;

v. Comply with federal and state laws, regulations, and policies that apply to and protect the confidentiality of LTCare Data Warehouse data that the MCO obtains; and

vi. Provide information and/or training to all staff members who have access to the LTCare Data Warehouse data to ensure they understand MCO policies and procedures to protect the confidentiality of this data, and the federal and state laws, regulations, and policies related to confidentiality.

c. Provisions related to confidentiality and disclosure of LTCare Data Warehouse data shall survive the term of this contract.

d. The MCO shall permit authorized representatives of the Department or its agents as well as authorized representatives of federal oversight agencies and their agents to make on-site inspections of the MCO to make sure that the MCO is meeting the requirements of the federal and state laws, regulations, and policies applicable to access to LTCare Data Warehouse or to the use of LTCare Data Warehouse data.

3. *Suspension of Access to LTCare Data Warehouse for Default*

The Department shall suspend access to the LTCare Data Warehouse in the event of any of the following:

a. The MCO uses any data that it obtains under this agreement for a purpose not specified in this article.

b. The MCO fails to protect the confidentiality of the LTCare Data Warehouse data that it obtains or to protect it against unauthorized access or disclosure.

c. The MCO fails to allow on-site inspections as required in this article.

Any suspension shall last until the Department is satisfied that the MCO is capable of complying with the responsibilities specified in this article.

XV. Functions and Duties of the Department

A. Division of Medicaid Services

The Division of Medicaid Services (DMS) is the primary point of contact between the Department, the MCO and other portions of the Department and the Department's contract agencies responsible for the administration and implementation of the Family Care and Partnership programs. DMS shall assist the MCO in identifying system barriers to implementation of the programs and shall facilitate intra- and interagency communications and work groups necessary to accomplish full implementation.

B. Reports from the MCOs

The Department will acknowledge receipt of the reports required provided at https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf. The Department shall have systems in place to ensure that reports and data required to be submitted by the MCO shall be reviewed and analyzed by the Department in a timely manner. The Department shall respond accordingly to any indications that the MCO is not making progress toward meeting all performance expectations (e.g., providing timely and accurate feedback to the MCO, and offering technical assistance to help the MCO correct any operational problems).

C. Enrollment and Disenrollment Reporting

The Department shall notify the MCO two times per month of all members that are enrolled in the MCO and disenrolled from the MCO under this contract. Notification shall be effected through MCO Enrollment Reports. All members listed as an ADD or CONTINUE on either the Initial or Final MCO Enrollment Reports are members of the MCO during the enrollment month indicated in the report. All members listed as a Disenroll with an effective date on either the Initial or Final MCO Enrollment Reports are members no longer enrolled in the MCO.

The reports shall be generated as specified in Section E, Capitation Payment Reporting, of this article. The MCO shall review the Enrollment Reports upon receipt and report inaccuracies to the Department as soon as possible but no later than ninety (90) calendar days following receipt of the reports. MCOs receive Enrollment Reports and the HIPAA 834 EDI X12 File transaction. The reports are available to MCOs via the ForwardHealth MCO Portal and Trading Partner Portal accounts.

D. ForwardHealth ID Cards

The Department will issue new ForwardHealth cards to Medicaid recipients after they are determined to be eligible for Medicaid. When providers verify Medicaid eligibility using the ForwardHealth card, they are given managed care enrollment information for the member on the requested dates.

E. Capitation Payment Reporting

The Department provides MCOs with Capitation Payment Reports on a weekly basis. The capitation payment report provides a detailed listing of each member and his/her enrollment and disenrollment date that is associated with each monthly capitation payment for that member. ForwardHealth interChange creates monthly capitation payments and reports on the first Friday of each month for that month. Capitation adjustments and reports are also created each week for members whose eligibility and/or enrollment information changed after a regular monthly capitation payment was made. MCOs receive both the Capitation Payment Listing Report and the HIPAA 820 EDI X12 File transaction. The reports are available to MCOs via the ForwardHealth MCO Portal and Trading Partner Portal accounts.

F. Utilization Review and Control

The Department shall waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of contract services including LTC benefit package services provided by the MCO to members.

G. Right to Review

The Department will submit to the MCO for prior approval materials that describe the MCO and that will be distributed by the Department, County or Resource Center to potential members and members.

H. Review of Study or Audit Results

1. *Release to the Public*

   The Department shall submit to the MCO for a fifteen (15) business day review/comment period, any studies or audits that are going to be released to the public that are about the MCO and Medicaid.

2. *Plan of Correction*

   Under normal circumstances, the Department will not implement a plan of correction prior to the MCO's review and response to a preliminary report. The Department may do so, however, if the circumstances warrant immediate action (i.e., if delays may jeopardize or threaten the health, safety, welfare, rights or other interest of members).

I. Provider Certification

The Department shall give the MCO access to the names and contact information for all Medicaid certified providers in the MCO's service area; in the alternative, the Department shall continue to give the MCO timely responses to the MCO's requests for confirmation of particular providers' Medicaid certification status.

J. Technical Assistance

The Department shall review reports and data submitted by the MCO and shall share results of this review with the MCO. In conjunction with the MCO, the Department shall determine whether technical assistance may be available to assist in improving performance in any areas of identified need. The Department, in consultation with the MCO, shall develop a technical assistance plan and schedule to assure compliance with all terms of this contract and quality service to members of the MCO.

K. Conflict of Interest

The Department maintains that Department employees are subject to safeguards to prevent conflict of interest as set forth in Wis. Stats. § 19.

XVI. Contractual Relationship

A. Contract

This contract is drafted in accordance with the requirements of Wis. Stat. §§ 46.2803 to 46.2895 and Wis. Admin. Code § DHS 10. This document, the Contract between the MCO and the Department, constitutes the entire contract between the MCO and the Department and no other expression, whether oral or written, constitutes any part of this contract.

B. Precedence When Conflict Occurs

In the event of any conflict among the following authorities, the order of precedence is as follows:

1. Federal law, state statutes, and administrative code;
2. This contract;
3. DHS numbered memos (including Contract Interpretation Bulletins and Technical Assistance Series documents);
4. MCO certification documents;
5. All documents comprising the RFP; and
6. The proposal.

Each Contract Interpretation Bulletin and Technical Assistance Series document shall be provided to the MCO for review and comment at least thirty (30) calendar days prior to its effective date.

C. Cooperation of Parties and Dispute Resolution

1. *Agreement to Cooperate*

   The parties agree to fully cooperate with each other in connection with the performance of their respective obligations and covenants under this contract.

2. *Contract Dispute Resolution*

   The parties shall use their best efforts to cooperatively resolve disputes and problems that arise in connection with this contract. When a dispute arises that the MCO and the Department have been unable to resolve, the Department reserves the right to final interpretation of contract language.

3. *Audit Dispute Resolution*

   If the MCO is dissatisfied with the Department's interpretation of an audit related issue, the MCO may pursue the review process used for audits to resolve the dispute.

4. *Performance of Contract Terms During Audit Dispute*

The existence of a dispute notwithstanding:

a. Both parties agree to continue without delay to carry out all their respective responsibilities which are not affected by the dispute; and

b. The MCO further agrees to abide by the interpretation of the Department regarding the matter in dispute while the MCO seeks further review of that interpretation.

D. MCO Certification

1. *Certification*

The MCO is required to demonstrate that it meets certification standards as defined by the Department.

2. *Certification Standards*

The certification standards are based on Wis. Stat. §§ 46.284(2) and (3) and Wis. Admin. Code § DHS 10.43. In addition, the MCO must meet standards of performance as outlined in this contract.

3. *Certification Information and Documents*

The MCO shall provide to the Department whatever information and documents the Department requests so that the Department can determine whether the MCO is meeting these standards.

The MCO agrees to submit the requested information by the deadlines identified in the request.

E. Sanctions for Violation, Breach, or Non-Performance

1. *Authority to Impose Sanctions*

The Department may impose sanctions or terminate the contract, as set forth in this article, if it determines the MCO has failed to meet the performance expectations described herein. The Department may base its determinations on findings from any source.

The Department may pursue all sanctions and remedial actions with the MCO that are taken with Medicaid fee-for-service providers, including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997, s.4707(a). If a basis for imposition of a sanction exists as described in this article, the MCO may be subject to sanctions as described herein.

2. *Sanctions*

a. Bases for Imposing Sanctions

The Department may impose sanctions if it determines the MCO has failed to meet any of the following performance expectations:

i. The MCO shall provide all necessary services that the MCO is required to provide, under law or under this contract to any member covered under the contract.

ii. The MCO shall not impose premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program.

iii. The MCO shall not act to discriminate among members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of enrollment or refusal to reenroll a recipient, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future contractual services.

iv. The MCO shall not misrepresent or falsify information that it furnishes to CMS or to the Department.

v. The MCO shall not misrepresent or falsify information that it furnishes to a member, potential member, subcontractor, or a provider.

vi. The MCO shall comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. § 422.208 and 422.210 and Article VIII.O., Physician Incentive Plans for Partnership.

vii. The MCO shall not distribute directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.

viii. The MCO shall not violate any of the other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

ix. The MCO shall meet financial performance expectations for solvency and financial stability as set forth in Article XVII.

x. The MCO shall meet the quality standards and performance criteria of this contract such that members are not at substantial risk of harm.

xi. The MCO shall not distribute directly or indirectly through any agent or independent contractor, any materials which describe or provide information regarding the Family Care or Partnership programs, which have not been approved by the Department.

xii. The MCO shall meet the encounter reporting submission and data certification due dates provided at https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf.

xiii. The MCO shall meet all obligations described in Article XIII.A in order to prevent the unauthorized use, disclosure, or loss of confidential information.

xiv. The MCO must not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising on behalf of a member who is his or her patient, for the following:

a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

b) Any information the member needs to decide among all relevant treatment options.

c) The risks, benefits, and consequences of treatment or non-treatment.

d) The member'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.

xv. The MCO shall meet all other obligations described in federal law, state law, or the contract, not otherwise specifically described, above.

b. Types of Sanctions

The Department may impose the following sanctions for the violations described in Article XVI.E.2.a. :

i. Civil monetary penalties.

ii. Appointment of temporary management for an MCO.

iii. Notifying the affected members of their right to disenroll.

a) The MCO shall provide assistance to any member electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's member record to new providers and/or a member's new MCO.

b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new MCO of the member's choosing.

iv. Suspension of all new enrollments after the effective date of the sanction.

The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the contract as provided under Article XIX, MCO Specific Contract Terms.

v. Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

vi. Imposition of a plan of correction and/or intensive oversight of MCO operations by the Department without appointment of a temporary manager.

vii. Denying payments for new members as provided for under the contract when, and for so long as, payment for those members is denied by CMS under 42 C.F.R. § 438.730(e).

viii. Withholding or recovering of capitation payments.

ix. Termination of the contract.

x. Any other sanction which the Department determines, in its sole discretion, to be appropriate.

c. Sanctions When an IHCP is Providing Care Management to the MCO's Members

The Department will not sanction the MCO for failing to meet a performance expectation under Article XVI.E.2.a that the Department determines is the responsibility of an IHCP.

d. Notice of Sanctions

i. Notice to MCO

Except as provided in Article XVI.E.2.f.iv. or 42 C.F.R. § 438.706(c), before imposing any of the sanctions described in Article XVI.E.2., the Department must give the affected MCO written notice that explains the following:

a) The basis and nature of the sanction.

b) Any other due process protections that the Department elects to provide.

ii. Notice to CMS

The Department must notify CMS no later than thirty (30) calendar days after the imposition or lifting of any sanction described in Article XVI.E.2. The notice shall include the name of the MCO,

the kind of sanction and the reason for the Department's decision to impose or lift the sanction.

e. Amounts of Civil Monetary Penalties

Civil monetary penalties may be imposed as follows:

i. A maximum of $25,000 for each violation of:

a) Article XVI.E.2.a.i. (Failure to provide services);

b) Article XVI.E.2.a.v. (Misrepresentation or false statements to members, potential members, subcontractors or providers);

c) Article XVI.E.2.a.vi. (Failure to comply with physician incentive plans); or

d) Article XVI.E.2.a.vii. (Marketing violations)

ii. A maximum of $100,000 for each violation of:

a) Article XVI.E.2.a.iii. (Discrimination); or

b) Article XVI.E.2.a.iv. (Misrepresentation or false statements to CMS or the Department)

iii. A maximum of $15,000 for each recipient the Department determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

iv. A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The Department must deduct from the penalty the amount of overcharge and return it to the affected member(s).

v. A maximum of $50,000 per incident for a violation described by Article XVI.E.2.a.xiii., consisting of:

a) $100 for each individual whose confidential information was used, disclosed, or lost; and

b) $100 per day for each day that the MCO fails to substantially comply with the Department's directives described by Article XIII.A.1.c.

c) In addition, in the event of a federal citation for a breach of confidentiality caused by an action or inaction of the MCO, the MCO is responsible for the full amount of any federal penalty imposed without regard to the limit set forth above.

vi. A maximum of $100,000 for any other violation described by Article XVI.E.2.a.

f. Special Rules for Temporary Management

i. Optional Imposition of Temporary Management

The Department may impose temporary management, as described by Article XVI.E.2.b.ii., only if it finds that:

a) There is continued egregious behavior by the MCO, including but not limited to behavior that is described by Article XVI.E.2.a. or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act; or

b) There is substantial risk to members' health; or

c) The sanction is necessary to ensure the health of the MCO's members:

- While improvements are made to remedy violations under this contract; or
- Until there is an orderly termination or reorganization of the MCO.

ii. Mandatory Imposition of Temporary Management

The Department must impose temporary management (regardless of any other sanction that may be imposed) if it finds that an MCO has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act, or this contract.

iii. Terminating Member Enrollment

Upon appointment of temporary management, the Department must notify the affected members of their right to terminate enrollment.

a) The MCO shall provide assistance to any member electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's member record to new providers and/or a member's new MCO.

b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new MCO of the member's choosing.

iv. Hearing

The Department may not delay imposition of temporary management to provide a hearing before imposing this sanction.

v. Duration of Sanction

The Department may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur.

g. Special Rules for Plans of Correction and Intensive Oversight

i. Plan of Correction

If the MCO fails to meet the performance expectations described in Article XVI.E.2.a., the Department may impose a plan of correction to ensure that the MCO thereafter meets all performance expectations.

ii. Imposition of Intensive Oversight

The Department may also implement intensive oversight of the MCO's operations in order to assist the MCO to come into compliance with its performance expectations.

When intensive oversight is imposed, the Department may place Department staff or designated representatives at the MCO to assist the MCO in meeting its performance expectations by providing technical guidance and correcting deficiencies.

h. Special Rules for Denying Payments for New Members

i. Basis for Denying Payments for New Members

The Department may recommend that CMS impose the denial of payment sanction described in Article XVI.E.2.b.vii. and 42 C.F.R. 438.730(e) if the Department determines that the MCO committed a violation described in Article XVI.E.2.a.i. through Article XVI.E.2.a.vi.

ii. Effect of Department Determination

a) The Department's determination becomes CMS's determination for purposes of section 1903(m)(5)(A) of the Social Security Act unless CMS reverses or modifies it within 15 days.

b) When the Department decides to recommend denying payments for new members, this recommendation becomes CMS's decision, for purposes of section 1903(m)(5)(B)(ii) of the Social Security Act, unless CMS rejects this recommendation within 15 days.

iii. Notice of Sanction

If the Department's determination becomes CMS's determination as described in Article XVI.E.2.h.ii.b)., the Department shall take the following actions:

a) Give the MCO written notice of the nature and basis of the proposed sanction;

b) Allow the MCO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommendation sanction;

c) The Department may extend the initial 15-day period for an additional 15 days if:

- The MCO submits a written request that includes a credible explanation of why it needs additional time;
- The request is received by CMS before the end of the initial period; and
- CMS has not determined that the MCO's conduct poses a threat to a member's health or safety.

iv. Informal Reconsideration

a) If the MCO submits a timely response to the notice of sanction, the Department shall:

- Conduct an informal reconsideration that includes a review of the evidence by a Department official who did not participate in the original recommendation;
- Give the MCO a concise written decision setting forth the factual and legal basis for the decision; and
- Forward the decision to CMS.

b) The Department decision described by Article XVI.E.2.h.iv.a). becomes CMS's decision unless CMS reverses or modifies the decision within 15 days from the date of receipt by CMS.

c) If CMS reverses or modifies the Department's decision, the Department shall send the MCO a copy of CMS's decision.

v. Denial of Payment

a) CMS, based upon the recommendation of the Department, may deny payment to the State for new members of the MCO under section 1903(m)(5)(B)(ii) of the Social Security Act in the following situations:

- If a CMS determination that an MCO has committed a violation described in Article XVI.E.2.a.i. through Article XVI.E.2.a.vi., is affirmed on review under Article XVI.E.2.h.iii.; or
- If the CMS determination is not timely contested by the MCO under Article XVI.E.2.h.iii.

b) In accordance with 42 C.F.R. 438.726(b), CMS's denial of payment for new members automatically results in a denial of Department payments to the MCO for the same members. (A new member is a member that applies for enrollment after the effective date in Article XVI.E.2.h.iii.a).)

vi. Effective Date of Sanction

a) If the MCO does not seek reconsideration, a sanction is effective 15 days after the date the MCO is notified under Article XVI.E.2.h.iii. of the decision to impose the sanction.

b) If the MCO seeks reconsideration, the following rules apply:

- Except as specified in Article XVI.E.2.h.iv.b)., the sanction is effective on the date specified in CMS's reconsideration notice.
- If CMS, in consultation with the Department, determines that the MCO's conduct poses a serious threat to a member's health or safety, the sanction may be made effective earlier than the date of the Department's reconsideration decision under Article XVI.E.2.h.iv.a).

vii. CMS' Role

a) CMS retains the right to independently perform the functions assigned to the Department under Article XVI.E.2.g.i. through Article XVI.E.2.g.ii.

b) At the same time the Department sends notice to the MCO as described by Article XVI.E.2.g.ii., CMS forwards a copy of the notice to the Office of the Inspector General.

c) CMS conveys the determination described by Article XVI.E.2.h.i. to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and part 1003 of Title 42 of the Code of Federal Regulations. In accordance with the provisions of part 1003, the OIG may impose civil money

penalties on the MCO in addition to, or in place of, the sanctions that may be imposed by this contract.

i. Special Rules for Withholding or Recovering Capitation Payments

i. Amount of Capitation Payment to be Withheld or Recovered and Recovery of Damages

The Department may withhold future capitation payments otherwise due to the MCO or may recover capitation payments already paid to the MCO in an amount determined by the Department to be appropriate based on the severity and persistency of the violation, breach, or non-performance.

In any case under this contract where the Department has the authority to withhold or recover capitation payments, the Department also has the authority to use all other legal processes for purposes including, but not limited to, the recovery of damages.

ii. Timeliness of Encounter Reporting

Notwithstanding other provisions of this Contract, the Department may withhold portions of capitation payments as liquidated damages or otherwise recover damages from the MCO if the MCO fails to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such data or information in the required form or format, by the deadline specified by the Department. The Department may immediately impose liquidated damages in the amount of $1,500 per day for each day beyond the deadline that the MCO fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the MCO's capitation payments.

Additionally, if it is found that the MCO failed to submit accurate and complete encounter data prior to the submission deadlines, the MCO may be held responsible for reimbursing the Department for the staffing and out-of-pocket costs incurred by the Department and its contractors associated with reviewing the delayed data submission, and developing and publishing revised rates.

iii. Notice to MCO

In the event the Department intends to withhold or recover capitation payments as described in this Article, the Department shall include as part of its notice described in Article XVI.E.2.d.i., documentation of:

a) The basis for withholding or recovering capitation payments; and

b) The amount of capitation payments that will be withheld and/or recovered, or the length of time in which capitation payments will be withheld.

