FAMILY CARE AGREEMENT

between

WISCONSIN DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAID SERVICES

and

<<Tribal Nation>>

and

<<MCO>>

Issued July 1, 2025

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PREAMBLE

Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA) and 42 CFR § 438.14(b)(4), eligible Indian Family Care enrollees may receive care management, specified in Article IV, through an Indian Health Care Provider (IHCP). The purpose of this agreement is to specify the operational and administrative requirements for the delivery of care management when an Indian enrollee chooses to receive care management from an IHCP.

This agreement, the DHS-MCO contract and the MCO's Member Handbook define the philosophy and basic methods for the Family Care program. It is the Department's expectation under this agreement 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 the member will live, how the member will make or maintain connections to the community and whether the member will seek competitive integrated employment.

This agreement describes the standards of operation the Department expects to be met by the MCO and IHCP. The IHCP is a sovereign government, and shall not by virtue of this agreement be considered a subcontractor of the MCO, nor shall it be considered a participating provider of the MCO.

This agreement is entered into between the State of Wisconsin represented by, the Department of Health Services, whose principal business address is One West Wilson Street, P.O. Box 309, Madison, Wisconsin, 53701-0309; <<Name of MCO>>, Managed Care Organization, hereafter MCO, whose principal business address is <<Insert address>>; and Tribal Nation, IHCP, whose principal business address is <<Insert address>>.

I. Definitions

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

1. **Abuse:** as defined by Wis. Stats. §46.90(1), means any of the following:
   a) Physical abuse: intentional or reckless infliction of bodily harm.
   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 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 the individual's 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. **Accepted Referral**: the point at which the IHCP has 1) verified the member's Indian status, 2) confirmed its capacity to perform care management, 3) and accepted the care management responsibility for the member. Upon accepted referred, the IHCP shall immediately assume all care management responsibilities for the Indian member.

3. **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.

4. **Adult Incident Reporting System or AIRS**: a centralized, web-based system that MCOs and IHCPs must use to report member incidents and other required information listed in Article V.

5. **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.

6. **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.

7. **Aging and Disability Resource Center (ADRC) 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.

8. **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.

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

10. **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.

11. **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).

12. **Benefit**: the package of services provided by the MCO or IHCP under this agreement 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:

    The Family Care Benefit Package

    a) The home and community-based waiver services defined in Addendum IV, A.

    b) The Medicaid State Plan Services identified in Addendum IV, B.; and

c) Any cost-effective health care services the MCO substitutes for a Medicaid State Plan service.

13. **Business Day**: Monday through Friday, except for state holidays.

14. **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.

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

16. **Centralized provider enrollment system:** Department enrollment system for adult long-term care (LTC) waiver service providers. This centralized technology system allows providers to submit all information necessary to become a certified Medicaid provider through the ForwardHealth Portal.

17. **Certifying Agency**: An agency authorized by the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes or by the Department to certify and recertify Adult Family Homes. Agencies authorized to certify AFHs using these standards include MCOs, county agencies, the Department or approved Department subcontractors.

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

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

20. **Competitive Integrated Employment:** Competitive Integrated Employment (CIE) is as defined at https://dwd.wisconsin.gov/dvr/partners/cie/definition.htm.

21. **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.

22. **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.

23. **Confidential Information**: all tangible and intangible information and materials accessed or disclosed in connection with this agreement, 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.

24. **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.

25. **Cost Share**: the contribution toward the cost of services required under 42 CFR § 435.726 as a condition of eligibility for Medicaid for some members who do not otherwise meet Medicaid categorical or medically needy income limits. Also referred to as Post-Eligibility Treatment of Income.

26. **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.

27. **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.

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

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

30. **Developmental Disability**: a disability attributable to brain injury, cerebral palsy, epilepsy, autism, or 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.

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

32. **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.

33. **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."

34. **Elder Adult at Risk**: as defined in Wis. Stat. § 46.90(1)(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.

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

    a) Who receives the service

b) Who provides the service

c) What service is provided

d) Where service is provided

e) Date of service

f) Time in and out

36. **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.

37. **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.

38. **Encounter Data**: detailed records of health care services or items that have been provided to MCO members by providers. The Department uses encounter data for rate setting, Federal Reporting, special programs, and any other purpose authorized by federal regulation or Wisconsin Statute or Administrative Code.

39. **Encounter Data Reporting**: electronic submission of encounter data from an MCO to the Department.

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

41. **Enrollment Counseling**: activities performed by ADRCs or Tribal ADRS 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 a publicly funded long-term care program, selecting an MCO, and advising on what factors to consider when choosing among these options.

42. **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, Indian Health Care Provider or an MCO in the petitioner's case should be corrected.

43. **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.

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

45. **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.

46. **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.

47. **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.

48. **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).

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

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

51. **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.

52. **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.

53. **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.

54. **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.

55. **HCBS Settings Rule Modification**: Restrictions or limitations to a member's HCBS rights defined in 42 CFR§ 441.301(c)(4)(vi)(B) through (D) for an individual resident that is implemented by the residential care provider (adult family homes of 1-2 beds, adult family homes of 3-4 beds, community-based residential facilities, residential care apartment complexes), supported by a specific assessed need to ensure the health, safety, and well-being of the individual or the community, and documented in accordance with 42 CFR § 441.301(c)(2)(xiii).

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

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

58. **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 occurrences.

59. **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.

60. **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 CFR § 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.

61. **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).

62. **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.

63. **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.

64. **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.

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

66. **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.

67. **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) 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 agreement 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 CFR § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker.

68. **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.

69. **Long-Term Care Benefit Package/LTC Benefit Package**: the services identified in Addendum IV, Benefit Package Services Definitions, sections A and B.

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

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

72. **Long Term Care Functional Screen or LTCFS**: a uniform screening tool administered by the Department and certified functional screeners 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.

73. **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 agreement. However, "Medicaid" is also known as "MA," "Medical Assistance," and "Wisconsin Medical Assistance Program" or "WMAP."

74. **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.

75. **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.

76. **Medically Necessary Services**: for the State plan services in Addendum IV, Benefit Package Service Definitions, 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 IV 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:

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

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

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

m) 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.

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

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

79. **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 or IHCP 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.

80. **Member Handbook/Evidence of Coverage**: a document describing the program benefits and policies that is approved by the Department and distributed to members.

81. **Member Incident**: an event involving an MCO member that the MCO and IHCP are required to report as identified in Article IV.J.

82. **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 to communicate with enrolled members.

83. **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.

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

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

86. **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.).

87. **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 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 IHCP, is cost-effective and 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.

88. **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).

89. **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) 1.b., Wis. Stats.

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

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

92. **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 agreement 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).

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

94. **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.

95. **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.

96. **Placing agency:** An agency responsible for facilitating the placement of a resident in an Adult Family Home. Placing agencies may be MCOs, IHCPs providing care management, the IRIS (Include, Respect, I Self-Direct) program and county agencies that certify and place individuals in certified 1-2 bed Adult Family Homes.

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

98. **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.

99. **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.

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

101. **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.

102. **Provider Agreement**: a written agreement between a provider and the MCO or a subcontractor to provide services to the MCO's members.

103. **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.

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

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

106. **Restrictive Measure**: any type of manual restraint, isolation, seclusion, protective equipment, medical procedure restraint, or restraint to allow for healing. Additional information about restrictive measures is available through the Restrictive Measures Guidelines and Standards, P-02572.

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

108. **Self-neglect**: means a significant danger to an individual's physical or mental health because the individual is responsible for their 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).

109. **Service Area**: the geographic area within which potential members must reside in order to enroll and remain enrolled in the MCO under this agreement.

110. **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.

111. **Subcontract**: a written agreement between the MCO or Indian Health Care Provider and a subcontractor to fulfill the administrative requirements of this agreement.

112. **Subcontractor**: any individual or entity that has a contract with the MCO or Indian Health Care Provider that relates directly or indirectly to the performance of the MCO's or Indian Health Care Provider's obligations under this agreement with the Department except for the provision of services to the MCO's members.

113. **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.

114. **Telehealth**: The use of telecommunications technology by a Medicaid-enrolled provider to deliver services allowable under Wis. Admin. Code § DHS 107.02(5) and § DHS 48.45(61) and § DHS 49.46(2)(b)21 to 23., including assessment, diagnosis, consultation, treatment, and transfer of medically relevant data in a functionally equivalent manner as that of an in-person contact. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a certified provider and a recipient that consists solely of an electronic mail message, text, or facsimile transmission.

115. **Third-Party Delegate:** An MCO employee who upon request by the IHCP or third-party provider, in extenuating provider circumstances, completes the provider's initial Medicaid provider enrollment, re-enrollment, revalidation demographic maintenance, or makes changes to programs or services in the ForwardHealth Portal on the provider's behalf.

116. **Tribal Aging and Disability Resource Specialist (Tribal ADRS)**: a position authorized under Wis. Stat. § 46.283(1) and under contract with the Wisconsin Department of Health Services to assure that tribal members receive culturally appropriate information on aging and disability services and benefits. If elected by the Tribal Nation, this position may also provide enrollment counseling to Tribal members to access publicly funded long-term care programs.

117. **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.

118. **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.

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

II. Eligibility Information

A. Eligibility Requirements

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, as appropriate, within ten (10) calendar days of the change.

Notwithstanding the member's reporting obligations, if the IHCP has information about a change in member circumstances (address, income, assets, need, or living arrangements) that may affect Medicaid eligibility, the IHCP is to provide that information to the MCO as soon as possible but in no event more than 10 calendar days from the date of discovery.