3. *Termination of Contract*

a. Authority to Terminate Contract

The Department has the authority to terminate an MCO's contract and enroll that entity's members in other MCOs of the member's choosing, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the MCO has failed to do either of the following:

i. Carry out the substantive terms of this Contract; or

ii. Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

b. Notice and Pre-Termination Hearing

Before terminating an MCO contract for failing to carry out substantive terms of the contract or to meet applicable requirements in sections 1932, 1903(m), or 1905(t) of the Social Security Act and 42 C.F.R. § 438.708, the Department must provide the MCO a pre-termination hearing.

The Department must do the following:

i. Give the MCO written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

ii. After the hearing, give the MCO written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and

iii. For an affirming decision, give members of the MCO notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

c. Disenrollment During Termination Hearing Process

After the Department notifies an MCO that it intends to terminate the contract for failing to carry out substantive terms of the contract or to meet applicable requirements in sections 1932, 1903(m), or 1915(t) of the Social Security Act and 42 C.F.R. § 438.708, the Department may do the following:

i. Give the MCO's members written notice of the Department's intent to terminate the contract

ii. Notify the MCO's members of their right to disenroll.

a) The MCO shall provide assistance to any member electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's member record to new providers and/or a member's new MCO.

b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new MCO of the member's choosing.

F. Modification and Termination of the Contract

1. *Modification*

a. This contract may be modified at any time by written mutual consent of the MCO and the Department.

b. This contract will be modified if changes in federal or state laws, rules, regulations or amendments to Wisconsin's CMS approved waivers or the state plan require modification to the contract. In the event of such change, the Department will notify the MCO in writing. If the change materially affects the MCO's rights or responsibilities under the contract and the MCO does not agree to the modification, the MCO may provide the Department with written notice of termination at least ninety (90) days prior to the proposed date of termination.

c. The capitation payment rate to the MCO can be modified only as provided in Article XVIII.D., Annual Determination of Capitation Rates.

If the Department exercises the right to renew this contract, the Department will recalculate the capitation payment rate for succeeding calendar years. The MCO shall have sixty (60) calendar days to accept the new capitation payment rate in writing or to initiate termination of the contract.

2. *Mutual Consent for Termination*

This contract may be terminated at any time by mutual written consent of both the MCO and the Department.

3. *Unilateral Termination*

This contract may be unilaterally terminated only as follows:

a. Termination for Convenience

Either party may terminate this Contract at any time, without cause, by providing a written notice to the other party at least 90 days in advance of the intended date of termination.

b. Changes in Federal or State Law

This contract may be terminated at any time, by either party, due to modifications mandated by changes in federal or state law or regulations that materially affect either party's rights or responsibilities under this contract.

In such case, the party initiating such termination procedures must notify the other party in writing, at least ninety (90) days prior to the proposed date of termination, of its intent to terminate this contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the MCO's reasonable and necessary costs to end operations and does not include ongoing expenses such as lease payments due after the date of termination.

c. Changes in Reporting Requirements

If the Department proposes additional reporting requirements during the term of the contract, the MCO will have thirty (30) days to review and comment on the fiscal impact of the additional reporting requirements. The Department will consider any potential fiscal impact on the MCO before requiring additional reporting. If the change has significant fiscal impact, the MCO may provide the Department with written notice of termination at least ninety (90) days prior to the proposed date of termination and will not be required to provide the additional reporting.

d. Termination for Cause

If either party fails to perform under the terms of this Contract, the other party may terminate this Contract by providing written notice of any defects or failures to the non-performing party. The non-performing party will have 30 calendar days from the date of receipt of notice to cure the failures or defects established within the notice sent by the other party. If the failures or defects are not cured within 30 days of the non-performing party receiving the notice, the other party may terminate the Contract.

e. Termination when Federal or State Funds are Unavailable

i. Permanent Loss of Funding

This contract may be terminated by either party, in the event federal or state funding of contractual services rendered by the MCO becomes permanently unavailable and such lack of funding would preclude reimbursement for the performance of the MCO's obligations. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the MCO will become unavailable, the Department shall immediately notify the MCO, in writing, identifying the basis for the anticipated unavailability of funding and the date on which the funding will

end. In the event of termination, the contract will terminate without termination costs to either party.

ii. Temporary Loss of Funding

In the event funding will become temporarily suspended or unavailable, the Department will suspend the MCO's performance of any or all of the MCO's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department shall attempt to give notice of suspension of performance of any or all of the MCO's obligations sixty (60) days prior to said suspension, if possible; otherwise, such notice of suspension should be made as soon as possible. Once the funding is reinstated, the MCO will resume the suspended services within thirty (30) days from the date the funds are reinstated. The contract will not terminate under a temporary loss of funding.

4. *Automatic Termination of Foreign Entity*

Pursuant to 42 C.F.R. § 438.602(i), DHS is prohibited from contracting with an MCO located outside of the United States. In the event an MCO moves outside of the United States, this contract will be terminated.

5. *Contract Non-Renewal*

The MCO or the Department may decide to not renew this contract. In the case of a non-renewal of this contract, the party deciding to not renew this contract must notify the other party in writing at least ninety (90) calendar days prior to the expiration date of this contract, and follow the procedures in para 6. and 7. of this section.

6. *Transition Plan*

In the case of this contract being terminated or a decision to not renew this contract, the MCO shall submit a written plan that receives the Department's approval, to ensure uninterrupted delivery of services to MCO members and their successful transition to applicable programs (e.g., Medicaid fee-for-service). The plan will include provisions for the transfer of all member related information held by the MCO or its providers and not also held by the Department.

a. Submission of the Transition Plan

The MCO shall submit the plan at one of the following times, depending on which applies: no less than ninety (90) calendar days prior to the contract's expiration when the MCO decides to not renew the contract; within ten (10) business days of notice of termination by the Department; or along with the MCO's notice of termination.

b. Management of the Transition

The MCO shall designate a person responsible for coordinating the transition plan and will assign staff as the Department determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as the Department determines is necessary.

c. Continuation of Services

If the MCO has been unable to successfully transition all members to applicable programs by the time specified in the approved transition plan, the MCO shall continue operating as an MCO under this contract until all members are successfully transitioned. The Department will determine when all members have been successfully transitioned to applicable programs.

If the Department determines it necessary to do so, the MCO will agree to extend this contract, in order to continue providing services to members until they are successfully transitioned to applicable programs. During this period the MCO remains responsible, and shall provide, the services in the benefit package, and all terms and conditions of the contract will apply during this period.

7. *Obligations of Contracting Parties*

When termination or non-renewal of this contract occurs, the following obligations shall be met by the parties:

a. Notice to Members

The Department shall be responsible for developing the format for notifying all members of the date of termination and process by which the members continue to receive services in the benefit package;

b. MCO Responsibilities

The MCO shall be responsible for duplication, mailing and postage expenses related to said notification;

c. Return of Advanced Payments

Any payments advanced to the MCO for coverage of members for periods after the date of termination or expiration shall be returned to the Department within forty-five (45) calendar days;

d. Transfer of Information

The MCO shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims; and

e. Recoupments

Recoupments will be handled through a payment by the MCO within ninety (90) calendar days of the end of this contract.

G. Delegations of Authority

The MCO shall oversee and remain accountable for any functions and responsibilities that it delegates to a subcontractor or provider. For all major or minor delegation of function or authority:

1. The MCO shall receive prior Department approval before entering into, changing or terminating a subcontract for the major functions in Article XIII.C.4.: care management; claims administration; or quality management.

   A proposed subcontract, change or termination shall be submitted by the MCO not less than sixty (60) calendar days prior to the effective date of the proposal.

2. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor or provider and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's or provider's performance is inadequate.

3. Before any delegation, the MCO shall evaluate the prospective subcontractor's or provider's ability to perform the activities to be delegated.

4. The MCO shall monitor the subcontractor's or provider's performance on an ongoing basis and subject the subcontractor or provider to formal review at least once a year.

5. The MCO shall maintain oversight of subcontractors' and providers' quality of services within the MCO's internal Quality Management (QM) program.

6. If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor or provider shall take corrective action.

7. If the MCO delegates selection of subcontractors or providers to another entity, the MCO retains the right to approve, suspend, or terminate any subcontractor or provider selected by that entity.

H. Indemnification

1. *MCO and the Department's Liability*

   The MCO will indemnify, defend if requested and hold harmless the state and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the MCO or any of its contractors, in prosecuting work under this contract.

   The Department acknowledges that the State may be required by Wis. Stat. § 895.46(1) to pay the cost of judgments against its officers, agents or employees,

and that an officer, agent or employee of the State may incur liability due to negligence or misconduct. To the extent protection is afforded under Wis. Stat. §§ 893.82 and 895.46(1), the Department agrees to be responsible to the MCO and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the negligence of the Department, its employees or agents in performing under this contract.

2. *Pass Along Federal Penalties*

   a. The MCO shall indemnify the Department for any federal fiscal sanction taken against the Department or any other state agency which is attributable to action or inaction by the MCO, its officers, employees, agents, providers or subcontractors that is contrary to the provisions of this contract.

   b. Prior to invoking this provision, the Department agrees to pursue any reasonable defense against the federal fiscal sanction in the available federal administrative forum. The MCO shall cooperate in that defense to the extent requested by the Department.

   c. Upon notice of a threatened federal fiscal sanction, the Department may withhold payments otherwise due to the MCO to the extent necessary to protect the Department against potential federal fiscal sanction. The Department will consider the MCO's requests regarding the timing and amount of any withholding adjustments.

I. Independent Capacity of the MCO

The Department and the MCO agree that the MCO and any agents or employees of the MCO, in the performance of this contract, shall act in an independent capacity, and not as officers or employees of the Department.

J. Omissions

In the event that either party hereto discovers any material omission in the provisions of this contract that is essential to the successful performance of this contract, said party may so inform the other party in writing. The parties hereto will thereafter promptly negotiate the issues in good faith in order to make reasonable adjustments necessary to perform the objectives of this contract.

K. Choice of Law

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The MCO shall be required to bring all legal proceedings against the Department in the state courts in Dane County, Wisconsin.

L. Waiver

No delay or failure by the MCO or the Department to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

M. Severability

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to members and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

N. Force Majeure

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

O. Headings

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

P. Assignability

Except as allowed under subcontracting and entering into provider agreements, this contract is not assignable by the MCO either in whole or in part, without the prior written consent of the Department.

Q. Right to Publish

The Department agrees to allow the MCO to write and have such writings published provided the MCO receives prior written approval from the Department before publishing writings on subjects associated with the work under this contract. The MCO agrees to protect the privacy of individual members, as required under 42 C.F.R. § 434.6(a)(8).

R. Survival

The terms and conditions contained in this contract that by their sense and context are intended to survive the performance by the parties shall so survive the completion of the performance, expiration or termination of the contract. This specifically includes, but is

not limited to recoupments and confidentiality provisions. All rights and remedies of the parties provided under this contract, including but not limited to any and all sanctions for violation, breach or non-performance, survive from one contract year to the next, and survive the completion of the performance, expiration or termination of the contract.

XVII. Fiscal Components/Provisions

A. Financial Management

Purpose: The MCO shall ensure continuity of care for enrolled members through sound financial management systems and practices. Financial management systems shall be sufficient to track, reconcile, report, and project the operational and financial results of the MCO, and support informed decision-making. Financial management practices shall ensure the overall financial health of the organization and support the maximization of quality services with the funds expended. An MCO shall also demonstrate the capacity for financial solvency and stability and the ability to assume the level of financial risk required under this contract and ensure continuity of care for enrolled members. The MCO shall demonstrate its overall financial management capacity to both the Wisconsin Department of Health Services and the Wisconsin Office of the Commissioner of Insurance.

1. *Capacity for Financial Solvency and Stability – programs operated under a Licensed HMO*

   Partnership MCOs are required to operate under a state-licensed HMO. Under a licensed HMO, the MCO must demonstrate the ability to retain operating capital and minimum risk and solvency reserves as required by the Wisconsin Office of the Commissioner of Insurance (OCI).

2. *Capacity for Financial Solvency and Stability – programs operated by MCOs that are not Licensed HMOs*

   The MCO shall demonstrate the ability to retain operating capital and minimum risk and solvency reserves as required by the Department and the OCI outlined below:

   a. Working Capital

      i. Purpose

         The purpose of working capital is to provide ongoing liquid assets to manage routine fluctuations in revenue and expenses that will occur in the normal course of business operations.

      ii. Working Capital Calculation and Minimum Balance

         The working capital calculation is the difference between current assets and current liabilities with a minimum balance maintained at a level not less than 3.0% of the budgeted annual capitation payments from the Department to the MCO for the period of this contract.

      iii. Failure to Maintain Required Minimum Balance

         In the event that the MCO fails to maintain and report the required working capital, the MCO will be placed under corrective action and shall submit a plan to the Department and the OCI for approval

that includes an analysis of the reasons for the shortfall and a plan for restoring the required working capital balance. If the MCO continues to maintain inadequate working capital, the Department may impose sanctions consistent with Article XVI.E., Sanctions for Violation, Breach, or Non-Performance or terminate the contract in accordance with Article XVI.F.3., Unilateral Termination.

Note: This calculation is subject to change based on annual review with the Department's contracted actuarial firm. Notice of changes to the schedule will be communicated to the MCO by July 1 of the current calendar year contract.

b. Restricted Reserve

i. Purpose

The purpose of the restricted reserve is to provide continuity of care for enrolled members, accountability to taxpayers, and effective program administration. The restricted reserve provides additional liquid assets to underwrite the risk of financial volatility due to extraordinary, unbudgeted program expenditures.

ii. Restricted Reserve Funds

The MCO shall establish and maintain a separately identifiable restricted investment reserve account in a financial institution. The invested funds and related income shall not be commingled with any other financial account. The MCO shall submit an investment policy and procedure for the restricted reserve funds to the Department annually for approval.

iii. Required Contributions

The requirements under this subsection apply during the period of this contract.

Contribution: the MCO shall deposit the required minimum balance on or before the beginning of the contract period as calculated using the schedule set forth in subsection (a) Required Minimum Fund Balance.

a) Required Minimum Fund Balance

The required minimum fund balance is an amount set for the term of each contract that is based on the budgeted annual capitation payment as projected by the MCO and approved by the Department. The required minimum fund balance is calculated as follows:

- 8% of the first $5 million of budgeted annual capitation

- 4% of the next $5 million of budgeted annual capitation
- 3% of the next $10 million of budgeted annual capitation
- 2% of the next $30 million of budgeted annual capitation
- 1% of any additional budgeted annual capitation.

Note: This schedule is subject to change based on annual review with the Department's contracted actuarial firm. Notice of changes to the schedule will be communicated to the MCO by July 1 of the current calendar year contract.

b) Earnings

Any income or gains generated by the restricted reserve funds are to remain within the account until the MCO meets the required minimum balance as set forth in subsection (a) Required Minimum Fund Balance immediately above. Income or gains generated by the restricted reserve funds beyond the minimum balance may be used as set forth in subsection (iv) Disbursements.

iv. Disbursements

Once the minimum balance is met, or when the Department allows, disbursements may be made from the restricted reserve account in order to fund operating expenses, or as approved by the Department, to further develop capacity within the long-term care system. For any withdrawals or disbursements that are made, the following requirements apply:

a) Disbursement Notifications

The MCO must file a plan for accessing the restricted reserve funds with the Department and the OCI at least thirty (30) calendar days prior to the proposed effective date. The MCO must obtain affirmative approval for withdrawals or disbursements, if the withdrawal or disbursement results in a balance below the required minimum balance. Additionally, the MCO must obtain the approval for withdrawals for a purpose other than payment of operating expenses. The Department and the OCI shall approve requests within fifteen (15) business days only after consideration of all solvency protections available to the MCO. Withdrawals or disbursements that result in an account balance below the required minimum balance will only be approved to fund the working capital, solvency fund, or operating expenses of the MCO.

b) Plans for Replenishing Restricted Reserve When Below Minimum

The MCO shall have a three year business plan, approved by the Department and the OCI which specifies the methods and timetable the MCO shall employ to replenish the restricted reserve fund if below the minimum balance. If the MCO fails to submit an acceptable three year business plan, the Department may impose sanctions consistent with Article XVI.E., Sanctions for Violation, Breach, or Non-Performance. In approving or disapproving the plan, the Department will take into account existing or additional solvency protections available to the MCO.

v. Reporting

The MCO shall report on the status of the restricted reserve account as part of the quarterly financial report required under this contract; or more frequently if the MCO is in a state of corrective action.

vi. Failure to Maintain Required Minimum Balance

In the event the MCO fails to maintain and report the required restricted reserve, the MCO will be placed under corrective action and shall submit a plan to the Department and the OCI for approval that includes an analysis of the reasons for the shortfall and a plan for restoring the required restrictive reserve balance. If the MCO continues to maintain an inadequate restrictive reserve balance, the Department and the OCI may impose sanctions consistent with Article XVI.E., Sanctions for Violation, Breach, or Non-Performance or terminate the contract in accordance with Article XVI.F.3., Unilateral Termination.

c. Solvency Fund

i. Purpose

The solvency fund provides for continuity of services and smooth transition of members from the existing MCO to another entity as described in Article XVI.F., Modification and Termination of the Contract or in the event the existing MCO becomes irreversibly insolvent.

ii. Solvency Requirements

The MCO shall demonstrate financial solvency and the ability to assume the level of financial risk required under this contract. The MCO shall inform the Department and the OCI of any change or anticipated change to the solvency protections of the MCO, or any

events or occurrences likely to affect the MCO's solvency, as soon as possible but no later than ten (10) business days after the MCO becomes aware of such changes, events or occurrences.

iii. Solvency Funding

a) Required Contributions

The requirements under this subsection apply during the period of this contract.

b) Contribution: the MCO shall deposit the required minimum balance ($250,000 or more as established by the Department) on or before the beginning of the contract period in an account designated by the OCI as calculated using the amount set forth in subsection (iv) Required Minimum Fund Balance.

iv. Required Minimum Fund Balance

The required minimum fund balance is an amount set for the term of each contract that is based on the budgeted annual enrollment as projected by the MCO and approved by the Department. The required minimum fund balance is calculated as follows:

- $20 PMPM on the annual budgeted member months

Note: As required by Wis. Stat. § 648.75(1), the required minimum fund balance will be at least $250,000. This amount is subject to change based on a review with the Department's contracted actuarial firm. The Department will notify the MCO 90 days in advance of a change to the amount.

If the solvency requirement has not been previously satisfied, the MCO's annual business plan submission will include a plan for additional deposits to achieve 100% of the required funding.

v. Earnings

Any income or gains generated by the solvency funds are to remain within the account until the MCO meets the required minimum balance as set forth above. Income or gains generated by the solvency funds beyond the minimum balance may be used as set forth in subsection (iv) Disbursements.

vi. Disbursements

a) Excess Accumulated Balance

Distribution of accumulated balance that exceeds the required minimum is allowed for the purpose of operations. Distribution of accumulated balance that exceeds the required minimum requires prior approval by the OCI.

b) Termination

Upon termination of a permitted entity's contract with the Department, the OCI commissioner may release assessed funds to DHS, and DHS will direct the disbursement of the funds from the solvency account in accordance with Wis. Stats. § 648.75. Priority shall be given to satisfying outstanding claims by the state or federal government (e.g., for recoupment or risk sharing).

vii. Failure to Maintain Required Minimum Balance

In the event the MCO fails to maintain and report the required solvency protection, the MCO may be put under corrective action and shall submit a plan to the Department for approval that includes an analysis of the reasons for the shortfall and a plan for restoring the required solvency protection. If the MCO continues to maintain inadequate solvency protection, the Department may impose sanctions consistent with Article XVI.E., Sanctions for Violation, Breach, or Non-Performance or terminate the contract in accordance with Article XVI.F.3., Unilateral Termination.

3. *Reporting a Substantial Proposed Change in Business Operations*

MCOs shall notify the DHS and the OCI in writing at least ninety (90) calendar days prior to any substantial change in business operations. Substantial changes include changes in articles and bylaws, organization type, geographical service areas, provider agreements, provider availability, plan administration, financial projections and guarantees, changes to the MCO's Medicaid, Medicare, or private lines of business, and any other change that might affect the financial solvency or create additional financial risk for the MCO. In addition, any transaction, or series of transactions, that exceed the lesser of 5% of the MCO's assets or 10% of net assets as of December 31 of the immediately preceding calendar year shall be deemed material and considered a substantial change. Furthermore, any changes in the items listed in Administrative Code Ins. 9.05(3) (FCP) and Ins 57.05(4) (FC) shall also be filed under this section.

The OCI, consulting with DHS as needed, shall evaluate the potential impact of the change(s) on the ongoing financial stability and day-to-day contracted operations of the MCO and may disapprove the change prior to the effective date or determine that the proposed change requires submission by the MCO of modifications to its approved business plan or revised financial projections. MCOs are referred to Administrative Code Ins. 57.06 for CMOs and 9.06 for HMOs for guidance and specific requirements.

For Partnership, MCOs should follow the guidance in Article XIX, SectionC.5 when notifying DHS about geographical service area changes.

MCOs must notify DHS, in writing, upon applying to CMS to offer a Partnership Dual Eligible SNP.

B. Financial Reporting

Purpose: The MCO will communicate the fiscal health of the organization and demonstrate the integrity of the financial operations consistent with the conditions of the contract and the goal to maximize services across the enrolled members through financial reporting.

1. *Financial Reporting to the Department*

   Financial reporting for all entities is due to the Department within forty-five (45) calendar days of the close of each of the first three (3) calendar quarters as described at https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf, and in accordance with Generally Accepted Accounting Principles (GAAP). Financial reporting for the fourth quarter of the contract year is due by March 15 of the following year.

   The submission of financial reports and calculations may be required on a more frequent basis at the discretion of the Department. Requests for an extension to the above stated reporting deadline(s) must be made prior to the due date and include the length of extension requested and a reason for the extension request.

   The Financial Statement Certification in Addendum V, Data Certification shall be signed by the MCO's financial officer and accompany the financial reporting submission.

2. *Financial Reporting to the Office of Commissioner of Insurance*

   A licensed HMO will submit financial reporting to the Office of Commissioner of Insurance (OCI) consistent with the OCI reporting requirements.

3. *Medicare Bid Information*

   Any contractor operating a Special Needs Plan (SNP) must provide their annual comprehensive Medicare bid information to the Department concurrently with its submission to CMS. The MCO must also file the final bid with the Department, if it differs from the original submission, or notify the Department if it did not differ, within one month of final approval by CMS.

4. *Payments in Excess of Capitation or Other Amounts Specified in the Contract*

   MCOs will submit a monthly report of any capitation payments or other payments in excess of amounts specified in the contract within sixty (60) calendar days of identification as required by 42 C.F.R. § 438.608(c)(3). The report will contain the following information:

   a. The MCO's name;

   b. The member's Medicaid number;

   c. The member's name;

d. The capitation month or number of capitation days if partial month;

e. The capitation rate paid;

f. The correct capitation rate;

g. The reason for the overpayment, if known;

h. The original date the overpayment was reported to DHS; and

i. The action taken by the MCO, if any.

C. Financial Certification Process

Purpose: The organization will demonstrate that it has policies, procedures, and a Department approved three year business plan, as defined by the Department, in place to continue fiscal operations required to serve the enrolled members.

The MCO shall submit financial certification materials as defined by DHS to the Department.

D. Financial Examinations

The MCO shall comply with financial examinations carried out by the Wisconsin Office of the Commissioner of Insurance, including, but not limited to, providing access to the premises and property of the MCO, complying with all reasonable requests of the financial examiners, and paying the reasonable costs associated with such examinations. Examination findings may result in DHS follow up to evidence that required changes are implemented.

E. Financial Audit

Purpose: The organization will demonstrate annually through a financial audit by an independent certified public accountant the reasonable assurance that the organization's financial statements are free from material misstatement in accordance with Generally Accepted Accounting Principles (GAAP). The audit report should demonstrate to the Department that the MCO's internal controls, and related reporting systems in operation by the MCO, are sufficient to ensure the integrity of the financial reporting systems.

1. *Deadline for Submission of Audited Financial Statements*

   The audited financial statements are due to the Department by June 1 of the contracted fiscal period. However, if the MCO is part of a county financial audit, the deadline for the MCO audit is nine (9) months after the close of the county fiscal year.

   Requests for an extension must be made within ten (10) calendar days prior to the audit submission due date and include the length of extension requested and provide a reason for the extension request.

2. *Auditor Qualifications*

   a. The MCO will communicate to the OCI the designation of the Independent CPA that is required under Wis. Admin. Code § Ins 57.31(1) and 57.31(3).

   b. The MCO will provide to the Department the required CPA Qualification Letter annually that is required under Wis. Admin. Code § Ins 57.37.

3. *Financial Audit*

   The financial audit will be performed by an independent certified public accountant following Generally Accepted Auditing Standards in accordance with GAAP and should include procedures outlined in the Managed Long-term Care Audit Guide (https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm). The full audit report will include the following:

   a. Comparative financial statements other than audit schedules and reports required for the type of financial audit necessary for the MCO entity and resulting audit report and opinion;

   b. Consolidated financial statements in a comparative format to support full reporting for the entity and all related companies;

   c. A report on the MCO internal control environment over financial reporting;

   d. A report describing the system of cost allocation for shared overhead and direct services between programs or lines of business as required;

   e. A supplemental financial report that demonstrates the financial results and segregated reserves of the MCO business for each state program contract where the organization serves members under multiple Medicaid managed care contracts and/or other lines of business. The report shall be in columnar format for the various programs as required;

   f. Letter(s) to Management as issued or written assurance that a Management Letter was not issued with the audit report;

   g. Management responses/corrective action plan for each audit issue identified in the audit report and/or Management letter; and

   h. The completed CPA audit checklist signed by a Financial Officer/Finance Director of the MCO (https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm).

   i. A completed supplemental audit report summarizing the number of claims sampled from the auditors' work papers and the number of claims that did and did not satisfy each of the required elements in the report. (https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm).

4. *Programs operated by a Licensed HMO(s) - Financial Audit Reports*

   Financial audit reports shall also meet the requirements of the OCI.

5. *Submission of the Audit Reports*

   The audit report should be submitted electronically in PDF format to DHSLTCFiscalOversight@dhs.wisconsin.gov.

   If the MCO is unable to submit the report electronically, then two complete paper copies must be mailed to:

   Director
   Department of Health Services
   Bureau of Rate Setting
   1 West Wilson Street, Room 472
   P.O. Box 309
   Madison, WI 53701-0309

6. *Access to Financial Auditor's Work Papers*

   When contracting with an audit firm, the MCO shall authorize its auditor to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of the Department and/or the Office of the Commissioner of Insurance. Such access shall include the right to obtain photocopies of the work papers and computer disks, or other electronic media, upon which records/working papers are stored.

7. *Failure to Comply with the Requirements of this Section*

   In the event that the MCO fails to have an appropriate financial audit performed or fails to provide a complete audit report to the Department within the specified timeframes, in addition to applying one or more of the remedies available under this contract, the Department may:

   a. Conduct an audit or arrange for an independent audit of the MCO and charge the cost of completing the audit to the MCO; and/or

   b. Charge the MCO for all loss of federal or state aid or for penalties assessed to the Department because the MCO did not submit a complete financial audit report within the required timeframe.

F. Other Regulatory Reviews and Identified Irregularities

The MCO will notify the Department within ten (10) business days of notice of any reviews, investigations, decisions and requirements for corrective action from other state and federal regulatory agencies including but not limited to the Office of the Commissioner of Insurance, Internal Revenue Service, Department of Workforce Development, State Department of Revenue, or the Department of Labor.

The MCO will notify the Department within ten (10) business days of any identified irregularities involving financial fraud from internal or contracted operations. See Article XIII, Section K. for additional information.

G. Reporting on Savings Initiatives

1. As a part of the business plan submitted by the MCO, the MCO shall report on regional or MCO-wide efforts to control costs in one or more service cost categories. The reporting shall include expected annual savings from these efforts.
2. During the contract year, the MCO shall report quarterly on savings associated with the efforts identified in the business plan, using a method identified by the Department.
3. Notwithstanding XVII.G.2. of this contract, MCOs under heightened financial monitoring shall report savings efforts as directed by the Department.

H. Medical Loss Ratio (MLR)

1. *MLR Requirement*

   The MCO is required to calculate and report a Medical Loss Ratio (MLR) each year consistent with MLR standards as specified by the Department and described in 42 C.F.R. § 438.8. The MLR is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)). The MLR calculation for the FC and FCP programs includes care management service expenses in the service cost component of the calculation. The MCO must submit the MLR on June 1 of the following year with the annual financial reporting submission in the designated worksheet within the MCO Financial Reporting Template. The MCO must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting MLR reports in the required Financial Statement Certification submitted with the required audit submissions. If the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the MCO must re-calculate the MLR for all MLR reporting years affected by the change. It must then submit a new MLR report meeting the applicable requirements in the designated worksheet within the MCO Financial Reporting Template in the next scheduled quarterly financial reporting submission based on the DHS reporting due dates.

2. *MLR Reporting Requirements*

   a. Each MCO expense must be included under only one type of expense category defined for MLR reporting, unless a proration between expense categories is required to reflect accuracy and a description of the allocation is provided.

   b. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

c. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

d. Shared expenses, including the expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

e. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

f. The MCO may add a credibility adjustment, which are published annually by CMS, to a calculated MLR if the MLR reporting year experience is partially credible.

g. The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. Any MCO with enrollment greater than the minimum number of member months set by CMS will be determined to be fully credible.

h. If an MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

i. The MCO will aggregate data for all Medicaid eligibility groups covered under the contract with the Department for the long-term care programs.

j. The MCO's MLR report must include the following:

   i. Total incurred claims including care management expenses

   ii. Expenditures on quality improving activities

   iii. Expenditures related to activities compliant with program integrity requirements

   iv. Non-claims costs

   v. Premium/capitation revenue

   vi. Taxes

   vii. Licensing fees

   viii. Regulatory fees

   ix. Methodology(ies) for allocation of expenditures

   x. Any credibility adjustment applied

   xi. The calculated MLR

   xii. Any remittance owed to the state, if applicable

   xiii. A reconciliation of the information reported to the annual financial report

xiv. A description of the aggregation method used to calculate total incurred claims

xv. The number of member months

xvi. Additional description and guidelines for the MLR report are located in the MLR worksheet within the DHS MCO Financial Reporting Template.

The MCO must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCO within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCO, whichever comes sooner, regardless of current contractual limitations, in order to calculate and validate the accuracy of MLR reporting to meet the DHS MLR reporting due date.

XVIII. Payment to the Managed Care Organization

A. Purpose

The purpose of the payment to the managed care organization is to cost-effectively fund the provision of services in the benefit package, and the administration thereof, within the framework of a risk-based contract.

B. Medicaid Capitation Rates

In full consideration of services in the Medicaid benefit package rendered by the MCO for each enrolled member, the Department agrees to pay the MCO a monthly capitation rate. The capitation rates shall be based on an actuarially sound methodology as required by federal regulations.

The capitation rates shall include funding to support relocation of members from institutional settings into the most integrated community setting.

The capitation rate shall not include any amount for recoupment of losses incurred by the MCO under previous contracts nor does it include services that are not covered under the State Plan.

When the rate cell used to process a member's capitation payment changes in the middle of a month, the Department will use a daily rate to calculate the capitation payment for the member. This daily rate is based on the annualized monthly capitation rate (i.e. monthly capitation rate times twelve months) divided by the number of days in the contracted calendar year and rounded to the fourth digit to the right of the decimal. Payment of the rate is based on the daily rate multiplied by the number of days the member was enrolled for the month and rounded to the nearest cent. Examples of mid-month changes that would require the use of a daily rate to calculate the capitation rate include enrollment and disenrollments between programs or MCOs, and changes between a nursing home level of care and a non-nursing home level of care for Family Care members.

C. Actuarial Basis

The capitation rate is calculated on an actuarial basis, recognizing the payment limits set forth in 42 C.F.R. § 438.6.

D. Annual Determination of Capitation Rates

The monthly capitation rates are calculated on an annual basis. The capitation rates are not subject to renegotiation once they have been accepted, unless such renegotiation is required by changes in federal or state laws, rules, or regulations.

E. Pay for Performance

The Department will implement a pay for performance mechanism in 2020. This incentive applies only to CY 2020 and will not be renewed automatically. The pay for performance withhold payments, as described in Article XVIII.E.1.c, will be based on

results from the member satisfaction survey. MCOs may additionally be eligible for an incentive payment based on results from the member satisfaction survey, and assisted living quality improvement incentive. The following programs and any payments thereunder are expressly contingent upon receiving federal approval for the programs.

The withhold and incentive percentages will be applied to the MCO's capitation rate before reductions for the high cost risk pool and member cost share. The payment amounts will be calculated based on the Long Term Care Functional Screen and enrollment data used to develop capitation rates for the next contract year. The payment amounts will reflect the Target Group Mix and Long-Term Care Functional Status retrospective adjustments.

1. *Member Satisfaction Survey*

   a. Criteria

      The Department will conduct a member satisfaction survey that will be sent to a sample of each MCO's members in the 3rd quarter of 2020. The pay for performance criteria will be based on four questions that are part of the complete survey. The four questions will assess:

      i. Member access to services

      ii. Member participation in the care planning process

      iii. Member satisfaction with care plan/team

      iv. Member satisfaction with services

      The Department will establish benchmarks and minimum performance standards for each of the four questions based on previous member satisfaction surveys. The MCOs will be notified of what the benchmarks are prior to survey distribution. If the responses and results of the survey show an MCO has met the minimum performance standard for a survey question, the portion of the capitated rate withheld for that question will be returned to the MCO. If an MCO meets the minimum performance standards for all four questions and meets or exceeds the targeted performance benchmark for one or more questions, the MCO will receive the entire amount withheld from the capitation rate and will receive an incentive payment to their capitated rate.

   b. Notification of Survey Results

      The Department shall notify each MCO of their survey results upon compilation.

   c. Methodology

      All MCOs will have 0.25% of their calendar year 2020 capitation rate withheld to be returned based on the MCO's performance on the member satisfaction survey. The MCO will receive one fourth of the 0.25% withheld from the capitation rate for each survey question in which they

meet the minimum performance standard set by the Department. MCOs that meet the minimum performance standards for all four questions will earn back all of the 0.25% withheld from the rate. MCOs will earn a 0.05% performance enhancement to their rate for each targeted performance benchmark they meet. The survey results used to make payments will be based on a statistically significant sample at the MCO level. Payments under this section will be made by December 31, 2021.

Survey Question	Meets Minimum Performance Standard	Meets Targeted Performance Benchmark
	MCO will earn 0.0625% withhold for each survey question for which it meets the minimum performance standard up to a total of 0.25%.	The MCO must meet the minimum performance standards for all 4 survey questions to qualify for an enhanced performance payment for meeting any one of the target performance benchmarks for the 4 survey questions. The MCO will earn 0.05% incentive payment for each survey question for which it meets the targeted performance benchmark up to a total of 0.20%.
1. Member access to services	0.0625% withhold returned	0.05% incentive payment
2. Member participation in the care planning process	0.0625% withhold returned	0.05% incentive payment
3. Member satisfaction with care plan/team	0.0625% withhold returned	0.05% incentive payment
4. Member satisfaction with services	0.0625% withhold returned	0.05% incentive payment

2. *Assisted Living Quality Improvement Incentive*

a. Criteria

MCOs may receive an incentive payment for each member residing in an assisted living facility if the assisted living facility satisfies one of two qualifying incentive criteria:

i. Incentive Criteria 1: Qualifies for the abbreviated Division of Quality Assurance survey and is compliant with Home and Community-Based Services settings rule; or

ii. Incentive Criteria 2: Qualifies for the abbreviated Division of Quality Assurance survey, is compliant with the Home and Community-Based Services settings rule, is a member in good standing with Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL), and has a rate of less than 3 falls with injury per 1000 occupied bed days from January 1, 2020, through December 31, 2020, as documented by WCCEAL. A fall with injury means a fall that results in an injury requiring medical treatment.

b. Reporting Requirement

The MCO must submit the completed template to the Department by January 31, 2021.

c. Amount of Incentive Payment

The amount of the per member incentive payment will be determined by the Department on a per-member basis. The total amount to be distributed for the assisted living quality improvement incentive is $2 million. One million dollars will be allocated to each incentive criteria (3.a.i. and 3.a.ii.). MCOs will only receive one payment per member living in an eligible assisted living facility; for members that reside in an assisted living facility that meets the criteria under 3.a.ii., the MCO will receive a payment only from the funding allocated to 3.a.ii.

MCOs receiving the assisted living quality improvement incentive payment must report to DHS how they spent, or intend to spend, the incentive funds by June 30, 2021.

F. Retention of Risk

The MCO must remain substantially at risk for providing services under this contract. Risk is defined as the possibility of the MCO's monetary loss or gain resulting from costs exceeding or being less than capitation payments made to the MCO by the Department.

G. Payment Schedule

Payment to the MCO shall be based on the MCO Enrollment Reports which the Department will transmit to the MCO. The Department will issue payments for each person listed as an ADD or CONTINUE in the MCO Enrollment Reports within sixty (60) calendar days of the date the report is generated. The MCO shall accept payments under this contract as payment in full and shall not bill, charge, collect or receive any other form of payment from the Department or the member, except as provided for in the 1915(c) waiver's post-eligibility treatment of income.

H. Payment Method

All payments, recoupments, and debit adjustments for payments made in error by the Department to the MCO will be made via Electronic Funds Transfer (EFT) via enrollment through the secure Forward Health Portal account.

MCOs are responsible for maintaining complete and accurate EFT information in order to receive payment. If an MCO fails to maintain complete and accurate information and the Department makes a payment to an incorrect account, the Department will be held harmless and will not reissue a payment if it is unable to recoup payment from the incorrect account.

All arrangements between the financial institution specified for EFT and the MCO must be in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.

EFT information provided by the MCOs via their secure ForwardHealth Portal account constitute a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of Wis. Stat. §§ 49.49(1) and (4m), and if any such information is false, criminal or other penalties may be imposed under these laws.

The requirements and obligations for EFT are in addition to any and all other requirements and obligations applicable to MCO in connection with their contract and their participation in any program that is part of ForwardHealth, including but not limited to requirements and obligations set forth in federal and state statutes and rules and applicable handbooks and updates.

I. Health Insurance Fee Reimbursement – Partnership Only

The Patient Protection and Affordable Care Act (PPACA) imposed an annual fee on health insurance providers based on their net written premiums ("Annual Fee"). The Department shall reimburse the MCO for the Wisconsin-specific Medicaid amount of the Annual Fee. The Department shall add an adjustment for the non-deductibility of the Annual Fee for Federal and State tax purposes (the "gross-up").

1. *Health Insurance Fee (HIF) Reimbursement Methodology Guide and WI HIF MA Calculation Template*

The guide and template outlining the reporting requirements necessary to receive reimbursement can be found on the ForwardHealth Portal in the Managed Care Organization section. The website is below:

https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabi d/38/Default.aspx

2. *Reporting Timeframes*

The MCO shall submit the following reports to the Department each calendar year in order to receive reimbursement for HIF for the prior year. The schedule below outlines several key dates associated with HIF. Only the dates in bold require the MCO to submit reports to the Department:

Date	*Explanation*
April 1	MCOs submit the NAIC MA filing for the prior year with OCI
April 15	IRS Form 8963 is filed with the IRS
July 15	Corrections to the April 15 filing sent to the IRS
July 31	**The NAIC Exhibits, WI HIF MA Calculation Template (based on 5066C), final IRS Form 8963 and the entire IRS Letter 5066C are sent to DHS**
August 31	IRS will issue the tax bill to the MCOs
September 10	**MCOs will send DHS the NAIC Exhibits, the entire IRS Letter 5066C, IRS Letter 5067C, final IRS Form 8963 and complete WI HIF MA Calculation Template (based on 5067C) and Signed Attestation**
September 30	MCO tax payment is due to the IRS
October 10	DHS will determine final reimbursement associated with the HIF
December 31	By this date, the State will issue a retroactive capitation rate and contract amendment based on the reimbursement

The non-bolded dates are provided for reference only. The MCO is responsible to inform the Department within 5 business days of the due date if an extension is necessary beyond the required dates.