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

Information that the IHCP must report to the MCO includes:

1. Information that may affect the member's functional eligibility;
2. The average monthly amount of medical/remedial expenses the member pays for out-of-pocket;
3. 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;
4. Non-payment of any required cost share (post eligibility treatment of income);
5. The member has died;
6. The member has been incarcerated;
7. The admission of a member who is age 21 or over and under age 65 to an Institute for Mental Disease;
8. The member has moved out of the county or MCO's service area;
9. Any known changes in the member's income or assets;
10. Changes in the member's marital status.

B. 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 IHCP 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.

   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.

b. Prior to the end of the deductible period, the IHCP 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 IHCP 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.

c. 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 Medicaid.

      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.

      Patient liability applies to members who reside in a nursing home or Intermediate Care Facilities for Individuals with Intellectual Disabilities

(ICF-IID) for thirty (30) or more consecutive days or are likely to reside there for thirty (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 CFR § 435.726. Patient liability is imposed in accordance with 42 CFR § 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.

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

   iv. The MCO will not collect a patient liability for the current month from a member who enrolls in Family Care after the 1st of the month if the member is residing in a nursing home and receiving nursing home Medicaid benefits. The member will pay their patient liability to the nursing home for the current month and their patient liability to the MCO beginning the next month.

   v. If a member fails to pay the cost share or patient liability as billed by the due date, the MCO, with the assistance of the IHCP, will:

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

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

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

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

e) If all efforts to assist the member to meet the financial obligation are unsuccessful, the MCO will refer the situation to the income maintenance agency for ongoing eligibility determination and the ADRC or Tribal Aging and Disability Resource Specialist (ADRS) for options counseling.

f) For a member with a cost share, inform the member that if the member is having a financial hardship, the member may file an Application for Reduction of Cost Share with the Department, requesting that it be reduced or waived (see Addendum VIII.10.). The MCO, with the assistance of the IHCP, shall also offer to assist the member in completing and submitting the Application.

g) Notify residential providers that member is in jeopardy of or will lose Medicaid eligibility at a minimum of 15 days prior to disenrolling member.

d. The MCO shall reimburse members for cost share or patient liability amounts that were collected by the MCO that need to be returned to the member. The MCO may apply the reimbursement amount towards an outstanding member cost share balance, but the MCO must issue the remainder amount to the member when the reimbursement amount is higher than the outstanding balance.

i. The income maintenance agency or the Department will retroactively adjust the member's cost share amount in CARES. Once the MCO is informed of retroactive adjustment of the member's cost share or patient liability, the MCO must reimburse the member for the incorrectly collected cost share or patient liability amount within thirty (30) calendar days.

ii. If the cost share retroactive adjustment is within the past 365 days, FHiC will adjust the MCO's capitation payment. If the retroactive adjustment is more than 365 days, the MCO may need to contact the Department via the enrollment discrepancy mailbox for an adjustment in capitation payment.

3. *Monitoring Cost Share or Patient Liability*

a. When the Department grants a cost share reduction due to financial hardship, the Department will provide the MCO with a copy of the member's cost share reduction award letter.

i. Annually thereafter, if the reduction is still in effect, the MCO, with assistance from the IHCP, shall verify whether the member continues to experience a financial hardship. The Interdisciplinary Team (IDT) shall conduct this verification during the member's annual reassessment.

a) If the member indicates that they continue to experience a financial hardship and therefore need a cost share reduction, the IDT must notify the MCO's enrollment/eligibility staff. Enrollment/eligibility staff shall verify whether the member's income and monthly necessary living expenses necessitate the continuation of their cost share reduction. MCO staff may request any documentation needed to verify whether an ongoing hardship exists.

b) If the member indicates that they no longer need a cost share reduction or the MCO is unable to verify that an ongoing financial hardship exists, the MCO must ensure that this change is reported to the local IM agency.

ii. The MCO is responsible for the ongoing monitoring of the cost share or patient liability amounts. The IHCP is responsible for reporting medical remedial expenses (MRE) information to the MCO. The MCO is responsible for knowing what the member's ongoing medical/remedial expenses are and reporting changes in those amounts to the income maintenance agency.

iii. The IHCP is responsible to report changes in other circumstances of members that may affect the amount of cost share or patient liability to the MCO within three (3) calendar days of the IHCP becoming aware of the change.

C. **Room and Board**

Indian members shall use their own income to pay for the cost of room and board. Any IHCP contribution to member room and board obligation shall be reported as non-reimbursable expenditures on the IHCP's cost report to the Department. For each member who resides in community-based residential care as defined in Addendum IV, Benefit Package Services Definitions, IHCP is responsible for all of the following tasks:

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

The IHCP determines the member's room and board obligation in the facility in which the member resides, excluding members who reside in subsidized housing. IHCPs must update member room and board obligations annually on February 1 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. 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: https://www.huduser.gov/portal/datasets/fmr.html
    - SNAP allocation: FoodShare Wisconsin Policy Handbook
- 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 all of the following 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.

i. Medical and remedial expenses, defined in MEH 15.7.3; and

j. State and federal income taxes.

2. *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 approved by DHS, and provides that amount to the member and IHCP.

The room and board obligation calculation is not pro-rated for partial months. The MCO may collect from the member the room and board for actual days in residence.

3. *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 IHCP either:

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

   b. Determines if the IHCP will contribute to the member's payment to the facility. The IHCP may use its discretion to determine an amount to contribute to the member's room and board obligation. Any IHCP contribution to a member's room and board obligation are funds that cannot be claimed on the IHCP's cost report to the Department.

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

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

      If the provider is contracted through the MCO then the MCO is responsible for collecting the member's income and paying the room and board.

   b. Upon request, the IHCP shall disclose the monthly amount attributable to services and supervision to the residential provider.

   c. If a member fails to pay the room and board as billed by the due date, the MCO will:

      i. Contact the member and the IHCP to determine the reason for non-payment.

      ii. The MCO and the IHCP will remind the member that non-payment may result in discharge from the facility.

      iii. The MCO and the IHCP will attempt to convince the member to make payment or negotiate a payment plan.

      iv. The MCO or the IHCP will offer the member assistance with financial management services or refer the member for establishment of a representative payee or legal decision maker if needed.

v. If all efforts to assist the member to meet the financial obligation are unsuccessful, the member may be discharged from the facility.

b. *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.

D. Monitoring and Coordination

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

The IHCP 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 occurrence of the change.

III. Enrollment, Disenrollment and IHCP Care Management Selection

A. Process for Selecting a Care Management IHCP

The ADRC or Tribal ADRS will describe the long-term care options available to potential members. This includes the option to have care management provided through an IHCP. If the potential member is interested in enrolling in the MCO that is party to this agreement, if the potential member is an eligible Indian and if the IHCP has adequate service capacity, the following process applies:

1. If there is service capacity, the ADRC or Tribal ADRS will enroll the individual in the MCO and inform the MCO and IHCP of the member's interest in IHCP care management.
2. If there is not service capacity and the potential member would like to be put on a wait list for IHCP care management, the ADRC or Tribal ADRS will notify the IHCP of the potential member's interest in IHCP care management. The IHCP will place the potential member on the wait list.

B. IHCP Capacity and Wait List

1. *IHCP Has Capacity*

When the IHCP has capacity, it will:

a. Accept any Indian referral under Article III.A.1.

Determine if the individual is an Indian within 24 hours of receiving the referral.

i. If the individual is not an Indian, the IHCP will decline the referral and notify the MCO to continue with the initial assessment and service authorization.

ii. If the IHCP is unable to make the determination within 24 hours of receiving the referral, the IHCP will:

a) While the IHCP is making the determination of Indian status, conduct the initial assessment and develop the initial member care plan pursuant to Article IV.D.1. in order to ensure health, safety and well-being of the member.

b) If Indian status cannot be confirmed after three calendar days, the IHCP will decline the referral and notify the MCO who shall proceed pursuant to Article IV.D.2.

2. *IHCP Does Not Have Capacity*

a. When the IHCP is at capacity, the IHCP will:

i. Maintain a wait list in a system specified by DHS;

ii. Accept referrals from the ADRC/Tribal ADRS for individuals interested in IHCP care management;

iii. Determine Indian status; and

iv. Add interested individuals to the waitlist.

b. When IHCP capacity becomes available, the IHCP will contact the next individual or individual's legal representative on the waitlist:

i. If an individual declines IHCP services, the IHCP will document this on the wait list and contact the next individual or individual's legal representative on the list.

ii. If an individual accepts IHCP services, the IHCP will:

a) For individuals enrolled in the MCO that is party to this agreement, immediately notify the MCO and update the wait list. The MCO and IHCP will jointly develop a care management transition plan for that individual.

b) For individuals not enrolled in the MCO or enrolled in an MCO that is not a party to this agreement, instruct the individual to contact their ADRC or Tribal ADRS to discuss enrollment into an MCO that is party to an IHCP-State-MCO agreement and referral to the IHCP. The IHCP will maintain the available capacity for the individual until the individual enrolls in an MCO that is party to an IHCP-State-MCO agreement and is referred to the IHCP. If, during the enrollment process, the individual decides not to be referred to the IHCP, the ADRC or Tribal ADRS will notify the IHCP. The IHCP will immediately update the wait list upon either action.

C. Process for Deselecting an IHCP

If the member informs the IHCP that they wish to receive care management from the MCO instead of the IHCP, the IHCP shall immediately notify the MCO. The IHCP shall cooperate with the MCO in developing a case management transition plan.

Only the MCO can request a disenrollment and must follow the requirements under Section E. of this Article.

D. Prohibited IHCP Involvement

1. The IHCP must not counsel or encourage a member to disenroll due to the member's life situation (e.g., homelessness, increased need for supervision) or not choose the IHCP for case management. The IHCP must refer members to the ADRC or Tribal ADRS for options counseling.

2. These instances should be reported to the Department who will take the necessary action.

E. Limiting Service

If the IHCP is considering limiting IHCP care management to only their Tribal members, it must notify the Department in writing in advance. The IHCP shall not limit the provision of care management service other Indians in advance of this notification and consideration by the Department.