Failure to submit any document, including the attestation form, that the Department finds necessary to calculate and verify the requested Medicaid reimbursement will forfeit the MCO's right to reimbursement. Failure to submit all of the requested documents by the due dates may result in the reimbursement being delayed.

3. *Capitation Rate Report Adjustment*

   The Department will provide reimbursement for the Annual Fee and the gross-up to the MCOs by approximately December 31, of each calendar year. The Department will issue a retroactive capitation rate amendment for the MCO's signature incorporating the MCO specific HIF reimbursement by approximately December 31, of each calendar year. The Department will adjust the acute and primary portion of the MCO capitation rate. The rate will be based on the annualized enrollment from the current calendar year. The HIF capitation rate amendment will not be subject to retroactive enrollment adjustments as the MCO's reimbursement and member months will be fixed at the time of the rate report adjustment.

4. *MCOs Participating in a Wisconsin Medicaid Program Other Than, Or In Addition To, Family Care Partnership*

   The MCO must clearly separate the premiums associated with each contract in a separate exhibit as well as apply all appropriate deductions. The template should include a breakout of the premiums associated with each program.

5. *Noncompliance*

   The Department shall have the right to audit any records of the MCO and to request any information to determine if the MCO has complied with the requirements in this section. If at any time the Department determines that the MCO has not complied with any requirement in this section, the Department will issue an order to the MCO to comply. The MCO shall comply within 15 calendar days after the Department's determination of noncompliance. If the MCO fails to comply after an order, the Department may pursue action against the MCO as provided under Article XVI. Additionally, action may include forfeiture of the reimbursement.

6. *Payment Disputes*

   The Department shall have the right to adjust the reimbursement outside the information provided by the MCO in the guide or template.

   The MCO may dispute the reimbursement amount by sending a letter to the Department no later than 30 days after receipt of payment. After 30 days, the MCO waives the right to dispute the reimbursement amount.

7. *Resolution of Reporting Errors*

   If the MCO discovers a reporting error, the Bureau of Rate Setting in the Division of Medicaid Services must be contacted in writing within 15 days of the discovery.

   Errors discovered after the retroactive capitation rate amendment is issued will be applied to the following year's reimbursement.

MCOs will be responsible for using the most updated version of the guide posted to the website. Questions should be directed by email to: DHSDLTCBFM@dhs.wisconsin.gov

J. Coordination of Benefits (COB)

1. *General Requirement*

The MCO shall ensure the pursuit and collection of monies from primary third party payers for covered services to members under this contract is completed by service providers prior to the MCO payment of claims for contracted services in accordance with 42 C.F.R. §433.138 except where the amount of reimbursement the MCO can reasonably expect to receive is less than the estimated cost of recovery. Pursuit of collections will include third party liability primary insurers and casualty collections such as private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs. If determined that a potentially liable third party exists, the MCO must ensure that the provider bills the third party first before sending the claim to the MCO. If the MCO has paid claims and subsequently discovers the existence of a liable third party it must attempt to recover the money from the liable third party.

In addition, in accordance with 42 C.F.R. §438.3(t), the MCO must enter into a Coordination of Benefits Agreement (COBA) with Medicare, participate in the automated claims crossover process, and execute all deliverables in the agreement.

a. Cost Effectiveness of Recovery

"Cost effectiveness" is determined by, but not limited to, time, effort, and capital outlay required to perform the recovery activity. Upon the Department's request, the MCO must establish the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe and explain the process by which the MCO determines that seeking reimbursement would not be cost effective. Recovery activities include post-payment billing (i.e. pay and chase), and pursuit of the MCO's subrogation rights under Wis. Stat. § 49.89. According to Wis. Stat. § 49.89 and Wis. Adm. Code ch. DHS 106, the MCO has the same COB and collection rights as does the Department, and may require providers to code claims for liability in order to assist with recovery efforts.

b. Section 1912(b) of the Social Security Act

Section 1912(b) of the Social Security Act is construed in a beneficiary-specific manner. The purpose of the distribution provision is to permit the beneficiary to retain third party liability benefits to which he or she is entitled, except to the extent that Family Care or Family Care Partnership is reimbursed for its costs.

The MCO is required, within the constraints of state law and this Contract, to recover the costs it incurred on behalf of its members and is free to make whatever case it can to recover these costs. The MCO may use the

maximum fee schedule, an estimate of what a provider would charge on a FFS basis, the value of the care provided in the market place or some other acceptable proxy as the basis of recovery. But, any excess recovery, over and above the cost of care must be returned to the beneficiary.

c. Types of Collections/Recoveries

i. The MCO must attempt to coordinate benefits with other available resources before claiming reimbursement from the Department for all services meeting the cost effectiveness threshold and all services to:

ii. Other available resources for benefit coordination and recovery may include, but are not limited to, all other state or federal medical care programs that are primary to Family Care or Family Care Partnership, group or individual health insurance, ERISAs, service benefit plans, disability insurance policy, the insurance of absent parents who may have insurance to pay medical care for spouses, subrogation/worker's compensation collections, and any other available medical payments coverage that is issued without regard to liability (even if contained within a liability insurance policy). To the extent payments coverage has been issued directly to a member instead of the MCO or provider for reimbursement of specific claims, the MCO may require such claims to be paid by the member out of these funds.

iii. Subrogation collections are any recoverable amounts arising out of the settlement or other resolution of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the MCO under Wis. Stat. § 49.89(9). After attorneys' fees and expenses have been paid, the MCO will collect the full amount paid on behalf of the member (subject to applicable law). Similarly, the MCO shall have the right to require a full accounting of claims already paid by a liability insurer under medical payments coverage prior to its payment to verify that the MCO is not issuing payment on a claim that has already been paid by an alternate funding source. To the extent a claim is undisputed (for example, worker's compensation or personal injury) and the third party insurer is covering related medical expenses, such insurance shall be considered primary to Medicaid for such claims and should make payment on any related claim(s) prior to payment by the MCO.

iv. In accordance with federal law, certain prenatal care may only be recovered through post-payment billing (pay and chase).

v. Payment of coinsurance or copayment for service under Part B of Medicare may not exceed the MCO's payment rate for the service minus the Medicare payment.

d. Responsibility of Network Providers

COB collections are the responsibility of the MCO or its providers. Providers must report COB information to the MCO. The MCO and provider shall not pursue collection from the enrollee, but directly from the third party payer. Access to services will not be restricted due to COB collection.

2. *Reporting Requirements*

To assure compliance, records shall be maintained by the MCO of COB policies, procedures and resulting collections. Reporting shall be made through the Department LTCare IES reporting system consistent with established protocols and reporting requirements.

The MCO must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for enrollees. The MCO must seek information on other available resources from all enrollees.

3. *MCO that is a Licensed HMO*

The following requirement shall apply if the MCO (or the MCO's parent firm and/or any subdivision or subsidiary of either the MCO's parent firm or of the MCO) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organizations(s), and/or employer self-insurer health plan(s):

a. Throughout the contract term, these insurers and third-party administrators shall comply in full with the provision of Wis. Stat. § 49.475. Such compliance shall include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided shall be consistent with the Department's written specifications.

b. Throughout the contract term, these insurers and third-party administrators shall also accept and properly process post-payment billings from the Department's fiscal agent for health care services and items received by Wisconsin Medicaid enrollees.

4. *Long-Term Care Insurance*

Section 9.2 of the Wisconsin Medicaid Eligibility Handbook instructs that payments from a long-term care insurance policy should be sent to the State of

Wisconsin. The State of Wisconsin will provide a payment to MCOs for long-term care insurance payouts it receives for a member of the MCO. These payments from the State of Wisconsin may be applied to service costs incurred for the member. Service expenditures used in future year capitation rate development will be expenditures net of revenue received by the MCO. If the long-term care insurance payment exceeds the cost of services for the member, then the MCO should forward any remaining amount to the State of Wisconsin through the contact information identified in Section 9.2 of the Wisconsin Medicaid Eligibility Handbook.

If a MCO receives a long-term care insurance payment from any source other than the State of Wisconsin, it should forward the payment to the State of Wisconsin in accordance with the policies identified in Section 9.2 of the Wisconsin Medicaid Eligibility Handbook.

K. Suspension of Payment Based on Credible Allegation of Fraud

1. *Requirement*

The Department shall suspend the capitation payment to the MCO if it determines that there is a credible allegation of fraud by the MCO, unless the Department determines there is good cause for not suspending payments or for only suspending them in part, pursuant to the requirements of 42 C.F.R. § 455.23.

2. *Credible Allegation of Fraud*

A credible allegation of fraud is, as defined in 42 C.F.R. § 455.2, one considered by the Department to have indicia of reliability based on a careful and judicious review by the Department of all assertions, facts and evidence on a case-by-case basis.

3. *Good Cause to Not Suspend Payments*

The Department shall determine whether good cause exists to not suspend payments, to suspend them only in part, or to lift a payment suspension based on the criteria under 42 C.F.R. § 455.23 (e) or (f). Good Cause shall exist if any of the following apply:

a. Law enforcement officials request that a payment suspension not be imposed because of a possible negative affect on an investigation;

b. Other available remedies more effectively or quickly protect Medicaid funds;

c. The Department determines based on written evidence submitted by the MCO that the suspension should be removed;

d. Member access to items or services would be jeopardized by a payment suspension because:

i. The MCO or a provider is the sole source of essential specialized services in a community; or

ii. The MCO or a provider serves a large number of members within an HRSA-designated medically underserved area;

e. Law enforcement declines to certify that a matter continues to be under investigation; or

f. The Department determines that payment suspension is not in the best interests of the Medicaid program.

4. *Notice Requirements*

The Department shall send the MCO written notice of any suspension of capitation payments:

a. Timeframes

i. Within five (5) business days after taking such action unless requested by a law enforcement agency to temporarily withhold such notice; or

ii. Within five (5) business days after taking such action if requested in writing by law enforcement to delay the notice, which request for delay may be renewed in writing up to twice but may not exceed ninety (90) days.

b. Content – The notice shall include the following:

i. A statement that payments are being suspended in accordance with 42 C.F.R. § 455.23.

ii. The general allegations as to the reason for the suspension.

iii. A statement that the suspension is temporary and the circumstances under which it will be ended.

iv. If the suspension is partial, the types of services or business units to which it applies.

v. The MCO's right to submit written evidence for consideration by the Department.

vi. The authority for the MCO to appeal the suspension and the procedures for doing so is Wis. Stats. ch. 277.

5. *Duration of Suspension*

A suspension of payment will end when:

a. The Department or a prosecuting authority determines there is insufficient evidence of fraud;

b. Legal proceedings related to the alleged fraud are completed; or

c. The Department determines there is good cause to terminate the suspension.

L. Recoupments

The Department will not normally recoup the MCO's capitation payments when the MCO has actually provided services. However, the Department may recoup the MCO's capitation payments in the following situations:

1. *Loss of Eligibility*

   The Department will recoup capitation payments made to the MCO on a pro rata basis when a member's eligibility status has changed because:

   a. The member voluntarily disenrolls;

   b. The member fails to meet functional or financial eligibility and the member has exhausted his/her grievances processes including a fair hearing which the member has requested;

   c. The member initiates a move out of the MCO service area;

   d. The member fails to pay, or to make satisfactory arrangements to pay, any cost share amount due the MCO after a thirty (30) calendar day grace period;

   e. The member dies; or,

   f. The member is ineligible for Medicaid as an Institutionalized Individual consistent with 42 C.F.R. § 435.1009 and as defined in 42 C.F.R. § 435.1010.

   No recoupment under this section will occur unless the MCO knew, or should have known, of such status change.

2. *Other Reasons for Recoupment*

   The Department will recoup the MCO's capitation payments for the following situations:

   a. Correction of a computer or human error; and

   b. Disenrollment of members.

3. *Disputed Membership*

   When membership is disputed, the Department shall be the final arbitrator of membership and reserves the right to recoup capitation payments that were inappropriately made.

4. *Contract Termination*

   If a contract is terminated, recoupments will be accomplished through a payment by the MCO within thirty (30) business days of contract termination.

M. IMD Stays Within a Capitation Month For Members Age 21-64

1. *No Capitation Payable*

   a. No capitation is payable to an MCO for the days of any month in which a member age 21-64 is in an IMD, unless a stay of no more than 15 days is covered by the MCO for a Partnership member as an in lieu of service pursuant to Article VII.A.7.c. Where an IMD stay is not covered as an in lieu of service, a partial capitation is payable for the days in such a month that the member is not in an IMD.

   b. Unless an IMD stay of a member age 21-64 is covered by the MCO as an in lieu of service, only the MCO's encounters for the days of the month that the member is not in the IMD are taken into account in setting capitation rates.

2. *Coverage of IMD as an Alternate Service*

   If a Partnership member age 21-64 has an IMD stay that is not covered by the MCO as an in lieu of service or that exceeds 15 days in a month, the MCO may cover the stay as an alternate service provided the conditions under Article VII.A.6 are met. However no capitation is payable to the MCO for the days of the month the member is in the IMD. MCO encounters where the IMD stay is covered as an alternate service are not included in rate-setting.

XIX. MCO Specific Contract Terms

A. Program

This contract covers the _____ Program. [Insert Family Care or Family Care Partnership]

B. Geographic Coverage Where Enrollment Is Accepted

The MCO will provide services in the following counties:

County	RFP Number	Contract Term
Geographic Service Region 1		
1. Chippewa	S-0505 DLTC-17	01/01/19-12/31/20
2. Dunn	S-0505 DLTC-17	01/01/19-12/31/20
3. Eau Claire	S-0505 DLTC-17	01/01/19-12/31/20
4. Pierce	S-0505 DLTC-17	01/01/19-12/31/20
5. St. Croix	S-0505 DLTC-17	01/01/19-12/31/20
6. Taylor	S-0505 DLTC-17	01/01/19-12/31/20
Geographic Service Region 2		
7. Buffalo	S-0647 DMS-17	01/01/20-12/31/21
8. Clark	S-0647 DMS-17	01/01/20-12/31/21
9. Jackson	S-0647 DMS-17	01/01/20-12/31/21
10. La Crosse	S-0647 DMS-17	01/01/20-12/31/21
11. Monroe	S-0647 DMS-17	01/01/20-12/31/21
12. Pepin	S-0647 DMS-17	01/01/20-12/31/21
13. Trempealeau	S-0647 DMS-17	01/01/20-12/31/21
14. Vernon	S-0647 DMS-17	01/01/20-12/31/21
Geographic Service Region 3		
15. Crawford	S-0647 DMS-17	01/01/20-12/31/21
16. Grant	S-0647 DMS-17	01/01/20-12/31/21
17. Green	S-0647 DMS-17	01/01/20-12/31/21
18. Iowa	S-0647 DMS-17	01/01/20-12/31/21
19. Juneau	S-0647 DMS-17	01/01/20-12/31/21
20. Lafayette	S-0647 DMS-17	01/01/20-12/31/21
21. Richland	S-0647 DMS-17	01/01/20-12/31/21
22. Sauk	S-0647 DMS-17	01/01/20-12/31/21
Geographic Service Region 4		
23. Florence	S-0505 DLTC-17	01/01/19-12/31/20
24. Forest	S-0505 DLTC-17	01/01/19-12/31/20
25. Langlade	S-0505 DLTC-17	01/01/19-12/31/20
26. Lincoln	S-0505 DLTC-17	01/01/19-12/31/20
27. Marathon	S-0505 DLTC-17	01/01/19-12/31/20
28. Oneida	S-0505 DLTC-17	01/01/19-12/31/20
29. Portage	S-0505 DLTC-17	01/01/19-12/31/20

County	RFP Number	Contract Term
30. Vilas	S-0505 DLTC-17	01/01/19-12/31/20
31. Wood	S-0505 DLTC-17	01/01/19-12/31/20
Geographic Service Region 5		
32. Adams	S-0505 DLTC-17	07/01/19-12/31/20
33. Columbia – Family Care	S-0505 DLTC-17	07/01/19-12/31/20
34. Columbia – Partnership	S-0505 DLTC-17	01/01/19-12/31/20
35. Dodge	S-0505 DLTC-17	07/01/19-12/31/20
36. Dodge – Partnership	S-0505-DLTC-17	01/01/19-12/31/19
37. Green Lake	S-0505 DLTC-17	07/01/19-12/31/20
38. Jefferson	S-0505 DLTC-17	07/01/19-12/31/20
39. Jefferson – Partnership	S-0505 DLTC-17	01/01/19-12/31/19
40. Marquette	S-0505 DLTC-17	07/01/19-12/31/20
41. Waushara	S-0505 DLTC-17	07/01/19-12/31/20
Geographic Service Region 6		
42. Ozaukee – Family Care	S-0505 DLTC-17	07/01/19-12/31/20
43. Ozaukee – Partnership	S-0505 DLTC-17	01/01/19-12/31/20
44. Sheboygan	S-0505 DLTC-17	07/01/19-12/31/20
45. Walworth	S-0505 DLTC-17	07/01/19-12/31/20
46. Washington – Family Care	S-0505 DLTC-17	07/01/19-12/31/20
47. Washington – Partnership	S-0505 DLTC-17	01/01/19-12/31/20
48. Waukesha – Family Care	S-0505 DLTC-17	07/01/19-12/31/20
49. Waukesha – Partnership	S-0505 DLTC-17	01/01/19-12/31/20
50.		
Geographic Service Region 7		
51. Ashland	S-0707 DMS-18	01/01/19-12/31/20
52. Barron	S-0707 DMS-18	01/01/19-12/31/20
53. Bayfield	S-0707 DMS-18	01/01/19-12/31/20
54. Burnett	S-0707 DMS-18	01/01/19-12/31/20
55. Douglas	S-0707 DMS-18	01/01/19-12/31/20
56. Iron	S-0707 DMS-18	01/01/19-12/31/20
57. Polk	S-0707 DMS-18	01/01/19-12/31/20
58. Price	S-0707 DMS-18	01/01/19-12/31/20
59. Rusk	S-0707 DMS-18	01/01/19-12/31/20
60. Sawyer	S-0707 DMS-18	01/01/19-12/31/20
61. Washburn	S-0707 DMS-18	01/01/19-12/31/20
Geographic Service Region 8		
62. Milwaukee – Family Care	S-0707 DMS-18	01/01/19-12/31/20
63. Milwaukee – Partnership	S-0706 DMS-18	01/01/19-12/31/20
Geographic Service Region 9		
64. Fond du Lac	DHS RPA FHI0876	01/01/20-06/30/20
65. Manitowoc	DHS RPA FHI0876	01/01/20-06/30/20
66. Winnebago	DHS RPA FHI0876	01/01/20-06/30/20

County	RFP Number	Contract Term
Geographic Service Region 10		
67. Calumet	DHS RPA FHI0876	01/01/20-06/30/20
68. Outagamie	DHS RPA FHI0876	01/01/20-06/30/20
69. Waupaca	DHS RPA FHI0876	01/01/20-06/30/20
Geographic Service Region 11		
70. Kenosha	S-0647 DMS-17	01/01/20-12/31/21
71. Racine	S-0647 DMS-17	01/01/20-12/31/21
Geographic Service Region 12		
72. Dane – Family Care	S-0648 DMS-17	01/01/20-12/31/21
73. Dane - Partnership	S-0706 DMS-18	01/01/19-12/31/20
Geographic Service Region 13		
74. Brown	S-0797 DMS-19	01/01/20-12/31/21
75. Door	S-0797 DMS-19	01/01/20-12/31/21
76. Kewaunee	S-0797 DMS-19	01/01/20-12/31/21
77. Marinette	S-0797 DMS-19	01/01/20-12/31/21
78. Menominee	S-0797 DMS-19	01/01/20-12/31/21
79. Oconto	S-0797 DMS-19	01/01/20-12/31/21
80. Shawano	S-0797 DMS-19	01/01/20-12/31/21
Geographic Service Region 14		
81. Rock	Not applicable	01/01/20-12/31/21

The MCO is permitted to phase in operations in the following counties as long as the MCO services are fully implemented by December 31, 2020:

a. County 1

b. County 2

C. Contracting Contingencies:

Contracting is contingent upon:

1. The contractor being certified by the Department as a managed care organization to provide the services in the Family Care benefit package and/or the Partnership benefit package to the projected enrollment.
2. For Family Care, the contractor being permitted by the Office of the Commissioner of Insurance (OCI) to transact the business of Care Management Organization – Family Care.
3. For Partnership, the MCO filing a business plan amendment with OCI in accordance with s. Ins 9.06, Wis. Adm. Code.
4. For Partnership, the MCO having a contract with CMS to offer a Dual Eligible SNP in the counties listed in B. above.
5. For Partnership, the MCO being approved by CMS to expand its service area to include the counties listed in paragraph B above. The MCO must notify the

Department of a planned service area expansion when it submits a service area expansion application to CMS. The MCO must also notify the Department as soon as it receives approval from CMS for a service area expansion.