For other Indians currently receiving IHCP care management, The IHCP must continue to provide this service to these members until an appropriate alternative is arranged.

F. Disenrollment

1. *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 IHCP shall provide the member with contact information for the Resource Center or the Tribal ADRS; and while the member is present, either in person or via live video or telephone call, the IHCP may contact the Resource Center or Tribal ADRS to make a referral for the member to receive options counseling.

2. *Involuntary Disenrollment*

   a. Involuntary Disenrollment – General

      The member will be involuntarily disenrolled from Family Care or Partnership, if and of the following events occur:

      i. The member fails to meet functional eligibility requirements.

      ii. The member initiates a move out of the MCO service area as defined in Article IV.L;

      iii. The member dies.

      iv. The member is age 21-64 and is admitted to an Institution for Mental Disease (IMD), except admission to an IMD for Residential Substance Use Disorder (RSUD) treatment. Partnership members admitted to an IMD as an in lieu of service should not be disenrolled.

   b. Disenrollment due to Loss of Medicaid Eligibility

      i. The member will lose Medicaid eligibility if the member does any of the following events occur:

         a) The member fails to meet financial eligibility requirements.

         b) 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.

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

2) 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.

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

4) 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.

c) The member is incarcerated as an inmate in a public institution.

ii. 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.

c. The MCO shall immediately notify the IHCP when a member served by the IHCP loses eligibility.

IV. Care Management

Functions of the IHCP 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 and IHCP in meeting the long-term care needs and supporting member outcomes while maintaining the financial health of the MCO and IHCP; and 3) the overall success of the Family Care program in providing eligible persons with access to and choices among high quality, cost-effective services.

A. Member Participation

1. The IHCP is required to ensure that each member has a meaningful opportunity to participate in the initial development of, and updating of, the member's MCP. The IHCP 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 IHCP 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 and other identity 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. If the member's enrollment form indicates the member is an American Indian/Alaskan Native, the MCO or IHCP must ask the member if the member would like to invite a representative from the member's tribe to participate in the care management process. The IHCP 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. The member's 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. The member's available choices regarding the services and supports the member receives and from whom.

3. The IHCP 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 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, licensed registered nurse and any other staff who are assigned or contracted by the IHCP 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 must include a social service coordinator and a licensed registered nurse.

   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.

   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.

   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. The IDT staff shall have knowledge of community alternatives for the target populations served by the Family Care program 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 Family Care program, and of the individual members to whom they are assigned.

3. The IHCP 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.

4. Before providing care management to members, IDT staff must be trained on the person-centered planning requirements under 42 CFR § 441.301(c)(1), (2) and (3) and Article IV of this contract, and the HCBS settings regulations under 42 CFR § 441.301(c)(4) and (5).

C. Assessment and Member-Centered Planning Process

Member-centered planning is an ongoing process and the 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 IV.D. 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, any risks to the member, 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 III), 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 IHCP must use an electronic case management system and policies and procedures approved by the Department. The MCO shall ensure that the IHCP only has access to member records for members receiving IHCP case management.

ii. The IHCP shall use an assessment protocol, which has been approved by DHS, that includes an in-person interview by the IDT social service coordinator and registered nurse every six (6) months. The interview must take place in the member's residence at least every twelve (12) months, or every six (6) months for a vulnerable/high risk member. The interview should take place with the member and other people identified by the member as important in the member's life.

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

iv. 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.

v. The IHCP 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 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. It will also assist the IDT staff to explore and identify any risks with the member, the level of each risk, and explore ways to mitigate and reduce risk.

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, medical compliance, nutrition and pain as clinically indicated. The nursing assessment will

include an evaluation of a member's ability to set-up, administer, and monitor their own medication as well as a review of the member's last medical appointments and the need for medical care that could result in a severe negative health outcome if not received. 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 behavior modifying medication is 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 medication.

   If a complex medication regimen is prescribed, the IDT staff nurse or other licensed medical professional shall ensure that the member's individual assessment includes the list of medications, and the diagnosis related to each medication.

iii. When there is a discrepancy between medications prescribed and medications being taken, the IDT staff nurse is responsible, in accordance with 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 the member's 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 the member's 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 IHCP or 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 other home and community-based residential setting options offered. If the member declines to consider other options, the MCP must document the member's declination.

xi. A risk assessment for the stability of housing and finances to sustain housing as indicated.

xii. An exploration with the member of the member's preferences for educational and vocational activities, including competitive integrated employment.

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

xiv. An assessment of the member's understanding of the member's rights, such as control of money, freedom of speech, freedom of religion, right to vote, right to privacy, freedom of association, right to possessions, right to competitive integrated employment, right to education, access to healthcare, and right to choose leisure and rest, 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.

xv. 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 IV.J.1, and an assessment of the member's understanding of abuse, neglect and exploitation.

xvi. IHCPs shall educate the member about the full range of waiver services available to the member not just those services provided by the IHCP. The IHCP shall educate the member that the member has a right to free choice of providers and can access services through the IHCP (if the IHCP has the capacity) or an MCO network provider. The IHCP shall ask the member to sign an attestation which shall be attached to the MCP indicating that IHCP has provided him/her with this information every twelve (12) months as part of the annual comprehensive assessment. The attestation must include information on the member's right to use the grievance process to dispute that the IHCP is the only willing and qualified entity in the service area to provide culturally appropriate care management. If the member refuses to sign the attestation, the IHCP will document that refusal in the member's care plan.

xvii. 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.

xviii. For members receiving residential care services, assessment to determine if an HCBS Settings Rule Modification is needed to ensure the health, safety, and well-being of the individual or the community.

a) If an HCBS Settings Rule modification is needed, the MCP must include the information required under Article V.C.3.c. iv.i.

2. *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 IHCP or MCO sufficient to assure the member's health, safety, and well-being including being free from abuse, neglect and exploitation.

ii. Member-centered planning results in a 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 IHCP or 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 and shall document all steps taken in the member care plan.

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

iii. The MCP shall document all of the following:

a) All services and supports whether authorized and paid for by the MCO or IHCP, or provided by natural and/or community supports that are consistent with the information collected in the comprehensive assessment.

b) The member's personal experience and long-term care outcomes.

c) The member's strengths and preferences.

d) The frequency of in-person and other contacts, consistent with the minimums required by Article IV.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 in-person visits.

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

f) 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.

g) The home and community-based residential setting option chosen by the member and other options presented to the member. If the member declines to consider other options, the MCP must document the member's declination.

h) 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.

i) For members receiving residential services, the MCP must document that all are assessed HCBS Settings Rule Modifications 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(s) of the HCBS Settings Rule Modification 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) an assurance that interventions and supports will cause no harm to the individual; and (8) the informed consent of the individual including an attestation of which modification(s) the member agrees to and a member signature indicating informed consent to the modification.

    1) If the member does not consent to an HCBS Settings rule modification that the IDT assesses as necessary under Article V.C.3.c.iv.i, document any associated risk as described in Article V.C.1.b.iv.

j) Verification of the current Notice of Compliance for adult day, prevocational, and group supported employment providers prior to authorizing the service for the member.

k) The plan for coordinating services outside the benefit package received by the member.

l) 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.

m) The specific period of time covered by the MCP.

n) Any areas of concern or risk that IDT staff identify or see as a potential risk that have been discussed with the member, including explored ways to mitigate the concern

or risk that the member has not agreed that reducing the risk is a priority at the present time. The plan will also include that the IDT staff will review with the member the identified concern or risk and ways to mitigate the concern or risk every three months, or more often, depending on the level of risk, until the risk or concern has been successfully mitigated or eliminated. These ongoing reviews will be documented in member's record. Identified concerns or risks may include 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 that time, and IDT staff have offered education about the potential negative consequences of not addressing the risk.

o) The source of primary care appropriate to the member's needs.

p) The person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.

d. Authorizing Services

IDT staff will prepare service authorizations in accordance with DHS-approved service authorization policies and procedures and Section K., Service Authorization, of this article.

e. Documenting Services Authorized by the IHCP

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 IHCP. The list shall include at a minimum:

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

ii. The units authorized for each long-term care service;

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

iv. The provider name for each service.

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 IHCP.

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 the member's agreement with the MCP. If the IHCP is unable to obtain the member or legal decision maker's signature, the IHCP must document the efforts made to obtain it.

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 the issues 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 reasons why the IDT staff and/or mental health professional believe that the member's signature should not be obtained; and

b) Reevaluate the decision to not obtain the member's signature on the MCP or provide the member with a copy of the MCP at each subsequent MCP rev

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 competitive integrated employment and small group community employment services and support).

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.

ii. 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. Electronic Signature

If the member or the member's legal decision maker 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/member's legal representative 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.

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

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

i. Satisfies all contract MCP signature timeframes; and

ii. Includes a process to verify the date of the electronic signature.

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

i. The member/member's legal decision maker's full name; and

ii. IDT staff signatures; and

iii. A list of the documents to which the electronic signature of the member/member's legal decision maker applies and a statement that the electronic signature is only valid for these documents; and

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

m. Distribution of, and access to, signed materials must meet contract requirements including all applicable Health Insurance Portability and Accountability Act (HIPAA) and confidentiality requirements.

n. Member-Centered Plan Distribution

The MCO or IHCP 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.

D. Timeframes

1. *Initial Assessment and MCP Timeframes*

a. Immediate Service Authorization

Beginning on the date of accepted referral for IHCP care management, the IHCP 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. The IDT must also authorize and arrange services and supports for members to discharge from the hospital in a timely manner. Such services may have time limited authorizations until completion of the member's full assessment and member-centered plan.

b. Initial Contact

The IHCP shall contact the member (in-person, via live video, or telephone call) within three (3) calendar days of choosing the IHCP for case management to:

i. Welcome the member to the IHCP;

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 IHCP for needed services;

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

v. For hospitalized members, the IDT must begin discharge planning; and

vi. Schedule an in-person contact with the IDT and member in the member's current residence.

c. Initial Assessment

Within ten (10) calendar days from date of accepted referral for IHCP care management, the IDT shall meet in-person with the member in the member's current residence to:

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

ii. Explain the Family Care 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 in the member's current residence, including an initial brief nursing assessment to examine the member's needs which at a minimum must include:

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

2) Does the member require assistance with medication administration?

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

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

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

6) Assess the stability of current supports in order to identify the services and supports necessary to sustain the member in the member's current living arrangement.

iv. For hospitalized members, the assessment must include documentation on the member's assessed needs to safely discharge in a timely manner.

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 accepted referral for IHCP care management and signed by the member or the member's legal decision maker within ten (10) calendar days of member choosing IHCP.

e. Initial MCP Development

The initial assessment and service authorization completed within the first ten (10) calendar days of date of accepted referral for IHCP care management 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 date of accepted referral for IHCP care management.

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 date of accepted referral for IHCP care management.

3. *Documentation Timelines*

The IHCP 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. Document the member's primary care provider, specialty care provider(s), and psychiatrist (if applicable) within thirty (30) calendar days of accepted referral for IHCP care management;

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

c. Provide information about the 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 IHCP'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 IHCP 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 IHCP, 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 IHCP and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the IHCP, MCO or emergency services provider in the absence of such an agreement.

4. *Monitoring Services*

IDT staff shall, using methods that include in-person 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.

d. A member's level of risk is considered when determining the timeliness of follow up on services and supports received. Members determined a higher risk will require more timely follow up. Follow up is required as soon as possible, but not later than the next required monthly contact.

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 IHCP may use the expedited procedures and reduced documentation requirements listed below in place of the procedures and documentation requirements set forth in Article IV. Sec. C.1.ii. and c. if:

a. The member re-selects IHCP care management or MCO care management;

b. An assessment that complies with the procedures and documentation requirements set forth in Article IV. Sec. C.1.. 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 the member de-selected IHCP care management.

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 IV.C.

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

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

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

3. *Reduced Documentation*

The IHCP 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 IV.F.2.b.

b. Any updates the IDT makes to the most recent comprehensive assessment conducted per Article IV.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 the sections of 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 entire IDT shall participate in the reassessment, which is completed no later than the end of the sixth month after the month in which the previous comprehensive assessment was completed. The reassessment must include an in-person interview with the member by the IDT social services coordinator and registered nurse. The IDT staff may complete in-person interviews at different times. The reassessment shall occur in the member's current residence at least every twelve (12) months, or every six (6) months for vulnerable/high risk members;

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 Section C.1.c.i. shall be met;

d. Any new or previous areas of concern or risk that IDT staff identified or see as a potential risk that have been discussed with the member, including explored ways to mitigate any concern or risk, that the member has not agreed reducing the risk is a priority at the present time.

e. 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 an in-person 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:

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

g. 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 In-Person Contacts*

IDT staff shall establish a schedule of in-person 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 IV.J.1. At minimum, IDT staff is required to conduct in-person visits with all members every three months.

The social services coordinator and registered nurse are further required to conduct an in-person visit every twelve (12) months with the member in the member's residence as a part of the annual comprehensive assessment, or every six (6) months in the member's current residence for vulnerable/high risk members. The annual comprehensive assessment visit and subsequent six (6)

month reassessment visit can count for two of the in-person contacts required by this subsection.

The IHCP must notify the Department's Member Care Quality Specialist about members who meet the vulnerable/high risk criteria but refuse in-person visit(s) in their current residence.

2. *Required Contacts for Members Residing in a 1-2 Bed Adult Family Home*

   a. For members residing in 1-2 Bed Adult Family Homes, a member of the IDT will be required to conduct an in-person visit to the home, as expeditiously as the member's situation requires but no later than thirty (30) days from the IDT receiving notice of any of the following situations:

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

      ii. There has been significant staff turnover at the Adult Family Home that poses a threat to residents' health or safety;

      iii. APS, police and/or crisis involvement;

      iv. IMD discharge; or

      v. The IDT receives notice of a concern about the care or treatment the member receives at the 1-2 bed AFH.

   b. A member of the IDT will be required to conduct an in-person visit to the member's home between fifteen (15) and thirty (30) days after a change is made to the member's Behavior Support Plan or Restrictive Measures plan.

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

   For any month in which there is not an in-person meeting with the member, IDT staff must make telephone call 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. The IDT cannot use text messaging to satisfy this contact requirement.

   a. IDT staff must document that each telephone call or live video contact covered all aspects of service monitoring as required under Article IV.E.4., including that the IDT staff ensured all of the following:

      i. The member is receiving the services and supports authorized, arranged for and coordinated by the IDT staff; and

      ii. The member is receiving the services and supports identified in the MCP as being provided by natural and community supports, and

iii. 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.

b. Live video messaging must occur in real time and be interactive. The IHCP cannot record the live video conference with the member without prior consent from the member; If consent is given orally, the IHCP must 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 Department approved policy and be documented in the member's record.

4. *Documentation*

The IHCP shall document care management contacts in a Department- approved format and provide care management contact data to the MCO.

I. Member Record

The IHCP shall develop and maintain a complete member record in accordance with Department approved policy and procedures as specified in Article XII.A.8, Contents of Member Records, for each member. A complete and accurate account of all care management activities shall be documented by IDT staff and included in the member's record. The IHCP 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 IHCP shall follow the MCO's DHS-approved policies and procedures regarding member safety and risk. IHCP 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 IV, section H.

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

e. Guidelines, trainings, and tools to assist IDT staff in identifying and mitigating risk with all members and/or their legal decision maker;

f. Training and guidance for all IDT staff that identified concerns and risks that require mitigation but a member chooses not to prioritize is reviewed with the member at least every three months, and documented in the members record as identified in the MCP;

g. 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 members including those identified as vulnerable/high risk as defined in Article IV, section H. At a minimum these protocols must include:

   i. Documentation of ongoing assessment of risk and conflict of interest, as required under sections IV.C.2.b.iv. of this Agreement;

   ii. Assessment of caregiver stress to identify the need for caregiver respite or other ways to reduce caregiver stress that is or may pose risk to a member's health and safety by using caregiver stress tool(s);

   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 IHCP 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 IV.E.4. of this Agreement;

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

h. Training and guidance for IDT staff that at every in-person contact, the IDT staff are required to check and document in the member record that each member with a Behavioral Support Plan (BSP) and/or Restrictive Measure have an effective, up to date BSP and/or Restrictive Measure in

place and that residential provider staff are trained and following the BSP and/or Restrictive Measure appropriately.

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

   The IHCP shall implement the MCO's DHS approved policy that expressly prohibits all forms of abuse, neglect, exploitation and mistreatment of members by IHCP employees and contracted providers. The MCO shall provide the IHCP with the proper reporting procedures to the MCO when abuse or neglect is suspected which shall include immediate notification to the MCO, in what format, to whom and how long it will take the MCO to review the report and take or prescribe follow-up action.

3. *Individual Choices in Safety and Risk*

   The IHCP 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 IHCP offers individualized supports to facilitate a safe environment for each member. The IHCP shall assure its performance is consistent with the understanding of the desired member outcomes and preferences. The IHCP 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 and IHCP 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. For each restrictive measure application, the MCO oversight committee must review the application and either approve the application as submitted, approve the application with conditions, request additional information, or deny the application. All MCO decisions must be communicated in writing to the member, the legal decision maker (if applicable), the IHCP and the provider. The written communication must identify each measure reviewed, describe reasons for the return or 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 include grievance information for the member, the legal decision maker (if applicable), and the provider.

   c. Requests for use of restrictive measures must be submitted to DHS via the Restrictive Measures database: https://ltcareies.forwardhealth.wi.gov/restrictiveMeasures/#/login. The MCO, IHCP 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 (https://www.dhs.wisconsin.gov/publications/p02572.pdf).

d. 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.

e. The MCO, IHCP 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.

f. The IHCP shall follow the MCO's DHS-approved policies and procedures regarding Restrictive Measures.

5. *Required Training for Member Safety and Risk*

The IHCP must meet all the following requirements:

a. The IDT must inform the member and/or the member's legal decision maker (and involved family and other unpaid caregivers, as appropriate) about abuse, neglect, and exploitation protections, at the initial assessment or upon member choosing IHCP, or at the initial comprehensive assessment, and at each annual comprehensive assessment thereafter. Completion of this task must be documented in the member record.

b. The IDT must inform the member and/or member's legal decision makers (and involved family and other unpaid caregivers, as appropriate) about how to report a member incident.

c. IHCP staff and third-party providers must be trained in identifying, responding to, documenting, and reporting member incidents. IHCPs must document IHCP staff's completion of training in the staff member's file. Completion of training for third-party providers must be documented and provided upon request to the Department.