D. Maximum Enrollment Level

The Department does not guarantee any minimum enrollment level.

Expansion Areas: Enrollment of current waiver participants and persons on waiting lists in expansion areas will be limited by a transition enrollment plan approved by the Department.

E. Age Group

This contract covers people beginning on the first date they achieve the age of 18.

F. Target Group

This contract covers:

1. Adults with physical disabilities, including persons with Alzheimer's disease or terminal illness;
2. Adults with developmental disabilities; and
3. Frail elders, including persons with Alzheimer's disease or terminal illness.

G. Capitation Rate

GSR 10 – list counties

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			

H. Signatures

In WITNESS WHEREOF, the State of Wisconsin and the MCO have executed this agreement:

Executed on behalf of Name of MCO	Executed on behalf of Department of Health Services
_____	_____
Authorized Signer Chief Executive Officer	Julie Willems Van Dijk Deputy Secretary
_____	_____
Date	Date

ADDENDUM

I. Actuarial Basis

A. Actuarial Soundness of Capitation Rates

Upon completion, the 2020 actuarial rate report for the Family Care and Partnership contracts will be posted to: https://www.dhs.wisconsin.gov/familycare/mcos/capitationrates.htm.

B. Retrospective Adjustments

1. *HIV/AIDS and Vent Dependent Acute and Primary Retrospective Adjustment – Partnership program*

For Partnership enrollees who meet the criteria in this section, the MCO is not at financial risk for changes in utilization or for Medicaid state plan acute and primary costs incurred that do not exceed the upper payment limits specified in 42 C.F.R. § 447.362. The Department will reimburse the MCOs annually for incurred cost for Medicaid-covered state plan acute and primary services provided to MCO enrollees who meet the criteria in this section. Acute and primary services are defined as services included in the development of the acute and primary portion of the capitation rate. These payments will be made based on the data submitted by the MCO to the Department via monthly encounter reporting utilizing the LTCare IES. The data submission schedule is included at https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf. For the purposes of calculating reimbursement for an MCO's enrollees who meet the criteria under this section, the encounter data submitted for acute and primary services will be priced at the Medicaid Fee-For-Service rates by the Department. Reimbursement already provided to the MCO for Medicaid costs in the form of the acute and primary component of capitation payments for qualified enrollees will be deducted from the repriced reimbursement payments for Medicaid costs. No reimbursement will be made for the long term care services provided or to the long term care component of the capitation payments as part of this adjustment.

The criteria for qualified enrollees are:

a. Ventilator Assisted Patients

Costs incurred for enrollees who need ventilator treatment services qualify for reimbursement if the enrollee meets the following criteria:

i. Criteria

For the purposes of this reimbursement, a ventilator-assisted patient must have died while on total respiratory support (or within 48 hours of removing total respiratory support) or must meet all of the criteria below:

a) The patient must require equipment that provides total respiratory support. This equipment may be a volume ventilator, a negative pressure ventilator, a continuous positive airway pressure (CPAP) system, or a Bi (inspiratory and expiratory) PAP. The patient may need a combination of these systems. Any equipment used only for the treatment of sleep apnea does not qualify as total respiratory support.

b) The total respiratory support must be required for a total of six or more hours per twenty-four (24) hours.

c) The patient must have total respiratory support for at least thirty (30) days, which need not be continuous.

d) The patient must have absolute need for the respiratory support as documented by appropriate blood gases.

ii. Documentation

The MCO will submit the following written documentation to qualify enrollees for reimbursement.

a) Member's full name, Medicaid ID, MCO requested start and end date for reimbursement, and amount of actual or anticipated payments from other sources.

b) A signed statement from the doctor attesting to the need of the patient.

c) Copies of progress notes that show the need for continuation of total ventilatory support, any change in the type of ventilatory support, and the removal of the ventilatory support.

d) Copies of lab reports must be submitted if the progress notes do not include blood gas levels.

iii. Methodology

The following methodology will be used to determine months that qualify for enhanced funding:

a) The first qualifying day is the day that the patient is placed on the ventilator. If the patient is on the ventilator for less than six hours on the first day, the use must continue into the next day and be more than six total hours.

b) Each day that the patient is on the ventilator for a part of any day, as long as it is part of the six total hours per twenty-four (24) hours, counts as a day for enhanced funding.

c) The period qualifying for enhanced funding starts on the first day of the month that the patient was placed on ventilator support. It ends on the last day of the month after which the patient is removed from the ventilatory support, or at the end of the hospital stay, whichever is later.

iv. Additional Reimbursement

Any additional reimbursement, received or anticipated, not reported in the encounter data should be disclosed when the MCO requests reimbursement. This includes, but is not limited to, reinsurance and third party liability payments.

b. AIDS or HIV-Positive with Antiretroviral Drug Treatment

i. Criteria

For the purposes of this reimbursement an individual with AIDS or HIV must meet the criteria below:

a) A signed statement from the doctor that indicates a diagnosis of AIDS or HIV-Positive (ICD10-CM diagnosis code)

b) Documentation that the patient is on an Antiretroviral Drug treatment approved by the Federal Drug Administration.

ii. Documentation

Written requests to qualify enrollees for reimbursement must be submitted by the MCO to the Department within 365 days of the first date of service for which the MCO is requesting payment. The request must include the member's full name, Medicaid ID, MCO requested start and end date for reimbursement, amount of actual or anticipated payments from other sources, and the required medical documentation.

iii. Methodology

The following methodology will be used to determine enhanced funding:

a) Reimbursement of acute and primary Medicaid services at the Medicaid Fee-For-Service rates will be available for services provided on or after the first day of the month in which treatment begins.

b) Any additional reimbursement, received or anticipated, not reported in the encounter data should be disclosed when the MCO requests reimbursement. This includes, but is not limited to, reinsurance and third party liability payments.

c) For AIDS and HIV-Positive members retroactively disenrolled under Article IV, Enrollment and Disenrollment, of the contract, the MCO will have to remove the care provided during the backdated period from the Department's LTCare IES.

c. Submission of Data for Ventilator Assistance and AIDS Treatment.

As required by Wisconsin law, payment data or adjustment data for enrollees in ss. b. iii. (a) and (c) above, must be received within the Department's LTCares IES within three hundred sixty-five (365) days after the date of the service. If the MCO cannot meet this requirement, the MCO must provide good cause documentation that substantiates the delay. The Department will make the final determination to waive the three hundred sixty-five (365) day billing requirement.

2. *Vent Dependent Long Term Care Retrospective Adjustment – Family Care and Partnership programs*

The Department will retroactively adjust the long-term care capitation rate for a change in the number of members dependent on ventilators between the base year and the rate year for an MCO.

The intent of this adjustment is to better reflect within the long-term care capitation rate method a change in the proportion of an MCO's membership who are ventilator dependent between the population in the base data and contract period enrollment. This adjustment pertains only to the current contract period and shall not be interpreted to apply to any other contract periods. This adjustment will be based on the Long Term Care Functional Screen and enrollment data used to develop capitation rates for the next contract year.

The methodology for calculating an adjustment:

a. Identify the predicted per member per month long-term care cost for an MCO's base year population from the rate report.

b. Identify the predicted per member per month long-term care cost for an MCO's base year population when the proportion of members dependent on ventilators is updated to reflect the actual contract period experience.

c. Calculate the per member per month cost difference between the rate report and actual contract period amounts.

d. Multiply the cost difference by actual contract period member months.

This amount shall represent the retrospective rate adjustment.

3. *Nursing Home Closures – Family Care and Partnership programs*

   When requested by an MCO, the Department will consider an adjustment in the capitation rate if the MCO quantifies a material cost increase due to an increase in the number of members who meet both of the following conditions:

   a. Have a nursing home stay greater than 100 consecutive days; and

   b. Become a member during the contract period within thirty-two (32) calendar days of their nursing home discharge date, or enrolled in the program while residing a nursing home.

   If the Department approves the request for an adjustment, the method used to calculate the adjustment will be as follows: the predicted per member per month long-term care cost (using the contract period's long-term care capitation rate model) will be calculated for the MCO's total membership, including the individuals meeting the above criteria. That predicted cost will be compared to the predicted per member per month long-term care cost based on the MCO's membership but excluding the individuals meeting the above criteria. The rate adjustment will be equal to the difference in those two per member per month long-term care cost figures.

   The intent of this adjustment is to better reflect within the long-term care component of the capitation rate method a material change in the proportion of an MCO's membership who are nursing home residents between the base population and the contract period enrollment. This adjustment pertains only to the current contract period and shall not be interpreted to apply to any other contract periods.

4. *Money Follows the Person Relocation Incentive Payment - Family Care and Partnership programs*

   The Department will provide an incentive payment to the MCO of $1,000 for each member of an MCO who is relocated from an institution into a community setting during the calendar year consistent with federal Money Follows the Person (MFP) guidelines.

   The amount of payment provided to an MCO will be determined after the end of the calendar year. The MCO will submit before December 31 of the calendar year a list of members for whom the MCO anticipates a receipt of an incentive payment. The Department will compare the MCO's list of members to the Department's list of Medicaid members for whom the Department is receiving an enhanced Medicaid match through the MFP program to determine the number of relocations to use for calculating the incentive payment to the MCO. The Department will notify the MCO of the estimated amount of the incentive payment and the list of MCO members for whom an incentive payment is being made prior to issuing the incentive payment.

The Money Follows the Person Relocation Incentive Payment arrangement is conducted in compliance with 42 C.F.R. 438.6(2)(b):

a. The payment may not exceed 105 percent of the approved capitation payment attributable to the members or services covered by the incentive payment;

b. The incentive arrangement is for a calendar year (a single per member payment available at the end of each 12-month rating period for that rating period);

c. Performance for the incentive arrangement must be measured during the rating period in which the incentive arrangement is applied.

d. The incentive arrangement does not renew automatically. At the end of each 12-month rating period the Department will reassess whether the arrangement will be made available for the subsequent 12-month rating period;

e. The incentive arrangement is available to all MCOs under the same terms of performance;

f. MCO participation in the incentive arrangement is not conditioned on the MCO entering into or adhering to intergovernmental transfer agreements.

g. This incentive arrangement is necessary to promote successful relocations of Family Care and Family Care Partnership members from institutions to community-based settings, as specified in the State's quality strategy required under Code of Federal Regulations Title 42, Chapter IV, Subchapter C, §438.340.

5. *Dual Eligibility Status – Partnership program*

The acute care component of the capitation rate shall be retrospectively adjusted to reflect the difference in the actuarially projected and actual proportion of an MCO's enrollees who are dually eligible for both Medicare and Medicaid coverage. For the purposes of this retrospective adjustment, enrollees are considered dual eligible if they are at least enrolled in Medicare Parts A and D. This adjustment will be based on the Medicare eligibility and enrollment data used to develop capitation rates for the next contract year.

6. *Target Group Mix – Family Care and Partnership programs*

Once sufficient data for the completed contract period is available, capitation rate for members with a nursing home level of care shall be adjusted for the actual target group mix of an MCO's membership, based on long-term care functional screen information, relative to the assumed target group mix in the prospective actuarial rate calculations.

The intent of this adjustment is to better reflect within the long-term care component of the capitation rate method the proportion of an MCO's membership

in each of the target groups. This adjustment pertains only to the current contract period and shall not be interpreted to apply to any other contract periods.

The method for this adjustment is as follows:

a. The capitation rate will be recalculated after the completion of the contract year and once sufficient long-term care functional screen, eligibility, and enrollment information is available. Specifically, the target group mix assumptions used to develop the long-term care component of the prospective capitation rate will be updated to account for the actual enrolled target group mix for the nursing home level of care population. The actual enrolled target group mix will be based on the Long Term Care Functional Screen and enrollment data used to develop capitation rates for the next contract year.

b. This rate will be compared to the capitation rate that was paid.

c. The difference between the new rate and the rate paid during the contract year will be multiplied by actual enrollment during the retrospective period to determine the retrospective adjustment that will be paid to or recouped from the MCO. Actual enrollment will be based on the enrollment data used to develop capitation rates for the next contract year.

7. *Long-Term Care Functional Status - Family Care and Partnership programs*

In new service regions for a program (i.e., regions or target groups in which the program has not previously provided services) the long-term care component of the capitation rate shall be adjusted for the actual acuity of an MCO's membership, as measured by the long-term care functional screen, relative to the acuity assumed in the prospective actuarial rate calculations.

The intent of this adjustment is to better reflect within the long-term care component of the capitation rate method a significant acuity change between the base population assumed in the calculation of the prospective capitation rate and the population enrolled in the program during the contract period. This adjustment will be implemented for the first three years the program covers a new service region. However, this adjustment pertains only to the current contract period and shall not be interpreted to apply to any other contract periods.

The method for this adjustment is as follows:

a. The long-term care component of the capitation rate will be re-calculated at the end of the contract period, using the same actuarial rate setting method as outlined above, to account for actual enrolled members' functional status as determined through the long-term care functional screen. Specifically, the case mix assumptions used to develop the long-term care component of the prospective capitation rate will be updated to account for the actual enrolled case mix. This adjustment will be based on the Long Term Care Functional Screen and enrollment data used to develop capitation rates for the next contract year.

b. This rate, recalculated to reflect actual enrolled members' functional status, will replace the original contracted capitation rate at the end of the contract period through a retrospective rate adjustment.

8. *High Cost Risk Pool – Family Care and Partnership programs*

The Department will use a portion of all MCOs' capitation rates to fund one risk pool for the developmental disability target group and another risk pool for the physical disability and frail elder target groups. The pools are intended to reimburse MCOs for "eligible costs" defined as 80% of long term care service costs, excluding care management, above $225,000 that MCOs incur for any one member during the contract period. Each MCO's eligible costs will be determined based on the encounter data submitted to the Department by April 30th of the following year. For each pool, MCOs will receive a percentage of the pooled funds equal to the MCO's percentage of statewide eligible costs. If statewide eligible costs exceed the pooled funds, MCOs will not be fully reimbursed for their eligible costs. If statewide eligible costs are less than the pooled funds, MCOs will be reimbursed for their eligible costs and any remaining funds will be distributed as a risk pool specific PMPM for all member months during the contract period.

ADDENDUM

II. Requirements for Memoranda of Understanding

The MCO is required to negotiate, or make a "good faith" effort to negotiate to have the following Memoranda of Understanding (MOU). The MCO shall submit MOUs referred to in this contract to the Department upon the Department's request. The MCO shall submit copies of changes in MOUs to the Department within fifteen (15) business days of the effective date of the MOU.

Title	Purpose	Party	Contract Provisions
Aging & Disability Resource Center	The MCO will cooperate fully in executing a memorandum of understanding or other written agreement with each ADRC within its service area that describes the circumstances in which the MCO will provide services to an individual who is functionally eligible but whose financial eligibility is pending.	All ADRCs within the MCO's service areas	Article IV.A.3.
Adult Protective Services MOU	The MCO will cooperate fully in executing memoranda of understanding with all county agencies in its service area that are responsible for adult protective services. The memoranda will define the roles and relationships of the county EA/AAR/APS agencies and the MCO as they work together to assure the care and safety of adults at risk who have been abused, neglected or financially exploited.	The county agencies that are responsible for Adult Protective Services in the MCO's service area	Article VII.N, Elder Adults/Adults at Risk Agencies and Adult Protective Services
MOU on Institute for Mental Disease (IMD) Discharge Planning	The expectation for discharge planning when the member, someone who was a member prior to losing eligibility due to institutional status, or someone who is eligible to enroll upon discharge, who is currently a resident of an IMD. The purpose of this discharge planning will be to return the individual to the most integrated setting appropriate to his/her needs.	All counties within the MCO's service areas	Article VII.P, MOU on Institute for Mental Disease (IMD) Discharge Planning
Disaster Planning and Emergency Response MOU	The MCO will be familiar with, and have involvement in, the emergency government plan of the counties in which they are providing services. The MOU will address the MCO's role in emergency response.	Each county in the MCO's service area	Article XIII.L, Business Continuity

Title	Purpose	Party	Contract Provisions
General MOU	An MCO may enter into an MOU with a business, provider or similar entity. Such an MOU may not violate any of the requirements found in this contract concerning contracts, subcontracts, or agreements between the MCO and a business, provider or similar entity	A business, provider or similar entity	Article XIII.E

ADDENDUM

III. MCO Quality Indicators

This addendum lists the quality indicators the MCO will report directly to the Department.

A. Quality Indicators

The following quality indicators pertain to Family Care and Partnership as specified:

1. *Family Care and Partnership*
   a. Care management (IDT staff) turnover
   b. Influenza vaccinations
   c. Pneumococcal (Pneumovax vaccinations)
2. *Partnership*
   a. Dental visits – this data will be compiled by the Department.

The Department will issue a technical assistance memo providing instructions for each of the quality indicators and definitions to be utilized by September 30 of the previous year (e.g., September 30, 2013 for 2014 quality indicators).

B. Other Quality Indicators –Partnership Program

The Partnership program must report to the Department all quality indicators and supporting information that are reported to CMS and any other entities which has quality oversight authority over the Partnership program. Quality indicators will include any available measures of members' outcomes (clinical, functional and personal experience outcomes). Reports must be submitted to the Department within ten (10) business days of being reported to the other entities. Reports should exclude member-specific identifying information, unless otherwise requested by the Department.

ADDENDUM

IV. Performance Improvement Projects

A. Performance Improvement Projects: Guidance

The following link should be used as guidance in developing a performance improvement project: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

This link opens to a webpage titled "Quality of Care External Quality Review (EQR)."

- **For PIP Validation: (Protocol 3):** Scroll down to "EQR-Related Activities and Protocols" → "Mandatory EQR-Related Activity Protocols" → "Protocol 3"
  - Click on "EQR Protocol 3: Validating Performance Improvement Projects (PIPS)"
    - Protocol 3:
      - Describes the components for PIP validation used by the EQRO
      - Is the direct reference for the *PIP Annual Report Format Guideline* provided by the EQRO
  - **For PIP Implementation: (Protocol 7:** describes the steps for conducting a PIP): Scroll down to "Optional EQR-Related Activity Protocols" → "Protocol 7"
  - Click on "EQR Protocol 7"
    - Protocol 7:
      - Describes the steps for conducting a PIP
      - Is intended as a guide for development of a PIP project

ADDENDUM

V. Data Certification

A. Encounter Data Certification

This certification requires the responsible party to attest that the submitted Encounter Data is accurate, complete and truthful to the best of his/her knowledge. This is required by 42 C.F.R. § 438.600 (e.g.) and the managed long-term care contract. **It is the responsibility of the certifying party to assure the necessary internal checks, audits, and testing procedures have been conducted to ensure the integrity of the data.**

After the MCO receives the **submission status report** indicating that the MCO's data has been **accepted and free of batch reject errors**, certification shall be made via the automated data certification method or, when the automated function is not available, via the Data Certification Form. The form is provided by DHS in accordance with 42 C.F.R. § 438.600. If it is necessary to use the form, it shall be emailed to the Department (DHSBMC@dhs.wisconsin.gov).