6. *Identifying and Responding to Member Incidents*

a. The IHCP must use the MCO's incident management system, that manages incidents occurring at the member and provider levels, to ensure member health and safety, reduce member incident risks, and enable development of strategies to prevent future incident occurrences. The MCO's internal incident management system can integrate with the AIRS.

b. The IHCP shall follow the MCO's Department-approved policies and procedures regarding the Incident Management System.

c. Immediately, but not more than three (3) business days after discovering or learning of a member incident that meets the definition of a member incident type, the IHCP must timely report a member incident. The IHCP

must follow the MCOs process to report a member incident. The MCO must then report the member incident to its Department Member Care Quality Specialist through AIRS.

d. The IHCP must require its third-party providers to report member incidents to designated IHCP staff no later than one (1) business day after discovering or learning of a member incident that meets the definition of a member incident type.

e. Member incidents that must be reported in AIRS include any of the following:

i. Abuse as defined in Article I, including physical abuse, sexual abuse, emotional abuse, treatment without consent, and unreasonable confinement or restraint);

ii. Neglect as defined in Article I;

iii. Self-Neglect as defined in Article I;

iv. Financial exploitation as defined in Article I;

v. Exploitation. Taking advantage of someone for personal gain with manipulation, intimidation, threats, or coercion. This could include, for example, human trafficking, forced labor, forced criminality, creation or possession of child pornography, slavery, coercion, blackmail, and sexual exploitation;

vi. Medication error. Any time a member does not receive their medication as prescribed that resulted in a moderate or severe injury or illness. This includes wrong medication, wrong dosage, wrong timing, omission, wrong route, and wrong technique;

a) A moderate injury or illness is one that requires medical evaluation and treatment beyond basic first aid in any type of medical setting (for example, office visit, clinic, urgent care, emergency room, or hospital observation without admission).

b) A severe injury or illness is one that has or could have the potential to have a major impact on one's life and well-being or that requires hospital admission for treatment and medical care, including life-threatening and fatal injuries.

vii. Missing person. When a member’s whereabouts are or were unknown and one or more of the following apply:

a) The member has a legal decision maker;

b) The member is under protective placement;

c) The member lives in a residential facility;

d) The member is considered vulnerable/high-risk;

e) The MCO believes the member's health and safety is or was at risk;

f) The area is experiencing potentially life-threatening weather conditions; or

g) The member experienced injury or illness while missing;

viii. Fall. An action where a member inadvertently descended to a lower level by losing control, losing balance, or collapsing that resulted in moderate to severe injury or illness directly related to the fall. A fall can be from a standing, sitting, or lying down position;

ix. Emergency use of restraints or restrictive measures. When an unanticipated situation has occurred where an individual suddenly engages in dangerous behavior, placing themselves or others at imminent, significant risk of physical injury. An emergency restrictive measure also applies to situations the IDT does not anticipate will occur again. This may include the appearance of a behavior that has not happened for years or has not been known to occur before or it could include current behaviors that suddenly and unexpectedly escalate to an intensity the team has not seen before;

x. Unapproved use of restraints or restrictive measures. When there is a need for a restrictive measure and the IDT is gathering information for Department approval or when approval for a restrictive measure has expired and is still being utilized;

xi. Death due to any of the member incidents (i. through x.) of this list, as well as death due to accident, suicide, psychotropic medication(s), or unexplained, unusual, or suspicious circumstances; and

xii. Any other type of accident, injury, illness, death, or unplanned law enforcement involvement that is unexplained, unusual, or around which suspicious circumstances exist and resulted in a moderate or severe illness/injury.

f. After discovering a member incident, the IHCP must immediately take effective steps to prevent further harm to or by the affected member(s);

g. 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;

h. 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 IHCP is not responsible for or a substitute for Adult Protective Service investigations;

i. Within three (3) business days of learning of a member incident, the IHCP must notify the member or member's legal decision maker of the incident, unless the member or member's legal decision maker reported the member incident to the IHCP, other legal decision maker is a subject of the investigation;

j. The IHCP must designate staff to conduct member incident investigations who:

   i. Are not directly responsible for authorizing or providing the member's care;
   ii. Have sufficient authority to obtain information from those involved and;
   iii. Have clinical expertise to evaluate the adequacy of the care provided relevant to the member incident.

k. The IHCP and MCO member incident investigation staff must investigate member incidents in a manner consistent with the relative scope, severity, and implications of the member incident; and determine and document, at a minimum, the following information:

   i. The facts of the reported member 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;
   ii. The cause(s) of the incident;
   iii. The outcome of the incident;
   iv. 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

l. The IHCP and MCO must determine if interventions and/or preventative strategies, like changes in the MCO's or third-party provider's policies or practices to help prevent occurrence of similar incidents in the future.

m. The IHCP and MCO must designate staff to provide oversight of IHCP member incident investigation staff or the third-party provider.

n. The IHCP must complete an investigation of each member incident within thirty (30) calendar days of the date that the IHCP learned about or discovered the incident. If the IHCP cannot obtain information or findings necessary to complete the investigation within thirty (30) days for reasons beyond the IHCP's control, the IHCP must complete the investigation as soon as possible.

o. Within five (5) business days of completion of the investigation, the IHCP or MCO must notify the member or member's legal decision maker of the results or outcomes of the investigation. The IHCP must document this notice in the member record.

p. In addition to the reporting requirements in Article V., IHCPs must also comply with all other reporting requirements in this Agreement, including, but not limited to, the reporting requirements provided at https://www.dhs.wisconsin.gov/familycare/mcos/report-reqs.pdf.

7. *Reporting Other Events Related to Member Safety Immediately, but not more than three (3) business days after discovering or learning of the following information, the MCO must also report the following information in AIRS:*

a. Member admission to a state IMD or Intensive Treatment Program (ITP).

b. Media event or social media event. Any instance when a news story, including a social media story, involves an IHCP member, the Family Care Program, the MCO, or the Department, and the news story includes individually identifiable health information;

c. Immediately, but not more than three (3) business days after discovering or learning of the following information, the MCO must also report the following information to the Department by e-mailing the information to the MCO's assigned Member Care Quality Specialist:

i. Media event or social media event. Any instance when a news story, including a social media story, involves an IHCP member, the Family Care Program, the MCO, or the Department, and the news story does not individually identifiable health information;

d. The MCO may report the following information in AIRS to track such information and to communicate with and receive feedback from the Department:

i. Relocation/discharge with the Department's oversight. Any instance when the IHCP or MCO has identified barriers to relocation or discharge of an enrolled member and either the Department, the IHCP, or the MCO has identified the need for additional oversight;

ii. Transition into Adult Long-Term Care. Any time an individual plans on enrolling into adult long-term care and who has extenuating circumstances which may include residing out of state, Justice-involved releases, transition from children's long-term care programs, or any other situation in which the IHCP, MCO or the Department has identified the need for additional oversight; or

iii. Any other event or notification that is identified as needing additional oversight by the IHCP, MCO and/or the Department.

iv. The MCO may use a 'proxy member' in AIRS if the information does not tie to a single member or the MCO does not have the necessary information required to submit a level 3 notification via AIRS for a member in transition to Adult Long-Term Care.

e. The IHCP must report incidents meeting criteria in Wis. Stat. §§ 46.90(4) or 55.043(1m) in accordance with the applicable statute to the appropriate authority. Such incidents may include when a member is at risk of serious bodily harm, death, sexual assault, or significant property loss, and is unable to make an informed judgment about whether to report the risk. The IHCP is not responsible for or a substitute for Adult Protective Service investigations.

f. The IHCP must report and require its third-party providers to report the following incidents to local law enforcement authorities:

i. Incidents where the member is a victim of a potential violation of the law are reported to local law enforcement authorities.

ii. Incidents where the member is suspected of violating the law are reported to local law enforcement, to the extent required by law.

8. *Responding to Requests and Inquiries from the Department through AIRS*

a. The IHCP will respond to all requests and inquiries received through AIRS from the Department within one (1) business day. This type of request or inquiry is called a "DHS Notice" and may contain PHI that is safely received and maintained by the IHCP through the MCO's incident management system integrated with AIRS.

b. Once a DHS Notice is received, the IHCP is required to review and either respond to the DHS Notice; enter an incident; and/or enter a notification in AIRS that relates to the information within the DHS Notice.

c. If an incident or notification is entered by the IHCP, all incident and notification requirements are to then be followed by the IHCP.

K. Service Authorization

1. *Service Authorization Policies and Procedures*

   a. Services in the Long-Term Care Benefit Package

      The IHCP must use a Department-approved electronic care management system to generate service authorizations and must follow a DHS-approved service authorization policy and procedures.

   b. Procedures

      IDT staff shall use a Department approved standardized service authorization policies, procedures and guidelines, as applicable. IDT staff shall explain to the member the 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 IHCP must have in effect mechanisms to ensure consistent applications of review criteria for authorization decisions; and consult with the requesting provider when appropriate.

   c. Remote Waiver Services and Interactive Telehealth

      i. Remote Waiver Services

         Remote waiver services means waiver services delivered using audiovisual communication technology that permits 2-way, real-time, interactive communications between a provider and a member. Other than telephonic care management contacts discussed in Art. IV., remote waiver services does not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail. The IDT cannot require the use of remote services to authorize the service.

         For services in Addendum IV.A, the IDT must first determine the service is necessary to support an outcome by using the RAD or other Department approved alternative and then determine whether it can be authorized remotely.

         To authorize a waiver service for remote delivery, the IDT must:

         a) Determine that the service is functionally equivalent to in-person service.

         b) Obtain informed consent from the member to receive the service remotely.

         c) Determine that the member has the proper equipment and connectivity to participate in the service remotely. The MCO and IHCP are not required to provide the proper equipment and connectivity to enable the member to access the service remotely.

If the IDT determines that the service cannot be authorized remotely based on the above, the IDT must authorize the service in-person. A member may grieve the IDT decision.

MCOs must include the modifier 95 when the MCO submits claims that are delivered remotely.

The following services in Addendum IV.A may not be authorized for remote delivery:

1) Adult Day Care Services
2) Home-delivered meals
3) Residential Care
4) Transportation – Community and Other
5) Relocation Services
6) Self – Directed Personal Care
7) Skilled Nursing Services RN/LPN
8) Specialized Medical Equipment and Supplies

ii. State Plan services via interactive telehealth

Interactive telehealth means telehealth delivered using multimedia communication technology that permits 2-way, real-time, interactive communications between a certified provider of Medical Assistance at a distant site and the Medical Assistance recipient or the recipient's provider.

For authorizing State Plan services in Addendum IV.B via interactive telehealth, the IDT 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.

2. *Necessity or Appropriateness of Services*

a. Use of Approved Service Authorization Policies

The IDT shall use Department-approved service authorization policies and procedures to authorize services. The IDT shall not deny services that are reasonable and necessary to 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.

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 and Nursing Home in Addendum IV, Benefit Package Service Definitions.

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 acuity/condition.

e. Resolving Disputes

Disputes between the IHCP and members about whether services are necessary to support outcomes are resolved through the MCO's grievance and appeals processes described in Article X. IHCPs must immediately refer members who have a dispute to the MCO.

3. *Authorization Limits*

The IHCP 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 VI, Services.

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 7, Responding to Direct Requests By a Member for a Service, of this section.

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

The IHCP must implement procedures to:

a. Ensure that each member has an ongoing source of primary care appropriate to the member's 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 IHCP 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 XII. A.

5. *Prohibited Compensation*

The IHCP 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.

6. *Communication of Guidelines*

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

7. *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 MCO's DHS-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 IHCP may authorize the service only if it complies with the requirements set forth in Article VI.B.);

d. 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;

e. 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 MCO's DHS-approved service authorization policies and procedures. The member is always a participant in the MCO's DHS-approved service authorization policies and procedures.

ii. If the service authorization process requires that additional IHCP employees or other professionals be involved in decision-making about a member request for service, the IHCP shall assure that:

a) The additional IHCP employee(s) shall join with the IDT staff;

b) The expanded IDT shall use 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 IHCP employees or other professionals.

d) 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.

e) The timeframe for decision-making must be in accordance with the timeframe outlined in paragraph 8, Timeframe for Decisions, below.

f. 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 8 below, if the service or item requested is in the benefit package, provide the member notice of action 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.

Failure to reach a service authorization decision within the timeframes specified in paragraph 8, Timeframe for Decisions, below constitutes a denial and therefore requires a notice of action. The notice of action must meet the requirements of Article X, Grievances and Appeals.

ii. When appropriate, notify the rendering provider of the authorization decision. Notices to providers need not be in writing.

iii. 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 MCO or Department upon request.

8. *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

Standard service authorization decisions shall be made no later than fourteen (14) calendar days following receipt of the request for the service unless the IHCP extends the timeframe for up to fourteen (14) additional

calendar days. If the timeframe is extended, the IHCP must send the following written notification of extension to the member no later than the fourteenth day after the original request:

Extension notice for Family Care and Partnership Medicaid-only: https://www.dhs.wisconsin.gov/forms/f0/f00232b.docx

b. Expedited Service Authorization Decisions

For cases in which a member or provider indicates, or the IHCP 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 IHCP shall make an expedited service authorization no later than seventy-two (72) hours after receipt of the request for service.

The IHCP may extend the timeframes of expedited service authorization decisions by up to fourteen (14) additional calendar days if the member or a provider requests the extension or if needed by the IHCP to gather more information. For any extension not requested by the member, the IHCP 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 action. The notice of action must meet the requirements of Article X, Grievances and Appeals.

9. *Notice of Action*

In accordance with Article X.D.1., the IHCP shall provide written notice of action 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.

10. *Notification of Non Covered Benefit*

In accordance with Article X.D.1., the IHCP shall provide a Notification of Non Covered Benefit (https://www.dhs.wisconsin.gov/library/collection/f-01283) 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. IHCP 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.

2. *IHCP Responsibilities*

   When the IHCP becomes aware that a member intends to change her or his residence, the IHCP shall immediately notifying the MCO, inform the MCO when the appropriate provision below occurs, timely update its records when the change of address occurs and do the following:

   a. For Moves Within the MCO's Geographic Service Region(s):

      i. Inform the member of any changes in care management provider, 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 (https://www.dhs.wisconsin.gov/library/collection/f-02404).

   b. For Moves to Another Geographic Service Region Served by the member's MCO:

      i. Inform the member of any changes in care management provider, 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 (https://www.dhs.wisconsin.gov/library/collection/f-02404).

      iii. Inform the member that options counseling is available from the ADRC or Tribal ADRS 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), long-term care program or care management providers.

   c. For Moves to Another Geographic Service Region Not Served by the member's MCO:

      i. Unless the move is due to an IHCP-initiated placement in a nursing home or community residential facility, inform the member that they will be disenrolled, will need to select a different MCO or long-term care program, 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 or Tribal ADRS 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 IHCP should facilitate this contact and coordinate disenrollment/enrollment dates with the receiving ADRC or Tribal ADRS.

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 (https://www.dhs.wisconsin.gov/library/collection/f-02404).

M. Requirement to Notify Counties and Tribal Human/Human and Family Services of At-Risk Members:

1. If an IHCP identifies risk factors for a member that indicate a need to coordinate planning efforts or provide information to a county and tribal Human Services agency, the IHCP will do the following:

   a. Send the Family Care Member County Notification Form F-02558, https://www.dhs.wisconsin.gov/forms/f02558.docx, to:

      i. The county of residence/responsibility on record, and

      ii. To the county where the person lives (if different), and

      iii. To the tribal Human/Human and Family Services agency.

   b. When appropriate or requested, work with the receiving county, tribal Human/Human and Family Services agency, and any relevant providers in the development of a behavior support plan, a crisis plan, or other community safety plans.

   c. Update the information on form F-02558 if the member's address or other essential information changes and provide that information to the county and tribal Human/Human and Family Services agency.

   d. If the member lives in a residential setting, provide a copy of the notification form to the member's residential provider agency.

   e. If a member moves voluntarily to a county in which the MCO does not operate, follow the Change Routing Notification process in Article IV.L.2.b.

   f. In instances in which the individual's county of legal residency comes into question, or when the individual does not provide written consent for the IHCP to provide this notification form to the county or tribal

Human/Human and Family Services agency, the IHCP will convey only the necessary information to ensure appropriate service coordination, as defined in Wis. Stat. § 46.22(1)(dm), about the individual to the appropriate county, tribal Human/Human and Family Services agency, or state agency involved in residency determinations and/or in the coordination of services.

N. Department Review

All records the IHCP maintains pursuant to this agreement shall be made available to the Department upon request with adequate notice for inspection, examination, or audit. Except when the Department determines that unusual circumstances exist, the Department will give the IHCP at least five (5) business days written notice to produce the requested records, unless the IHCP consents to a shorter time frame.

V. Self-Directed Supports

A. IHCP Requirements

The IHCP must present Self-Directed Supports (SDS) as a choice to all members as specified in Wis. Admin. Code § DHS 10.44(6). Specific responsibilities of the IHCP 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 IHCP staff who have expertise in SDS.
5. Follow the MCO's DHS-approved policy and procedure for setting budgets.
6. Ensure that all IDT staff understand how to create a budget with a member or have access to IHCP staff who have expertise in SDS who can assist with setting budgets.
7. Ensure that all IDT staff understand how to monitor SDS with a member and their IDT or have access to Indian Health Care Provider (IHCP) staff who have expertise in SDS who can assist with monitoring for quality and safety.
8. 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 IHCP staff who have expertise in SDS who can assist with mitigating such conflicts.
9. Develop and implement a Department-approved policy and procedure describing conditions under which the IHCP may restrict the level of self-direction 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-direction exercised by a member may be approved by DHS in relation to other situations that the IHCP has identified as having negative consequences.

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.

B. IHCP IDT Staff Responsibilities

It is the responsibility of the IHCP IDT staff to provide:

1. 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 member's 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;

d. An explanation of the member's right to request a grievance, as specified in Article X., if the IDT denies the member's request to self-direct a service; and

e. An overview of the conditions in which the IHCP may limit a member's existing level of self-direction, the actions that would result in the removal of the limitation, and the member's right to request a grievance, as specified in Article X, Grievances and Appeals, if the member disagrees with the IHCP's decision to limit the member's existing level of self-direction.

2. 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 Indian Health Care Provider (IHCP) 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 Indian Health Care Provider (IHCP) 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 Indian Health Care Provider (IHCP) interdisciplinary team."
3. Maintain the signed form as required in Article V.B.2. above.
4. 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.

5. 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.
6. 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.
7. Implement the policies and procedures regarding member safety and risk described under Article IV.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.
8. 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

VI. Services

A. General Provisions

1. *Comprehensive Service Delivery System*

   The IHCP will provide members with high-quality long-term 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 that are cost effective.

   d. Comply with 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.

3. *Coverage Responsibility*

   The IHCP is responsible for authorizing services in the benefit package that 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. *Inform Members of the Benefit Package*

   The IHCP will inform members of the full range of services in the benefit package appropriate for their level of care.

5. *In Lieu of Services*

   The MCO and IHCP may only provide a service as an in lieu of service if it is so specified in this agreement.

   a. Definition

      In lieu of services (ILOS) are a subset of services that the Department has, as a general matter, determined are medically appropriate and cost-effective substitutes for covered services in the benefit package, and:

      i. Are offered to a member at the discretion of the IHCP;

ii. The member agrees to as a substitute service; and

iii. For which the IHCP or MCO pays no more than the Medicaid fee-for-service rate of the covered service in the benefit package for which the substitute service is being provided in lieu of.

b. Process for Determining use of ILOS

The IDT must consistently use member-centered planning required by Article IV to identify the medically appropriate and cost-effective use of ILOS.