B. Financial Certification

This certification requires the responsible party to attest that the submitted financial statement is accurate, complete and truthful to the best of his/her knowledge. This is required by 42 C.F.R. § 438.600 (e.g.) and the managed long-term care contract. **It is the responsibility of the responsible party to develop the necessary internal checks, audits, and testing procedures to assure the integrity of the financial statement.**

Certification must be included with submission of the financial statement to the State. Email the completed form to the Department (DHSLTCFiscalOversight@dhs.wisconsin.gov).

Form should be created on MCO letterhead

ENCOUNTER DATA CERTIFICATION

Pursuant to the Family Care Partnership Program contract(s) between the State of Wisconsin, Department of Health Services, Division of Long-Term Care, and the _____ _____ Managed Care Organization, hereafter known as the MCO. The MCO certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as an MCO. The MCO acknowledges that Federal Code 42 C.F.R. § 438.600 (e.g.) requires that the data submitted must be certified by a Chief Financial officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Wisconsin Medicaid program based on encounter data submitted and in so doing makes the following certification to the State of Wisconsin as required by Federal Code 42 C.F.R. § 438.600 (e.g.).

The MCO has reported to the State of Wisconsin for the month/year of _____ all new encounters included in batch ID# _____. The MCO has reviewed the encounter data for the period and batch listed above and I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, _____(enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) **acknowledge that the information described above may directly affect the calculation of payments to the MCO. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact**.

_____ _____

SIGNATURE - NAME AND TITLE OF CFO, CEO OR DELEGATE DATE SIGNED

Form should be created on MCO letterhead.

FINANCIAL STATEMENT CERTIFICATION

Pursuant to the Family Care Partnership Program contract(s) between the State of Wisconsin, Department of Health Services, Division of Long-Term Care, and the _____ _____ Managed Care Organization, hereafter referred to as the MCO. The MCO certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as an MCO.

The MCO acknowledges that if payment is based on any information required by the State and contained in financial statements, Federal Code 42 C.F.R. § 438.600 (e.g.) requires that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Wisconsin Medicaid program based on any information required by the State and contained in financial statements submitted and in so doing makes the following certification to the State of Wisconsin as required by Federal Code 42 C.F.R. § 438.600 (e.g.).

The MCO has reported to the State of Wisconsin for the period of _____ _____ (indicate dates) all information required by the State and contained in financial statements. The MCO has reviewed the information submitted for the period listed above and I, _____ _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) **acknowledge that the information described above may directly affect the calculation of payments to the MCO. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.**

_____ _____

SIGNATURE - NAME AND TITLE OF CFO, CEO OR DELEGATE **DATE SIGNED**

ADDENDUM

VI. Personal Experience Outcomes in Long-Term Care

Assisting people to achieve their desired individual quality-of-life outcomes is one of the primary goals of managed long-term care. The following personal experience outcome domains are the areas of life that people in long-term care programs have identified as being important to their quality of life. They provide a framework for learning about and understanding the individual's needs, values, preferences, and priorities in the assessment and care planning process and in monitoring the quality of our long-term care programs. It is expected that each of these domains will be assessed during the member-centered planning process.

Choice – choosing:

- Where and with whom to live
- Supports and services
- Daily routines

Personal Experience – having:

- Interaction with family and friends
- Work or other meaningful activities
- Community involvement
- Stability
- Respect and fairness
- Privacy

Health and Safety – being:

- Healthy
- Safe
- Free from abuse and neglect

ADDENDUM

VII. Benefit Package Service Definitions

A. Home and Community-Based Waiver Services

Services under a waiver service category may not duplicate any service provided under another waiver service category or through the Medicaid State Plan.

The following services, defined in Wisconsin's s. 1915 (c) home and community-based waiver services waiver #0367.90 required under Wis. Stat. § 46.281(1)(d) and approved by the Centers for Medicare & Medicaid Services (CMS) are included in the Family Care and Partnership benefit packages:

1. **Adaptive aids** are controls or appliances that enable members to increase their abilities to perform ADLs and IADLs or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable members to access, participate and function in their community and competitive integrated employment. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications, etc. that allow the vehicle to be used by the member to access the community) or those costs associated with the maintenance of these items. The adaptive aids service includes the evaluation of the adaptive aids needs of a member, including a functional evaluation of the impact of the provision of appropriate adaptive aids in the customary environment of the member. The adaptive aids service also includes (1) the purchase of a fully trained service dog from a reputable provider with experience providing structured training for service dogs; (2) the post-purchase training with a reputable provider with experience providing structured training for service dogs necessary to partner a fully trained service dog with its owner (i.e. enable the fully trained service dog and the member to work together); and (3) the ongoing maintenance costs of a fully trained service dog obtained from a reputable provider with experience providing structured training for service dogs based on DHS guidelines. For the purpose of coverage as an adaptive aid benefit, a service dog is a dog that has been individually trained by a reputable provider experienced in providing structured training for service dogs to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability. Excludes costs related to a dog that does not meet the definition of a service dog for the purpose of coverage as an adaptive aid benefit (i.e. emotional support dog, therapy dog, dog training to become a service dog, household pet). Providers of adaptive aids must be Medicaid certified providers (excluding service dog providers). Electronic devices must meet UL or FCC standards. For service dogs, provider must be a reputable provider with experience providing structured training for service dogs.

2. **Adult day care services** are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision, and/or protection. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site. Transportation between the member's place of residence and the adult day care center may be provided as a component of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day). The MCO may only enter a provider agreement with adult day care centers that have been certified by the Department, under Wis. Stat. § 49.45(2)(a)(11), to provide adult day care services.

3. **Assistive technology/communication aid** is an item, piece of equipment or product system--whether acquired commercially, modified, or customized-- that enables members to (1) increase their ability to perform ADLs and IADLs or control the environment in which they live and (2) access, participate, and function in their community and in competitive integrated employment. Assistive technology is a service that directly assists a member in the selection, acquisition, or use of an assistive technology device. Assistive technology includes the following:

   a. Evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services in the customary environment of the member;

   b. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the member;

   c. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;

   d. Coordination and use of necessary therapies, interventions or services with assistive technology devices, such as therapies, interventions or services associated with other services in the service plan;

   e. Training or technical assistance for the member or, where appropriate, family members, advocates, legal decision makers, or other persons designated by the member; and

   f. Training or technical assistance for professionals or other individuals who provide services to, employ or are otherwise substantially involved in the major life functions of members.

   Assistive technology includes communication aids, which are devices or services needed to assist members with hearing, speech, communication or vision impairments. These items or services assist the individual to effectively

communicate with others, decrease reliance on paid staff, increase personal safety, enhance independence, and improve social and emotional well-being.

Communication aids include any device that addresses these objectives such as augmentative and alternative communication systems, hearing or speech amplification devices, aids and assistive devices, interpreters, cognitive retraining aids and the repair and/or servicing of such systems. Communication aids also include electronic technology, such as tablets, mobile devices and related software that assists with communication, when the use provides assistance to a person who needs such assistance due to his or her disabilities. Applications for mobile devices or other technology also are covered under this service, when the use is primarily medical in nature or provides assistance to a member who needs such assistance due to his or her disabilities. This list is intended to be illustrative and is not exhaustive. Excludes interpreter services that are otherwise available, including for communication with the managed care organization, its contractors or other health care professionals, which are required to provide interpreter services as part of their rate.

Individual interpreters must be on the state or national interpreter registry. Communication aids vendors must be Medicaid certified providers. Electronic devices must meet UL or FCC standards.

4. **Care management** (sometimes called support and service coordination) is provided by an interdisciplinary care management team (IDT). The member is the center of the IDT. The IDT consists of, at minimum, a registered nurse and a social services coordinator, and may also include other professionals as appropriate to the needs of the member, as well as family or other informal supports requested by the member. The IDT initiates and oversees the initial comprehensive assessment of needs and reassessment process, the results of which are used in developing the individual's member-centered plan (MCP). The IDT identifies the member's preferred outcomes and the services needed to achieve those outcomes and monitors the member's health and welfare, the delivery of services, and progress in achieving identified outcomes. The IDT also carries out activities that help members and their families to identify other service needs and gain access to medical, social, rehabilitation, vocational, educational and other services identified.

   Care management is always provided by individuals employed by the managed care organization or by a subcontracted agency of the managed care organization. Care management services are provided by the case manager with the member and other participants of the IDT team and include:

   a. A comprehensive assessment of the member's strengths, abilities, functional limitations, lifestyle, personal circumstances, values, preferences and choices;

   b. Development of the MCP;

   c. Authorization for the purchase of paid services identified in the MCP;

d. Monitoring of the delivery and quality of the paid services identified in the MCP;

e. Monitoring of the member's circumstances and ongoing health and well-being;

f. Maintenance of the member record and all documentation associated with the delivery of services and any required waiver procedures; and

g. Development of a plan to assure continuity of the member's independence, care, living arrangements, and preferences in the face of changes in circumstances.

For providers of this service: Wis. Stat. Ch. 441 applies to Registered Nurses. A Social Service Coordinator is required to be one of the following:

a. A social worker certified under Wis. Stat. Ch. 457 with a minimum of one (1) year's experience working with at least one of the Family Care target populations; or

b. An individual with a four year bachelor's degree or more advanced degree in the human services area and a minimum of one year's experience working with at least one of the Family Care target populations; or

c. An individual with a four-year bachelor's degree or more advanced degree in any area other than human services with a minimum of three (3) years' experience working with at least one of the Family Care target populations.

5. **Consultative clinical and therapeutic services for caregivers**. The purpose of consultative services is to improve the ability of unpaid caregivers and paid direct support staff to carry out therapeutic interventions.

Clinical and therapeutic services assist unpaid caregivers and/or paid support staff in carrying out the member's treatment/support plans, are not covered by the Medicaid State Plan and are necessary to improve the member's independence and inclusion in their community.

The service includes assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans and monitoring of the member and the caregiver/staff in the implementation of the plans.

This service includes the provision of training for caregivers/staff that are or will be serving members with complex needs (beyond routine care). For example, when an individual with complex needs is relocating from one of the State Centers for the Intellectually Disabled, this service could be used to train caregivers/staff on the behavioral support plans necessary for community integration.

This service may also include consultation with service providers and potential providers to identify providers that can meet the unique needs of the member and

to identify additional supports necessary for caregivers to perform therapeutic interventions.

Excludes training in member self-advocacy or caregiver advocacy on behalf of a member, which are covered under consumer education and training.

Individual counselors must have current state licensure or certification in their field of practice. Counseling agencies must comply with Wis. Admin. Code DHS § 61.35.

6. **Consumer directed supports (self-directed supports) broker** is an individual who assists a member in planning, securing and directing self-directed supports. The services of a support broker are paid for from the member's self-directed supports budget authority. Support brokers are subject to criminal background checks and must be independent of any other waiver service provider. A support broker shall be knowledgeable of the local service delivery system and local community-integrated services and resources available to the member. A support broker shall also be knowledgeable of the typical kinds of needs of persons in the member's target group. The member and interdisciplinary team staff are responsible to assure that a support broker selected by the member has the appropriate knowledge.

   Excludes the cost of any direct services authorized and obtained by a consumer through an SDS plan, which is paid for and reported under the appropriate service definition. Excludes the cost of fiscal agent services, which is paid for and reported as financial management services.

   A provider of this service must have knowledge of the unique needs/preferences of the participant and the service system.

7. **Consumer education and training** is designed to help members develop self-advocacy skills, support self-determination, exercise civil rights and acquire skills needed to exercise control and responsibility over other support services. Self-advocacy skills enable members to communicate wants and needs, make informed decisions, voice their choices, and develop trusted supports with whomever they can share concerns. The consumer education and training service includes education and training for members, their caregivers, and legal decision makers that is directly related to developing such skills. Managed care organizations assure that information about educational and/or training opportunities is available to members, their caregivers, and legal decision makers. Covered expenses may include enrollment fees, books and other educational materials, and transportation related to participation in training courses, conferences, and other similar events. Excludes educationally related services available under Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq) or other relevant funding sources. Excludes education/training costs exceeding $2500 per participant annually. Excludes payment for hotel and meal expenses while members or their legal decision makers attend allowable training/education events.

Providers must have expertise in problem solving, self-advocacy skills development, self-determination, community integration, financial management and decision-making.

8. **Counseling and therapeutic resources** are professional, treatment-oriented services that address a member's identified needs for personal, social, physical, medical, behavioral, emotional, cognitive, mental, or substance abuse disorders.

   Counseling and therapeutic services may include assistance in adjusting to aging and/or disabilities including understanding capabilities and limitations. Services may also include assistance with interpersonal relationships, recreational therapies, music therapy, art therapy, nutritional counseling, medical counseling, weight counseling, and grief counseling.

   Counseling and therapeutic services must meet clearly defined outcomes, be proven effective for the member's condition or outcome, and be cost-effective. Any alternative therapies and treatments must meet DHS requirements. Excludes inpatient services, services provided by a physician and services covered by the Medicare program (except for payment of any Medicare cost share).

   Counseling agencies must comply with Wis. Admin. Code DHS § 61.35. All providers must have current state licensure or certification in their field of practice.

9. **Environmental accessibility adaptations (home modifications)** are the provision of services and items to assess the need for, arrange for, and provide modifications and or improvements to a member's living quarters in order to increase accessibility or safety. Modifications may provide for safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, enable members to increase their abilities to perform ADLs or IADLs, and decrease reliance on paid providers. Home modifications may include materials and services such as ramps, stair lifts, wheelchair lifts or other mechanical devices to lift persons with impaired mobility from one vertical level to another; kitchen and/or bathroom modifications; specialized accessibility/safety adaptations; and voice-activated, light-activated, motion-activated, and other electronic devices that increase the member's self-reliance and capacity to function independently. Home modifications may include modifications that add to the square footage of the residence if the modifications are to assure the health, safety, or independence of the person; prevent institutionalization; and are the most cost effective means of meeting the accessibility or safety need. Contractors must comply with local and/or state housing and building codes.

10. **Financial management services** assist members and their families to manage service dollars or their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member or legal decision maker authorizes payment to be made for services included in the member's approved self-directed supports plan. Financial management services providers, sometimes referred to as fiscal intermediaries or fiscal agents, are

organizations or individuals who pay personnel costs, tax withholding, worker's compensation, health insurance premiums, and other taxes and benefits as indicated in the individual's self-directed supports plan and budget for services. Financial management services are purchased directly by the MCO and made available to the member/family to ensure that appropriate compensation is paid to providers. Additionally, this service includes the provision of assistance to members who are unable to manage their own personal funds. This service includes assistance to the member to effectively budget personal funds to ensure sufficient resources are available for housing, board and other essential costs. This service includes paying bills authorized by the member or his or her legal decision maker and keeping an account of disbursements. Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions. Excludes payment for the cost of room and board.

An MCO must have standards in place that ensure at minimum that a financial management services provider: 1) is an agency, unit of an agency or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; 2) has training and experience in accounting or bookkeeping; and 3) has a system in place that recognizes the authorization of payment by the participant or legal decision maker, that promptly issues payment as authorized and that documents budget authority and summarizes payments in a manner that can be readily understood by the participant or legal decision maker.

11. **Habilitation Services**

a. **Daily living skills training** is the provision of education and skill development to teach members the skills involved in performing activities of daily living, including skills intended to increase the member's independence and participation in community life. This service may include teaching money management, home care maintenance, food preparation, mobility training, self-care skills, and the skills necessary for accessing and using community resources. Daily living skills training may involve training the member or the natural support person to assist the member.

For daily living skills training agencies, the MCO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

For individual daily living skills trainers, the MCO shall assure that the provider has the ability and qualifications to provide this service, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services. However, a member self-directing this service may employ qualified persons with less experience. In that event, the MCO and member must ensure that the individual provider receives member-specific training sufficient to enable the individual to competently provide the daily living skills training services to the member consistent with the care plan. If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

Relatives and legal guardians meeting the requirements under Article VIII.N.2 may be paid to provide daily living skills training.

b. **Day habilitation services** are the provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that enhance social development and develop skills in performing activities of daily living and full community citizenship. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.

Day habilitation services focus on enabling the member to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the member -centered plan, such as physical, occupational, or speech therapy. For members with degenerative conditions, day habilitation activities may include training and supports to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Day habilitation services may also be used to provide retirement activities. As some members get older, they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities.

Day habilitation may be furnished in a variety of settings in the community except for the member's residence. Day habilitation services are not limited to fixed-site facilities but may take place in stores, restaurants, libraries, parks, recreational facilities, community centers, or any other place in the community.

Transportation may be provided between a member's place of residence and the site of day habilitation activities or between habilitation activities sites (in cases where the member receives habilitation services in more than one place) as a component of day habilitation activities. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Personal care/assistance may be a component of day habilitation services as necessary to meet the need of members, but may not comprise the entirety of the service. Members who receive day habilitation services may also receive educational, supported employment, and prevocational services. Day habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).

For day habilitation providers, the MCO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

12. **Home delivered meals** are meals provided to recipients who are unable to prepare or obtain nourishing meals without assistance, including those who may be unable to manage a special diet recommended by their physician. Home-delivered meal costs may include the costs associated with the purchase and planning of food, nutrition services, supplies, equipment, labor, and transportation to deliver one or two meals a day.

    Home delivered meals may not constitute a "full nutritional regimen" (3 meals per day).

    This service does not include payment for meals at federally subsidized nutrition sites.

    Hospitals and nursing homes must comply with Wis. Admin. Code Ch. DHS 124, DHS 132, and DHS 134; aging network agencies must comply with Wis. Stat. § 46.82(3); and restaurants must comply with Wis. Admin. Code Ch. ATCP 75.

13. **Housing counseling** provides assistance to a member who is acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of housing counseling is to promote consumer choice and control, increase access to affordable housing, and promote community inclusion. Housing counseling includes exploring home ownership and rental options and individual and shared housing options, including options where the member lives with his or her family. Services include counseling and assistance in identifying

housing options; identifying financial resources and determining affordability; identifying preferences of location and type of housing; identifying accessibility and modification needs; locating available housing; identifying and assisting in access to financing; explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications and how to file a complaint; and planning for ongoing management and maintenance. Housing counseling is not a one-time service and may be accessed by a member at any time. A qualified provider must be an agency, or unit of an agency, that provides housing counseling to people who need assistance with housing as a regular part of its mission or activities. Counseling providers must have specialized training and experience in housing issues. This service is excluded if it is otherwise provided free to the general public. This service may not be provided by an agency that also provides residential support services or support/service coordination to the member. Providers must have expertise in housing issues relevant to the participant and may not be a provider of residential support services to the participant.

14. **Personal emergency response system (PERS)** provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate response and assistance in the event of a physical, emotional, or environmental emergency. This service may include devices and services necessary for operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate. Electronic devices must meet UL Standards. Telephonic devices must meet FCC regulations.

15. **Prevocational services** are designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services allow the member to develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time as determined by the member and his or her care planning team. Services are expected to specifically involve strategies that enhance a member's employability in integrated, community settings.

    Prevocational services should enable each member to attain the highest possible wage and work in the most integrated setting that is matched to the member’s interests, strengths, priorities, and abilities. Services intend to develop general skills that lead to employment, including: the ability to communicate effectively and establish appropriate boundaries with supervisors, co-workers and customers; express and understand expectations; engage in generally accepted community workplace conduct and adopt appropriate workplace dress; follow directions; attend to tasks; workplace problem solve; manage conflicts; and adhere to general

workplace safety.
Services may include mobility training.

Prevocational services may be delivered in a variety of locations in the community and are not limited to fixed-site facilities. Some examples of community sites include the library, job center, banks or businesses.

Prevocational services, regardless of how and where they are delivered, are expected to help people make reasonable and continued progress toward participation in at least part-time, integrated employment. Prevocational services are not considered outcomes; competitive employment and supported employment are considered successful outcomes of prevocational services. The optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

Prevocational services may not duplicate services that are provided as part of an Individualized Plan for Employment (IPE) under the Rehabilitation Act of 1973, as amended, or as part of an approved Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA).