The IDT, including the member and licensed clinical staff or contracted network provider, use their personal and professional expertise to identify medically necessary, appropriate and adequate services and supports to be authorized, provided and/or coordinated by the IHCP sufficient to assure the member's health, safety, and well-being including being free from abuse, neglect and exploitation.

c. Required Documentation

The IDT must document the ILOS in the Member Centered Plan.

d. In Lieu of Services for Members Functionally Eligible at the Non-Nursing Home Level of Care

This ILOS is available for members eligible at the non-nursing home level of care.:

i. The following ILOS are a substitute for state plan service home health care in Addendum IV.B.6 or state plan service personal care in Addendum IV.B.14 Provider qualifications and other limitations and protocols for each in lieu of service are identified in the referenced addendum:

a) Supportive home care in Addendum IV. A.24. The MCO must submit encounter claims with S5120, S5121, S5125, S5126, S5135, or S5136;

b) Respite care in Addendum IV.A.17. The MCO must submit encounter claims with 0660, 0663, S9125, or T1005;

c) Personal emergency response system in Addendum IV.A.13. The MCO must submit encounter claims with S5160, S5161, or S5162;

d) Daily living skills training in Addendum IV.A.10.a. The MOC must submit encounter claims with H2014, T2012, or T2013;

e) Day habilitation services in Addendum IV.A. 10.b. The MCO must submit encounter claims with T2020 or T2021;

f) Prevocational services in Addendum IV.A.14. The MCO must submit encounter claims with T2014 or T2015;

g) Residential care services in Addendum IV.A.16. The MCO must submit encounter claims with 0240, 0241, 0242, 0243, or 0670;

h) Home delivered meals in Addendum IV.A.11. The MCO must submit encounter claims with S5170 or S9977.; or

i) Counseling and therapeutic services in Addendum IV.A.7. The MCO must submit encounter claims with 90899, 90901, 97139, 97799, G0151, G0176, H2028, H2032, H2035, S8940, S8990, S9128, S9129, S9131, S9449, S9451, S9452, S9453, S9454, S9470, S9472, S9473, S9970, or T1023; or

ii. The following ILOS is a substitute for State Plan transportation services in Addendum IV.B.16. Specialized transportation–other transportation in Addendum IV.A.27.. and the MCO must submit encounter claims with A0090, A0100, A0110, A0120, A0130, A0160, A0170, A0180, A0190, A0200, A0209, S0210, S0215, T2001, T2002, T2003, T2004, T2005, T2007, T2049

B. Provision of Services in the Family Care Benefit Package

1. *Services for Members at the Nursing Home Level of Care*

The IHCP shall promptly provide or arrange for the provision of all health and long-term care services in the benefit package, consistent with the MCP described in Article IV.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 IV.A.;

b. The long-term care Medicaid State Plan Services identified in Addendum IV.B.; and

c. Any cost-effective health care services the IHCP substitutes for a long-term care service in the Medicaid State Plan identified in Addendum IV.B.

2. *Services for Members at the Non-Nursing Home Level of Care*

The following policies apply to Family Care members who are at the non-nursing home level of care:

a. The IHCP 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 IV.B.

b. If a member at the non-nursing home level of care is admitted to a nursing facility or ICF-IID the IHCP must immediately notify the MCO as the LTCFS 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 IHCP shall:

   i. Within three (3) business days of the rescreening result the MCO will contact the Division of Medicaid Services Nursing Home Section in the Bureau of Long-Term Care Financing at DHSDLTCBFM@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 CFR §438.210 that the IHCP's coverage of nursing home services is no more restrictive than what applies under FFS, the IHCP 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 IHCP shall notify the member and nursing facility that this service is not in the member's benefit package. If the IHCP will terminate the nursing home service, it must provide appropriate notice in accordance with Article X.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 IHCP should notify the MCO immediately and the LTCFS 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 IHCP 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 IHCP shall notify the member and nursing facility that this service is not in the member's benefit package. If the IHCP will terminate the nursing home service, it must provide appropriate notice in accordance with Article X.D., Notice of Adverse Benefit Determination.

3. Requirements related to the delivery of specific services

a. Remote Monitoring and Support

i. The IHCP shall develop and submit to the Department for approval a policy and procedure regarding the authorization and provision of Remote Monitoring and Support as described in Addendum VI.A. The policy and procedure shall address the following:

a) Policies related to how the IHCP will ensure that use of the service maximizes the member's privacy and individual rights, and confirm that devices with video and audio feed are not placed in bedrooms or bathrooms.

b) Policies and procedures for obtaining, documenting, and updating informed consent of the member, legal decision-maker, and any individuals living with the member. The IHCP may also address how visitors will be notified of any monitoring equipment or devices.

c) Procedures for creating and using a back-up support plan for the member in the event of an emergency, equipment malfunction, or if the member otherwise needs in person support.

d) Procedures and timeframes for deactivating devices and using back-up supports if the member, legal decision-maker, or individuals living with the member retract their consent.

e) Procedures for determining that the service is sufficient to ensure the member's health and welfare, including how the IHCP will address any risks related to the service (for example, if the member chooses to turn off devices).

f) Policies and procedures for ensuring that monitoring equipment is not used to monitor or surveil in-person support staff.

C. Prohibited Services

The IHCP 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 be used under the Assisted Suicide Funding Restriction Act of 1997.

D. Primary Care and Coordination of Health Care Services

The IHCP must follow Department approved procedures to:

1. *Ensure an Ongoing Source of Primary Care*

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

2. *Coordinate Services*

   Coordinate the services the IHCP authorizes for the member with the services the member receives from any other provider of health care or insurance plan.

3. *Protect Privacy*

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

E. 24-Hour Coverage

1. *Responsibility*

   The IHCP 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 IHCP shall:

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.

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 MCO or Department upon request.

e. Notify members and the MCO and Department of any changes of the phone number within seven (7) business days of change.

F. Billing Members

1. *Prohibition on Billing Recipients for Covered Services*

The IHCP, 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 Article II of this agreement. Post-eligibility treatment of income is not a bill for services. This provision pertains even if any of the following occur:

a. IHCP becomes insolvent.

b. MCO or Department does not pay the IHCP 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.

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 IHCP's insolvency, IHCP shall not bill members for debts of the IHCP or for services in the benefit package and provided during the member's period of MCO enrollment.

G. Department Policy for Member Use of Personal Resources

1. *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 process with notice that meets the requirements under Article X.D. (Notice of Action), no additional counseling is required.

b. In any other situation where use of personal resources is permitted under sub-section 2 the IHCP shall counsel the member that such use of personal resources is entirely voluntary and shall document this counseling in the case record.

2. *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 IHCP is aware of a planned payment, the IHCP 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.

3. *Reporting*

a. The IHCP shall report quarterly to the MCO:

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 IHCP; and

iii. All circumstances when the member uses personal resources for an item or service in the benefit package.

b. The IHCP does not need to report to the MCO in the quarterly report:

i. Voluntary payments the IHCP 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.

H. Court-Ordered Services

1. *Coordinate with County Agencies*

The IHCP shall attempt to coordinate the provision of court-ordered services with the county agencies that provide services to the court.

2. *Arrange for Court-ordered Services*

The IHCP shall arrange 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 IHCP 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 IHCP 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 IHCP responds in writing.

4. *Collaborate on the Plan of Care*

Whenever possible, the IHCP 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.

I. Elder Adults/Adults at Risk Agencies and Adult Protective Services

1. *IHCP Responsibility*

The IHCP shall make reasonable efforts to ensure that the members they serve are free from abuse, neglect, self-neglect and financial exploitation.

2. *Policies and Procedures*

The IHCP shall ensure that IHCP staff:

a. Are able to recognize the signs of abuse, neglect, self-neglect, and financial exploitation as defined in Wis. Stats. §§ 46.90 and 55.01.

b. Identify members who may be at risk of abuse, self-neglect and financial exploitation and in need of elder adult/adult-at-risk or adult protective services (EA/AAR/APS).

c. Report incidents to the MCO involving member abuse, neglect, self-neglect and financial 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 IHCP shall involve the entity in the following capacities:

   a. The IHCP 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; and

   b. The IHCP 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.

   c. The IHCP shall designate a contact person to assist staff working in county EA/AAR/APS agencies to develop service options for members or potential members. This contact person, or a representative of the member's Indian Health Care Provider (IHCP) interdisciplinary team, may participate in the county EA/AAR interdisciplinary team.

4. *Examination and Treatment Services*

   The IHCP 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 IHCP shall consult with human service agencies on appropriate providers in their community.

   The IHCP 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. *Court Ordered Services*

   The IHCP shall comply with the provisions in Section H, Court-Ordered Services, in this article for all adult protective services through Wis. Stats. §§ 51, 54, or 55.

J. Electronic Visit Verification (EVV)

With the assistance of the MCO, the IHCP must use EVV for designated service codes by the deadlines established by the Department. The IHCP and MCO must submit a daily authorizations file for all EVV-required services outlined on the Department's EVV website (https://dhs.wisconsin.gov/evv/programadmin.htm). The IHCP and MCO must use a daily file that contains all the verified EVV visits to ensure that claims processed for

EVV services can be associated with EVV visit information. Encounters without a valid EVV record may be excluded in future rate setting development. The MCO must outline expectations for contracted providers, and IHCPs, regarding the use of the EVV data collection system within the subcontractors and/or provider manuals. The MCO must also provide assistance and support to the Department and the State's contracted EVV vendor for training, outreach, and utilization of the data collection system, as requested. The IHCP and MCO must submit accurate, complete, and timely data.

VII. Provider Network

A. Member Choice

1. *Information to Members*

   The IHCP shall inform members about the full range of provider choice available to them, including free choice of medical and other providers through the MCO or that remain fee-for-service for Family Care members, as applicable.

2. *Member Choice of Interdisciplinary Teams*

   The IHCP shall inform the member that the member is allowed to change to an MCO interdisciplinary team at any time.

B. Member Communications

1. *Licensed Health Care Providers Advising and Advocating*

   An IHCP may not prohibit, or otherwise restrict, a third-party provider acting within the lawful scope of practice, from advising or advocating on behalf of an member who is the provider's 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 the member's 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 IHCP shall make available:

   a. The licensure, certification and accreditation status of the IHCP, its staff and the providers it contracts with;

   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 are contracted by the IHCP or which are provided by the IHCP.