The contracted provider of pre-vocational services must complete a six month progress report and service plan document for the interdisciplinary care management team (IDT). The purpose is to ensure and document that prevocational services are assisting the member in progressing toward a goal of at least part-time, integrated employment. Timely completion of this document is required for the IDT to consider reauthorization of prevocational services.

Participation in prevocational services is not a prerequisite for individual or small group supported employment services. Members who receive prevocational services may also receive educational, supported employment and/or day services. A member centered plan may include two or more types of non-residential services. However, different types of non-residential services may not be billed for the same period of time.

Members participating in prevocational services shall be compensated in accordance with applicable Federal and State laws and regulations.

Transportation may be provided between the member's residence and the site of the prevocational services or between prevocational service sites in cases where the member receives prevocational services in more than one place as a component part of prevocational services or under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met. If the transportation is provided by the prevocational services provider, the cost of this transportation is included in the rate paid to the provider.

Personal care provided to a member during the receipt of prevocational services may be included in the reimbursement paid to the prevocational services provider,

or it may be covered and reimbursed under another waiver service so long as there is no duplication of payment.

Prevocational services may be provided to supplement, but may not duplicate services provided under supported employment or vocational futures planning and support services provided under the waiver.

The MCO shall assure the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable experience for a qualified entity, including a minimum of two years of experience working with the target population providing employment-related services that have a goal of integrated employment in the community at minimum wage or above.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

16. **Relocation services** are services and essential items needed to establish a community living arrangement for members who are relocating from an institution, or a family home, to an independent living arrangement. This service includes person-specific services, supports, or goods that are put in place to prepare for the member's relocation to a safe, accessible and affordable community living arrangement. Services or items covered by this service may not be purchased more than 180 days prior to the date that the member relocates to the new community living arrangement. Relocation services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings, and kitchen appliances that are not otherwise included in a rental arrangement if applicable. Relocation services may include the payment of a security deposit, utility connection costs, and telephone installation charges. This service includes payment for moving the member's personal belongings to the new community living arrangement, general cleaning, and household organization needed to prepare the selected community living arrangement for occupancy. Relocation services exclude home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided as the waiver service home modifications. Excludes housekeeping services provided after occupancy which are considered the waiver service supportive home care. Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.). Providers must be reputable contractors or companies.

17. **Residential care**

Residential care services may be authorized only:

- When members' long-term care outcomes cannot be cost-effectively supported in the member's home, or when members' health and safety cannot be adequately safe-guarded in the member's home; or
- When residential care services are a cost-effective option for meeting that member's long-term care needs.

Types of residential care:

a. **Adult residential care – 1-2 bed adult family homes** are places in which the operator provides care, treatment, support, or services above the level of room and board to up to two adults. Services typically include supportive home care, personal care, and supervision. Services may also include recreational/social activities, behavior and social supports, daily living skills training, and transportation if provided by the operator or designee of the operator. The service includes homes that are the primary domicile of the operator and homes that are controlled and operated by a third party that hires staff to provide support and services.

   Adult family home services also include coordination with other services and providers, including health care, vocational, or day services. Services may also include the provision of other waiver services as specified in the contract between the MCO and residential provider. Waiver funds may not be used to pay for the cost of room and board.

   Relatives and legal guardians meeting the requirements under Article VIII.N.2 may be paid to provide adult residential care in a 1-2 bed adult family home.

   An adult family home sponsor must comply with WI Medicaid Waiver Standards for Certified 1-2 Bed AFH and Wis. Admin. Code Ch. DHS 82 for Barrett Homes.

b. **Adult residential care – 3-4 bed adult family homes** are licensed under Wis. Admin. Code Ch. DHS 88 and are places where 3-4 adults, who are not related to the licensee reside, receive care, treatment or services above the level of room and board, and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care, and supervision. Other services provided may include behavior and social supports, daily living skills training, and transportation performed by the operator or designee of the operator. This service type also includes homes of 3-4 beds, specified under Wis. Stat. § 50.01(1)(a), which are licensed as a foster home under Wis. Stat. § 48.62 and certified by a certifying agency as defined under Wis. Admin. Code Ch. DHS 82. The latter are owner-occupied homes for persons with intellectual disabilities who are aging out of foster care. This category of homes

permits such persons to remain in the same home, promoting continuity of care. Waiver funds may not be used to pay for the cost of room and board. A licensed adult family home must comply with Wis. Admin. Code Ch. DHS 88.

c. **Adult residential care - community-based residential facilities (CBRF)** are a residences where five (5) or more adults not related to the operator or administrator of the facility, reside and receive care, treatment, support, supervision, and training. An individual with an intellectual disability may only reside in a CBRF that is licensed for eight (8) or fewer residents, unless that person has been determined to require No Active Treatment (NAT) for her or his intellectual disability. Services may include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation and up to three hours per week of nursing care per resident. Waiver funds may not be used to pay for the cost of room and board. A licensed CBRF must comply with Wis. Admin. Code Ch. DHS 83.

d. **Adult residential care - residential care apartment complexes (RCAC)** are services provided in a homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct from each other. Persons who reside in the facility also receive the following services: supportive services (e.g., laundry, house cleaning), personal assistance (e.g., personal care), nursing services (e.g., wound care, medication management), and assistance in the event of an emergency (e.g., PERS and response). Waiver funds may not be used to pay for the cost of room and board. A certified RCAC must comply with Wis. Admin. Code DHS Ch. 89.

18. **Respite** is provided for a member on a short-term basis to ease the member's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Respite care may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, certified residential care apartment complex, in the member's own home or the home of a respite care provider.

For providers of this service: supportive home care agencies, individual respite providers and personal care agencies must comply with the Training and Documentation Standards for Supportive Home Care and In-Home Respite Care; 1-2 bed adult family homes must comply with WI Medicaid Waiver Standards for 1-2 bed adult family homes and Wis. Admin. Code Ch. DHS 82 for Barrett Homes; residential care apartment complexes must comply with Wis. Admin. Code Ch. DHS 89; and hospital, nursing homes, community-based residential facilities and 3-4 bed adult family homes must comply with DHS 124, DHS 132, DHS 134, DHS 83, and DHS 88 as applicable.

Relatives and legal guardians meeting the requirements under Article VIII.N.2 may be paid to provide respite.

19. **Self-directed personal care** consists of activities that assist a member with activities of daily living, instrumental activities of daily living, and housekeeping services directly related to the care of the member to maintain the member in his or her place of residence and to assist the member to access the community. Services may include the following:

    a. Assistance with activities of daily living (ADLs): bathing; getting in and out of bed; oral, hair, and skin care excluding skilled wound care; help with toileting; simple transfers; assistance with mobility and ambulation; assistance with eating; and assistance with dressing and undressing.

    b. Assistance with instrumental activities of daily living (IADLs): managing medications and treatments normally self-administered, care of eyeglasses and hearing aids, meal preparation and serving, bill paying and other aspects of money management, using the telephone or other forms of communication, arranging and using transportation, and physical assistance to function at a job site.

    c. Housekeeping services related to the care of the person: cleaning in essential areas of the home used when assisting with ADLs and IADLs, laundry of the member's clothes and bedding and changing of bedding, and shopping for the member's food.

    d. Accompanying and assisting the member to access the community for medical care, employment, recreation, shopping and other purposes, as long as the provision of assistance with ADLs and IADLs is required during such trips.

    e. Medically-oriented tasks delegated by a registered nurse pursuant to an agreement between the member and the interdisciplinary care team (IDT) staff.

    Services are provided by either an individual or agency selected by the member, pursuant to a physician's order (a state law requirement) and following a member-centered plan (MCP) developed jointly by the member and IDT staff including a registered nurse. The MCP shall specify delegated nursing tasks, if any. The member may use as a provider any individual who passes a background check and is not barred from participating in the Medicaid or Medicare program, including relatives and legal guardians meeting the requirements under Article VIII.N.2. The member may also use an agency that is not barred from participating in the Medicaid or Medicare program. The MCP, including self-directed personal care and all other services received, is reviewed by the member and care team staff at least every six months or more often as needed. Visits by the consulting RN, who may be a member of the IDT or other nurse consultant, to the member's residence will occur at least once a year unless the member and RN agree on a more frequent visits or the RN determines that delegated nursing tasks need to be

reviewed more often. The member and IDT will determine any training needed by selected providers and how it will be obtained. The member shall be the common law employer of individual providers; if the member selects an agency, the member shall be a managing, co-employer of the worker and the agency shall hire any worker referred by the member who passes the background check and is, or can become competent in required tasks. Services may be provided both in the member's residence and outside the residence in other community settings.

Members must have budget authority over an allocation of waiver funding through the Self-Directed Services option to receive personal care through this service and must function themselves or through a representative as either the common law employer of an individual worker or the managing, co-employer of an agency-provided worker. Members without budget authority who are authorized by the MCO to receive personal care services would receive them through the State Plan personal care benefit instead.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days where there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

f. Medically-Related

   i. Hospitalization;

   ii. Nursing home or ICF /IID admission;

   iii. Receipt of medical or rehabilitative care entailing at least an overnight absence; or

   iv. Participation in a therapeutic rehabilitative program as defined in Wis. Admin. § DHS 101.03(175).

   There is no yearly limit on the number of medically-related episodes for which retainer payments may be made.

g. Non-Medically Related

   i. Planned vacation entailing at least an overnight absence and unaccompanied by the worker;

   ii. Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence;

   iii. Obtaining education, employment or job, habilitative, or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or

iv. Recreational activities unaccompanied by the worker entailing at least an overnight absence.

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

MCOs shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

Agency-employed, member-directed workers must comply with Wis. Admin. Code Ch. DHS 105.17. Member-employed individual workers must comply with Training and Documentation Standards for Supportive Home Care and In-Home Respite Care.

20. **Skilled nursing services RN/LPN** is "professional nursing" as defined in Wisconsin's Nurse Practice Act, Wis. Stat., Ch. 441. Nursing services are medically necessary, skilled nursing services that may only be provided safely and effectively by an advanced practice nurse, a registered nurse or a licensed practical nurse who is working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act, consistent with the member centered plan, authorized by the MCO and not otherwise available to the member under the Medicaid State Plan or through Medicare. However, the lack of coverage under the State Plan or through Medicare does not preclude the coverage of skilled nursing as a waiver service when services are within the scope of the Wisconsin Nurse Practice Act.

Under the Wisconsin Nurse Practice Act, professional nursing includes any of the following:

Professional skilled nursing means the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, that requires substantial nursing skill, knowledge, training, or application of nursing principles based on biological, physical and social sciences. Professional skilled nursing includes any of the following:

a. The observation and recording of symptoms and reactions;

b. The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under Wis. Stat. Ch. 448, dentist licensed under Wis. Stat. Ch. 447, or optometrist licensed under Wis. Stat. Ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state;

c. The execution of general nursing procedures and techniques; or

d. The supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants in accordance with Wis. Stat. Ch. 441.

Nursing services may include periodic assessment of the member's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a member's fragile or complex medical condition, as well as the monitoring of a member who has a history of non-adherence with medication or other medical treatment needs.

Delegation of nursing tasks to less skilled personnel shall be in accordance with Wis. Stat. Ch. 441 and Wis. Admin. Code Ch. N6, and the Wisconsin Nurses Association's Guidelines for Registered Nurse Delegation to Unlicensed Assistive Personnel.

These services are provided when nursing services identified as needed in a plan of care and furnished under the approved State plan limits are exhausted or when the nursing services are not covered under the Medicaid State Plan. For members enrolled in Medicare, this excludes services that are available through the Medicare program except for payment of Medicare cost share. RNs and LPNs must comply with Wis. Stat. Ch. 441.

Relatives and legal guardians meeting the requirements under Article VIII.N.2 may be paid to provide skilled nursing services.

21. **Specialized medical equipment and supplies.** Specialized medical equipment, items, devices and supplies are those items necessary to maintain the member's health, manage a medical or physical condition, improve functioning or enhance independence. Items or devices provided must be of direct medical or remedial benefit to the member. Allowable items, devices or supplies may include: incontinence supplies; wound dressings; IV or life support equipment; orthotics; enteral nutrition products and associated supplies and equipment not covered under the Medicaid State Plan but needed for the member to obtain adequate nutrition; over the counter medications with a National Drug Code (NDC) if not covered under the State Plan drug benefit and when prescribed by any licensed and authorized prescriber; medically necessary prescribed skin conditioning lotions/lubricants; and prescribed Vitamin D, a prescribed multivitamin and prescribed calcium supplements. (The Department of Health Services may add other prescribed vitamins or nutritional supplements in the future based on clear and convincing evidence substantiating their safety and effectiveness in maintaining health or treating or managing a medical condition.) Additionally, allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, humidifiers and water treatment systems may be allowable when needed to support a member's health and safety outcomes.

Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid State Plan when coverage of the additional items or devices has been denied.

Excludes items considered as and regulated by the federal Food and Drug Administration (FDA) as nutritional supplements unless specifically covered under this definition or under the Medicaid State Plan.

Authorized DME vendors and licensed pharmacies must comply with Wis. Admin. Code Ch. DHS 105.40 or Wis. Stat. Ch. 450.

22. **Supported employment – individual employment support** is the ongoing support provided to members who, because of their disabilities, need intensive ongoing support to obtain and maintain competitive, customized, or self-employment, in an integrated work setting, in the general workforce. A member receiving this service shall be compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage, in an integrated setting, in the general workforce, and in a job that meets personal and career goals.

    Individual employment support services are individualized and may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, job supports, work incentive benefits analysis and counseling, training and work planning, transportation, and career advancement services. Additional services include those that are not specifically related to job skill training that enable the member to successfully integrate into the job setting.

    Individual employment supports may include support to maintain self-employment, including home-based self-employment. This service may also include services and supports that assist the member in achieving self-employment; however, Medicaid funds may not be used to defray the expenses associated with starting or operating a business. Assistance for self-employment may include the following: assistance in identifying potential business opportunities; assistance in developing a business plan, including identifying potential sources of business financing and developing and launching a business; identification of the supports that are necessary in order for the member to operate the business; and ongoing assistance, counseling, and guidance once the business has been launched.

    Individual employment support does not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers in similar positions in the business. Individual employment support services may be provided by a co-worker or other job site personnel when (a) the

services are not part of the normal duties of the co-worker, supervisor or other personnel; and (b) the individual meets the established qualifications for individual providers of this service. Employers may be reimbursed for supported employment services provided by co-workers.

Supported employment services do not include vocational services that are provided in facility-based work settings and not in general community work places. Supported employment services may not include volunteer work.

Members receiving individual employment supports may also receive educational, pre-vocational and/or day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded under the §110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq).

Coverage does not include incentive payments, subsidies, or unrelated vocational training expenses, such as:

a. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment or

b. Wages or other payments that are passed through to users of supported employment services.

Payment for individual employment support services may be based on different methods, including, but not limited to, co-worker support models, payments for work milestones, such as length of time on the job, or number of hours the member works.

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider or may reimbursed under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but it may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider or may be reimbursed under the supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

When personal care/assistance or transportation or both are a component of this service, payment may not be made for such assistance or transport under another waiver service for the same period of time.

For the individual on the job support person, the MCO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Holding the Certified Employment Support Professional accreditation.
- Meeting the ASPE Quality Indicators for Supported Employment Personnel.
- Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the MCO and member shall ensure that the individual provider has the member –specific competencies to effectively provide the service.

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

For the supported employment agency, the MCO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
- Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
- Comparable experience for a qualified entity, including a minimum two years of experience working with the target population providing integrated employment services in the community.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

Relatives and legal guardians meeting the requirements under Article VIII.N.2 may be paid to provide individual employment support.

23. **Supported employment - small group employment support** consists of services and training activities that are provided in a regular business, industry, or community setting for groups of two to eight workers with disabilities. Examples include mobile crews and other business-based workgroups who employ small groups of workers with disabilities in employment in a community setting. Small group employment support must be provided in a manner that promotes

integration into the workplace and integration between members and people without disabilities in those workplaces. The outcome of this service is sustained paid employment, work experience that leads to further career development, and individual integrated community-based employment for which a member is compensated at or above the minimum wage, but not less than the customary wage level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Small group employment support services may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. This service also includes are other workplace support services that are specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Small group employment support does not include payment for supervision, training, support, or adaptations that are typically available to workers without disabilities who fill similar positions in the business. Employers may be reimbursed for supported employment services provided by co-workers or other job site personnel, when the services that are furnished are not part of the normal duties of the co-worker or other personnel, and when these individuals meet the qualifications established below for individual providers of service.

Supported employment services do not include vocational services provided in facility-based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places. Supported employment services may not include volunteer work.

Members receiving small group employment support may also receive educational, pre-vocational, career planning, and day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded by § 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1401 et seq).

Coverage does not include incentive payments, subsidies, or unrelated vocational training expenses, like the following:

a. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or

b. Wages or other payments that are passed through to users of supported employment services.

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider or reimbursed under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but it may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider or may be reimbursed under supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

When personal care/assistance or transportation or both are a component of supported employment services, payment may not be made for such assistance or transport under another waiver service for the same period of time.

The MCO shall assure that supported employment agencies have the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
- Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
- Comparable experience for a qualified entity, including a minimum two years of experience working with the target population providing integrated employment services in the community.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

The MCO shall assure that the individual on the job support person has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Holding the Certified Employment Support Professional accreditation.
- Meeting the ASPE Quality Indicators for Supported Employment Personnel.
- Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the MCO and

member shall ensure that the individual provider has the member –specific competencies to effectively provide the service.

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

Relatives and legal guardians meeting the requirements under Article VIII.N.2 may be paid to provide small group employment support.

24. **Supportive home care (SHC)** is the provision of services to directly assist people with daily living activities and personal needs and to assure adequate functioning and safety in their home and community. Services include the following:

a. Hands-on assistance with activities of daily living such as dressing/undressing; bathing; feeding; managing medications and treatments that are normally self-administered; toileting; assistance with ambulation (including the use of a walker, cane, etc.); carrying out professional therapeutic treatment plans; and grooming, such as care of hair, teeth or dentures. This may also include preparation and cleaning of areas that are used during provision of personal assistance such as the bathroom and kitchen.

b. Direct assistance with instrumental activities of daily living, as well as observation or cueing of the member, to ensure that the member safely and appropriately completes activities of daily living and instrumental activities of daily living.

c. Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, and arrangement and use of transportation and personal assistance at a job site and in non-employment related community activities.

d. Routine housekeeping and cleaning activities performed for a member, consisting of tasks that take place on a daily, weekly, or other regular basis. These tasks may include: washing dishes, doing laundry, dusting, vacuuming, cooking, shopping, and similar activities that do not involve hands-on care of the member.

e. Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event for reasons of health and safety or the need to assure the member's continued community living. These tasks may include outdoor activities, such as yard work and snow removal; indoor activities, such as window washing; cleaning of attics and

basements; cleaning of carpets, rugs, and drapery; refrigerator/freezer defrosting; the necessary cleaning of vehicles, wheelchairs and other adaptive equipment; bed bug inspection and extermination; and home modifications such as ramps. This also may include assistance with packing/unpacking and household cleaning/organizing when a member moves.

An unrelated live-in caregiver may provide any or all of the types of supportive home care services. Relatives and legal guardians (live-in or otherwise) meeting the requirements under Article VIII.N.2. may be paid to provide any or all of the types of supportive home care. Payment of a live-in caregiver may be reduced by the value of room and board in accordance with any applicable wage and hour laws.

Excludes training provided to a member intended to improve the member's ability to independently perform routine daily living tasks, which may be provided as daily living skills training.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days when there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment or, if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

Medically- Related

i. Hospitalization;

ii. Nursing home or ICF-IID admission ;

iii. Receipt of medical or rehabilitative care entailing at least an overnight absence; or

iv. Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175).

There is no yearly limit on the number of medically-related episodes for which retainer payments may be made.

Non-Medically Related

i. Planned vacation entailing at least an overnight absence and unaccompanied by the worker;

ii. Visit to relatives or friends entailing at least an overnight absence and unaccompanied by the worker;

iii. Obtaining education, employment or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or

iv. Recreational activities unaccompanied by the worker entailing at least an overnight absence.

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

MCOs shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

All workers must comply with the Training and Documentation Standards for Supportive Home Care and In-Home Respite Care.

25. **Training services for unpaid caregivers** is the provision of training services for individuals who provide uncompensated care, training, companionship, supervision, or other supports to members.

Training includes instruction about treatment regimens and other services that are included in the member's care plan, use of equipment specified in the service plan and guidance to safely maintain the member in the community. Training must be aimed at assisting the unpaid caregiver in meeting the needs of the member. All training for individuals who provide unpaid support to the member must be included in the member's care plan and must directly relate to the individual's role in supporting the member.

This service includes, but is not limited to, on-line or in-person training; conferences; or resource materials on the specific disabilities, illnesses, or conditions that affect the member. The purpose of the training is for the caregiver to learn more about member's condition, what to expect, and how to provide the best care for someone with that specific condition. For example, training could be provided on how to effectively care for a member with dementia.

Training includes registration costs and fees associated with formal instruction in areas that are relevant to the needs identified in the member's care plan.

This service may not be provided in order to train paid caregivers. This service excludes payment for lodging and meal expenses incurred while attending a training event or conference. This service does not cover teaching self-advocacy which is covered under consumer education and training services.

This service must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

26. **Transportation (specialized transportation) – community transportation** is the provision of transportation services or items that enable a member to gain

access to waiver and other community services, activities and resources, as specified in the member's care plan. This service may consist of items such as tickets, fare cards or other fare media, or services where the common carrier, specialized medical vehicle or other provider directly conveys a member and her or his attendant, if any, to destinations. Whenever possible, family, neighbors, friends or community agencies who can provide this service without charge will be utilized.

Excludes transportation to receive non-emergency medical services which are covered under the Medicaid State Plan transportation benefit, or in the case of a self-directing member with budget authority to purchase such services, under the Other Transportation service. Excludes emergency (ambulance) medical transportation covered under the Medicaid State Plan service.

Taxis or common carriers must comply with Wis. Stat. Ch. 194. Public mass transit must comply with Wis. Stat. § 85.20. Relatives and legal guardians meeting the requirements under Article VIII.N.2 may be paid to provide specialized transportation (community transportation).

27. **Transportation (specialized transportation) - other transportation** consists of transportation to receive non-emergency, Medicaid–covered medical services. This service may include items such as tickets, fare cards or other fare media, reimbursement of mileage expenses, or payment for services where the provider directly conveys the member and her or his attendant, if any, by common carrier or specialized medical vehicle (SMV) as appropriate to and from receiving Medicaid–covered medical services.

    Members eligible for this service must have decision-making authority over a budget for the purchase of such services. Such members (1) are not limited to providers in the MCO's network, although the MCO must verify credentials of specialized medical vehicle providers, (2) are not required to obtain prior authorization to purchase any transportation service from a qualified provider to any Medicaid-covered medical service if the member's budget is sufficient to pay for the service, and (3) are not required to schedule routine trips if the member can obtain transport.

    Excludes ambulance transportation, which is available through the Medicaid State plan. Excludes non-emergency medical transportation when authorized by the MCO as a State Plan service for members without budget authority. Excludes non-medical transportation which is provided under the sub-service of Community Transportation; however the same ride may be used to provide transport to medical appointments and community activities as long as there is not duplication of payment.

    Specialized transportation agencies must comply with Wis. Stat. § 85.21 and Wis. Admin. Code DHS § 61.45. Individual providers must have a valid driver's license and liability insurance. Relatives and legal guardians meeting the

requirements under Article VIII.N.2 may be paid to provide specialized transportation (other transportation).

28. **Vocational futures planning and support (VFPS)** is a person-centered, team-based comprehensive employment planning and support service that provides assistance for members to obtain, maintain or advance in employment or self-employment/microenterprise. The agency providing VFPS services will ensure that the following service strategies are available as needed to the member:

    a. Development of an employment plan based on an individualized determination of the member's strengths, needs, and interests ; the barriers to work, including an assistive technology pre-screen or in-depth assessment; and identification of the assets that a member brings to employment;

    b. Work Incentive Benefits analysis and support;

    c. Resource team coordination;

    d. Career exploration and employment goal validation;

    e. Job seeking support; and

    f. Job follow-up and long-term support.

    VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefit specialist, and an assistive technology consultant. When this service is provided, the member record must contain activity reports, completed by the appropriate VFPS team member(s), within thirty (30) days of completing a particular service strategy. When ongoing support is provided, monthly ongoing support reports must be completed by the provider of the ongoing support.

    VFPS excludes services that could be provided as prevocational or as supported employment. Such services may be used to supplement, but may not duplicate any VFPS services provided under the waiver. VFPS excludes services funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401(16 and 17).

    All providers shall have skills and knowledge typically acquired through completion of an advanced degree in human services, or an equivalent combination of education and experience, with ongoing training and technical assistance appropriate to their specific specialty.

B. Medicaid State Plan Services – Family Care Benefit Package

The following Medicaid State Plan long-term care services defined in Wis. Admin. Code Ch. DHS 107 with specific service definitions as noted in the reference(s) following each service are included in the Family Care Benefit Package. MCOs will determine which services require prior authorization and use the member-centered planning process to define the service limitations, rather than using the requirements in Wis. Admin. Code

Ch. DHS 107. For informational purposes, information about specific services is found in the BadgerCare Plus and Medicaid handbooks at: https://www.forwardhealth.wi.gov/WIPortal/OnlineHandbooks/Display/tabid/152/Default.aspx.

1. **AODA day treatment** services as defined in Wis. Admin. Code DHS § 107.13 (excluding hospital-based or physician-provided)
2. **AODA** services as defined in Wis. Admin. Code DHS § 107.13 (excluding inpatient or physician-provided)
3. **Case management** as defined in Wis. Admin. Code DHS § 107.32
4. **Community support program** as defined in Wis. Admin. Code DHS § 107.13 (6) (excluding physician provided)
5. **Disposable medical supplies** as defined in Wis. Admin. Code DHS § 107.24
6. **Durable medical equipment** as defined in Wis. Admin. Code DHS § 107.24 (excluding hearing aids, prosthetics and family planning supplies)
7. **Home health services** as defined in Wis. Admin. Code DHS § 107.11. The MCO shall only contract for home health care services with a licensed, Medicare certified home health agency that provides the Department with a surety bond as specified in § 1861(o)(7) of the Social Security Act.
8. **Mental health day treatment** as defined in Wis. Admin. Code DHS § 107.13
9. **Mental health services** as defined in Wis. Admin. Code DHS § 107.13 (excluding inpatient or physician-provided or comprehensive community services)
10. **Medicare deductible and coinsurance amounts** for a dual eligible Family Care member, the MCO shall pay any deductible, coinsurance or copayment amount for a Medicare service that Medicaid would pay for fee-for-service recipients, if the service is also a Medicaid State Plan service in the Family Care benefit package. For non-network providers, the MCO must remit Medicare deductible and coinsurance amounts to providers if the claim is submitted within 365 days from the date of service or 90 days from Medicare disposition, whichever is later, in accordance with Wis. Admin. Code DHS § 106.03.
11. **Nursing home stays** as defined in Wis. Admin. Code DHS § 107.09 (nursing home, institution for mental disease (IMD) and ICF-I/ID facility). Inpatient services are only covered for IMD nursing home residents under the age of 21 years or age 65 or older, except that services may be provided to a 21 year old resident of an IMD if the person was a resident immediately prior to turning 21 and continues to be a resident after turning 21. This exception only applies until the person's 22nd birthday.

    Nursing home services include coverage of 95% of the MCO's nursing home daily rate for MCO members who are in hospice and reside in nursing homes,

excluding those members who are receiving nursing home hospice respite services for less than 5 day stays in a nursing home.

For members at the non-nursing home level of care nursing home services are coverable only if re-screening results in a change to a nursing home level of care or the member's most recent Minimum Data Set (MDS) assessment in the nursing home indicates that the services are Medicaid reimbursable. See Article VI.B.2.b. and c.

Nursing home services may be authorized to provide skilled nursing or rehabilitation services aimed at helping the member regain the ability to live more independently in his or her own home. Long-term care services in a nursing home may be authorized only:

a. When members' long-term care outcomes cannot be cost-effectively supported in the member's home, or when members' health and safety cannot be adequately safe-guarded, in the member's home; or

b. When nursing home services are a cost-effective option for meeting that member's long-term care needs.

12. **Nursing** as defined in Wis. Admin. Code DHS § 107.11, and § 107.12 (including intermittent and private duty)

13. **Occupational therapy** as defined in Wis. Admin. Code DHS § 107.17 (excluding inpatient hospital)

14. **Personal care** services as defined in Wis. Admin. Code DHS § 107.112

15. **Physical therapy** as defined in Wis. Admin. Code DHS § 107.16 (excluding inpatient hospital)

16. **Respiratory care** as defined in Wis. Admin. Code DHS § 107.113

17. **Speech and language pathology services** as defined in Wis. Admin. Code DHS § 107.18 (excluding inpatient hospital)

18. **Transportation** as defined in Wis. Admin. Code DHS § 107.23 (excluding ambulance)

C. Medicaid State Plan Services – Partnership Benefit Packages

The MCO must provide for the provision of all services required under Attachment 3.1-A, Supplement 1, Services provided to the categorically needy, https://www.dhs.wisconsin.gov/mandatoryreports/mastateplan/3-1a-supplement1.pdf, as applicable to the particular member; except those listed below. The MCO shall offer information and assistance to members who want to access the following services on a fee-for-service basis:

1. Behavioral treatment services;

2. Comprehensive community services;

3. Community recovery services;
4. Prenatal care coordination;
5. School-based services;
6. Medication therapy management;
7. Tuberculosis-related services;
8. Prescription drugs administered by a physician as part of a physician office visit or incident to a physician's service that are not covered under Medicare;
9. Residential substance use disorder treatment.

In addition to the services required under Attachment 3.1-A, Supplement 1 the MCO must also provide:

1. Ambulatory surgical center services (Wis. Admin. Code DHS § 107.30);
2. Anesthesiology services (Wis. Admin. Code DHS § 107.065);
3. Blood services (Wis. Admin. Code DHS § 107.27);
4. Dialysis services (Wis. Admin. Code DHS § 107.26);
5. Medicare deductible and coinsurance (Wis. Admin. Code DHS § 107.02(1)(b));

MCOs will determine which services require prior authorization and use the member-centered planning process to define the service limitations. Information about specific services is found in the BadgerCare Plus and Medicaid Handbooks;

The MCO must provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to the member under fee for service Medicaid, as set forth in 42 CFR § 438.210(a)(2), 42 CFR § 440.230, and 42 CFR part 441, subpart B.

The factors used to determine which services require prior authorization and the planning process used to define service limitations must be comparable and applied no more stringently for mental health and substance abuse benefits than for medical/surgical benefits as required by the Mental Health Parity and Addiction Equity Act.

ADDENDUM

VIII. Materials Cited in This Contract & Other Related Communications

Title	URL
1. Agency Data Security Staff User Agreement	https://www.dhs.wisconsin.gov/forms/f0/f00639.pdf
2. Appeal Log for Family Care, Partnership, and PACE	https://www.dhs.wisconsin.gov/library/f-02466.htm
3. Authorizing Supported Employment Job Coaching for Family Care, Partnership and PACE Members, RS memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/rs12-02.pdf
4. Business Associate Agreement, F-00759	https://www.dhs.wisconsin.gov/forms/f0/f00759.pdf
5. Civil Rights Compliance Information	www.dhs.wisconsin.gov/civil-rights
6. Claims Audit Report for Long-Term Care MCOs, F-02022	www.dhs.wisconsin.gov/forms/f02022.docx
7. Community Support Program (CSP) Coverage and Billing, TA memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-03.pdf
8. Community Support Program (CSP), Medicaid Maximum Allowable Fee Schedule	https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-03maxfeecsp.pdf
9. Cost Share Cap Memo	www.dhs.wisconsin.gov/dltc/memos/2019-01.pdf
10. Cost Share Reduction Application, F-01827	www.dhs.wisconsin.gov/library/f-01827.htm
11. Data Security Staff User Agreement	https://www.dhs.wisconsin.gov/forms/f0/f00639.pdf
12. Direct Care Workforce Funding Initiative	www.dhs.wisconsin.gov/medicaid/ltc-workforce-funding-faq.htm
13. Electronic Visit Verification (EVV)	www.dhs.wisconsin.gov/evv
14. Encounter Data Reporting	www.dhs.wisconsin.gov/ies
15. Enrollment Discrepancy Report, F-01655	www.dhs.wisconsin.gov/forms/f01655.xlsx
16. Enrollment Discrepancy Resolution, TA memo	www.dhs.wisconsin.gov/publications/p01048-15-02.pdf

17. Estate Recovery Program Handbook	www.dhs.wisconsin.gov/library/P-13032.htm
18. Family Care Agreement Between DMS, Tribal Nation, and MCO	www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf
19. Financial Audit Guide	https://www.dhs.wisconsin.gov/publications/p0/p00466.pdf
20. Financial Reporting Template, F-01284	www.dhs.wisconsin.gov/forms/f0/f01284.xlsx
21. ForwardHealth	www.forwardhealth.wi.gov/WIPortal/Default.aspx
22. ForwardHealth Community Partners	www.dhs.wisconsin.gov/forwardhealth/partners.htm
23. ForwardHealth Enrollment and Benefits Handbook, P-00079	www.dhs.wisconsin.gov/library/p-00079.htm
24. ForwardHealth Family Care Pricing Administration Guide	www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Managed%20Care%20Organization/reports_data/FH_FC_Pricing_Administration_Guide.pdf.spage
25. ForwardHealth Online Provider Handbooks	www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx
26. ForwardHealth Report Matrix	www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage
27. Fraud Reporting System	https://www.reportfraud.wisconsin.gov/RptFrd/
28. Functional Screener Certification Training Course	https://wss.ccdet.uwosh.edu/stc/dhsfunctscreen
29. Home and Community-Based Services (HCBS) Settings Rule	www.dhs.wisconsin.gov/hcbs
30. HUD Fair Market Rental (FMR) Amounts	www.huduser.gov/portal/datasets/fmr.html
31. Long Term Care Functional Screen	www.dhs.wisconsin.gov/functionalscreen
32. Long Term Care Information Exchange System	https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html
33. Medicaid Change Report, F-10137	www.dhs.wisconsin.gov/forms/f1/f10137.pdf
34. Medicaid Eligibility Handbook	www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm

35. Medical and Remedial Expense Checklist, F-00295	www.dhs.wisconsin.gov/forms/f0/f00295.docx
36. Medical and Remedial Expenses FAQs	https://www.dhs.wisconsin.gov/publications/p02006.pdf
37. Medical and Remedial Expenses in Family Care, Partnership, PACE, and IRIS, DMS Memo 2017-03	www.dhs.wisconsin.gov/dltc/memos/2017-03.pdf
38. Member Handbook Template for Family Care, P-00649	www.dhs.wisconsin.gov/library/p-00649.htm
39. Nursing Home Commissions formed under Wis. Stat. § 49.49(7): MCO Access and Contracts, TA memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta11-02.pdf
40. Nursing Home Commissions: Fiscal Year Rates	www.dhs.wisconsin.gov/familycare/mcos/nh-rates.htm
41. Out-of-County Notification Form, F-02558	www.dhs.wisconsin.gov/forms/f02558.docx
42. Pay Over Medicaid Fee-For-Service Rate, F-00152	www.dhs.wisconsin.gov/forms/f0/f00152.docx
43. Prohibited Restrictive Measures in Community-Based Programs and Facilities, DMS Memo 2017-01	www.dhs.wisconsin.gov/dltc/memos/2017-01.pdf
44. Project SEARCH™ for Family Care and Family Care Partnership Members, RS Memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/rs13-02.pdf
45. Promoting Integrated Community Living in Family Care, Partnership, and PACE, TA Memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-01.pdf
46. RAD guidelines, TA Memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-02.pdf
47. Resident Relocation Manual	www.dhs.wisconsin.gov/relocation
48. Residential Provider Rate That Results in Member Move, TA Memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta10-06.pdf
49. Restrictive Measures Database	https://ltcareies.forwardhealth.wi.gov/restrictiveMeasures/#/login

50. Restrictive Measures Guidelines and Procedures	https://www.dhs.wisconsin.gov/publications/p02572.pdf
51. Service Guide Dog, TA memo	www.dhs.wisconsin.gov/publications/p01048-15-01.pdf
52. SSI-E Policy Handbook	www.emhandbooks.wisconsin.gov/ssi-e/ssi-e.htm
53. Standard Definitions of Managed Care Terminology	www.dhs.wisconsin.gov/familycare/mcos/standard-terminology.htm
54. Standards for Certified 1-2 Bed AFHs	www.dhs.wisconsin.gov/regulations/afh/1-2bed
55. Statements of Deficiency (SODs), TA Memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta12-01.pdf
56. Supplemental Nutrition Assistance Allocation (SNAP)	www.dhs.wisconsin.gov/foodshare/fpl.htm
57. Supportive Home Care (SHC) Training and Documentation Standards	www.dhs.wisconsin.gov/publications/p01602.pdf
58. Transition of Care Between Medicaid Programs or Between Agencies Within a Medicaid Program	www.dhs.wisconsin.gov/publications/p02364.pdf
59. Undue Hardship Waiver Request, F-10193	www.dhs.wisconsin.gov/forms/f10193.docx
60. Work Incentives Benefits Counseling and its Role in Employment for Family Care and Partnership Members, RS Memo	https://www.dhs.wisconsin.gov/familycare/mcos/communication/rs13-01.pdf
Enrollment and Disenrollment Forms	
61. Change Routing Form, F-02404	www.dhs.wisconsin.gov/forms/f0/f02404.docx
62. Family Care Enrollment Form, F-00046	www.dhs.wisconsin.gov/library/f-00046.htm
63. Family Care Member-Requested Disenrollment or Transfer, F-00221	www.dhs.wisconsin.gov/library/F-00221.htm
64. Partnership Enrollment Form, F-00533	www.dhs.wisconsin.gov/library/F-00533.htm
65. Partnership Member-Requested Disenrollment or Transfer Form, F-00534	www.dhs.wisconsin.gov/library/f-00534.htm

66. Program-Requested Disenrollment Form, F-02403	www.dhs.wisconsin.gov/forms/f02403.docx
67. Urgent Services Agreement, F-02140	www.dhs.wisconsin.gov/library/f-02140.htm
Grievance and Appeals Forms	
68. Adverse Benefit Determination Notice, F-00232	www.dhs.wisconsin.gov/library/f-00232.htm
69. Appeal Request Forms	https://ww.dhs.wisconsin.gov/familycare/mcoappeal.htm
70. Change in Level of Care Notice, F-01590	www.dhs.wisconsin.gov/library/f-01590.htm
71. Decision Letter: Decision Reversed, F-00232D	www.dhs.wisconsin.gov/library/f-00232d.htm
72. Decision Letter: Decision Upheld, F-00232E	www.dhs.wisconsin.gov/library/f-00232e.htm
73. Decision Letter: Notice of Extension for a Decision Request, F-00232B	www.dhs.wisconsin.gov/library/f-00232b.htm
74. Fair Hearing Request Form, F-00236	www.dhs.wisconsin.gov/library/f-00236.htm
75. Fair Hearing Voluntary Withdrawal	https://doa.wi.gov/DHA/WFSVW.pdf
76. Non-Covered Benefit Notice, F-01283	www.dhs.wisconsin.gov/library/f-01283.htm
77. Partnership Notice of Denial of Medical Coverage, F00950	www.dhs.wisconsin.gov/library/f-00950.htm