C. Provider Agreements

IHCP provider agreement templates must be approved by the Department prior to the IHCP executing a provider agreement with a third-party provider. A provider agreement

is not required when the IHCP is the provider of the service. This section shall not apply when the IHCP is the provider of the service, although the IHCP shall remain subject to the requirements of this agreement. All IHCP provider agreements for member services with third parties shall be in writing and shall comply with any general requirements of this agreement that are appropriate to the service. All amendments to provider agreements shall be in writing and signed and dated by both the third-party provider and the IHCP.

The third-party provider must agree to abide by all applicable provisions of this agreement. Provider compliance with this agreement 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 IHCP and third-party 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 third-party provider.

4. *Compensation*

   The provider agreement specifies rates for purchasing services from the third-party provider. The provider agreement specifies payment arrangements in accordance with Article VII.F.

5. *Term and Termination*

   a. Provider agreement.

      The provider agreement specifies the start date of the provider agreement and the means to renew, terminate and renegotiate. The provider agreement specifies the IHCP's ability to terminate and suspend the provider agreement and a process for the provider to appeal the termination or suspension decision.

   b. The Department is responsible for monitoring and terminating providers from the Medicaid program for reasons listed under Wisconsin Admin. Code § DHS 106.06 as well as the reasons listed below in Art. VII.C.5.d and g. The Department will inform the IHCP when a provider is terminated from the Wisconsin Medicaid program for cause and the IHCP must terminate that provider from its network.

   c. The IHCP is primarily responsible for monitoring and terminating waiver services providers for the reasons listed below in Art. VII.C.5.d. and g.

d. The IHCP must terminate a provider for cause in all the following circumstances:

   i. Criminal Conviction. The provider or any person with a 5 percent or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted (as defined in 42 CFR § 1001.2) of a Federal or State criminal offense related to that person's involvement with Medicare, Medicaid or CHIP. This requirement applies unless the IHCP receives permission from the Department to not terminate the provider as identified in VII.C.5.e.

   ii. Failure to Comply with Screening Requirements. Where any person with a 5 percent or more direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR § 455.416(a).

   iii. Failure to Submit Fingerprints. Where the provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Department within thirty (30) days of a CMS or the Department's request. This requirement applies unless the IHCP receives permission from the Department to not terminate the provider as identified in VII.C.5.e.

   iv. Failure to Submit Timely and Accurate Information. The provider or a person with an ownership control interest, an agent, or managing employee of the provider fails to submit timely and accurate information. This requirement applies unless the IHCP receives permission from the Department to not terminate the provider as identified in VII.C.5.e.

   v. Onsite Review. The provider fails to permit access to provider locations for any site visit. This requirement applies unless the IHCP receives permission from the Department to not terminate the provider as identified in VII.C.5.e.

   vi. Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment. The provider's enrollment has been terminated or revoked "for cause" by Medicare or another state's Medicaid program.

e. The IHCP must terminate a provider due to a reason in Article VII.C.5.d.i and iii. through v., unless the IHCP obtains approval from the Department to not terminate the provider. This process is not available for an IHCP when a provider must be terminated due to a reason in Article VII.C.5.d.ii and vi. The IHCP must contact its contract coordinator to request permission to not terminate the provider. The contractor coordinator shall

alert the DHS OIG of the request. The DHS OIG will determine whether the termination can be waived.

f. The IHCP is required to notify the Department at mailto: DHSDMSLTC@dhs.wisconsin.gov within seven (7) calendar days when any notice is given by the IHCP to a provider, or any notice given to the IHCP from a provider, when the IHCP receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the IHCP.

g. The IHCP may terminate a provider for cause in all the following circumstances:

   i. Abuse of Billing Privileges. The provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service including when the beneficiary is deceased, where the directive physician or the beneficiary is not in the state when the services were furnished unless otherwise authorized by telehealth rules, or when the equipment necessary for testing is not present where the testing is said to have occurred.

   ii. Billing with Suspended License. Billing for services furnished while the provider's license is in a state of suspension.

   iii. Improper Prescribing Practices. The IHCP determines that a provider has a pattern of practice of prescribing drugs that is abusive, as defined in 42 CFR § 455.2, or represents a threat to the health and safety of members.

   iv. Misuse of Billing Number. The provider knowingly sells to or allows another individual or entity to use its billing number, other than a valid reassignment of benefits.

   v. Noncompliance with Licensure Standards. When the provider has been subject to an adverse licensure action resulting in the loss of license. This does not include license expiration.

   vi. Prescribing Authority. The provider's Drug Enforcement Administration Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any state in which the provider practices suspends or revokes the provider's ability to prescribe drugs.

   vii. Provider Conduct. The provider or any owner, managing employee, or medical director of the provider is excluded from the Medicare or Medicaid programs.

h. 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 IHCP and third-party provider.

ii. When a member's change in condition warrants a change in the acuity-based rate setting model.

iii. An adjustment in payment rate made pursuant to VIII.L.6.c-e, whether resulting in a State directed rate increase or rate decrease, shall not be considered a rate change for purposes of this twelve (12) month period.

iv. 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 IHCP must provide a sixty-day written notice to the third-party 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 ii are protected from additional decreases during the subsequent twelve (12) month period.

i. 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 IHCP shall specify in its provider agreements with third-party providers of supportive home care or in-home respite care services that the third-party 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 IHCP.

If the IHCP delegates selection of third-party providers to another entity, the IHCP retains the right to approve, suspend, or terminate any provider selected by that entity.

8. *Quality Management (QM) Programs*

The third-party provider agrees to participate in and contribute required data to the IHCP QM programs as required in Article XIII.

9. *Restrictive Measures*

The IHCP must require its third-party 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 IV.J.4. Use of Isolation, Seclusion and Restrictive Measures.

10. *Member Incidents*

The IHCP must require third-party providers it contracts with to identify, respond to, document, and report member incidents as required in Article IV.J.6. Identifying and Responding to Member Incidents.

11. *Non-Discrimination*

The third-party provider agrees to comply with all applicable non-discrimination requirements and all applicable affirmative action and civil rights compliance laws and regulations as described in Article X. (also reference https://www.dhs.wisconsin.gov/civil-rights/index.htm). No term or condition of the provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible under federal law for services from the IHCP.

12. *Insurance and Indemnification*

The third-party provider attests to carrying the appropriate insurance and indemnification.

13. *Notices*

The provider agreement specifies a means and a contact person for each party for purposes related to the subcontract (e.g., interpretations, subcontract termination).

14. *Access to Premises and Audit Rights*

The third-party provider agrees to provide representatives of the IHCP, 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 XII. F. If not self-insured:

The IHCP agrees that in order to protect itself as well as the Department under the indemnity agreement provision set forth in the preceding paragraph, the IHCP will at all times during the terms of this agreement keep in force a liability insurance policy issued by a company authorized to do business in the State of Wisconsin and licensed by the Office of Commissioner of Insurance. In the event of any action, suit, or proceeding against the Department upon any matter herein

indemnified, the Department shall, within five (5) working days, notify the IHCP by certified mail, addressed to its post office address, of the action.

15. *If self-insured:*

    The IHCP shall be responsible for any loss or expense (including cost and attorney fees) incurred by or attributed to any act, error, or omission of its agent or agents.

16. *Certification and Licensure*

    The third-party provider agrees to provide applicable licensure, certification and accreditation status upon request of the IHCP or MCO and to comply with all applicable regulations. third-party providers who are certified by Medicaid agree to provide information about their education, board certification and recertification upon request of the IHCP or MCO. The third-party provider agrees to notify the IHCP of changes in licensure. The third-party provider agrees to keep provider enrollment documentation and all personnel files related to persons providing direct care to members for 10 years from the final date of the contract period or from the date of completion of any audit.

17. *Sanctions/Criminal Investigations*

    The third-party provider must notify the IHCP of any sanctions imposed by a governmental regulatory agency and /or regarding any criminal investigations(s) involving the third-party provider. The IHCP must report this information to the MCO and DHS.

18. *Cooperation with Investigations*

    To the extent permitted by law, the provider agreement shall require the third-party provider to fully cooperate with any member-related investigation conducted by the IHCP, MCO, the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity.

19. *Records*

    The third-party provider agrees to comply with all applicable Federal and State record retention requirements in Article XIII.C.

20. *Member Records*

    The third-party provider agrees to the requirements for the confidentiality protection, maintenance and transfer of member records described in Article XII.A.1.

    The third-party provider agrees to make records available to members and individuals the member has authorized in writing to receive records 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 CFR Wis. Stats. § 164.524 (b)(2).

The third-party provider agrees to forward records to the IHCP and MCO pursuant to grievances and appeals within fifteen (15) business days of the IHCP or MCO's request or immediately if the appeal is expedited. If the provider does not meet the fifteen (15) business day requirement, the third-party provider must explain why and indicate when the records will be provided.

21. *Confidentiality*

The third-party provider agrees otherwise to preserve the full confidentiality of records, in accordance with Article XII.A. 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 MCO, Department and CMS which, require information in order to perform their duties related to this agreement or the DHS-MCO contract.

22. *Access to Services*

The third-party 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 third-party provider on how to obtain information that delineates the process the third-party provider follows to receive authorization for providing services in the benefit package to members. The IHCP agrees to clearly specify authorization requirements to its providers and in any provider agreements with its providers.

The IHCP shall ensure service authorization is given to the third-party 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 third-party providers promptly, with sufficient notice to allow third-party 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 IHCP and/or any third-party payer will be the sole compensation for services rendered under the agreement or the DHS-MCO contract. The third-party provider agrees not to bill members and to hold harmless individual members, the MCO, Department and CMS in the event the IHCP cannot pay for services that are the legal obligation of the IHCP to pay, including,

but not limited to, the IHCP's insolvency, breach of agreement, and provider billing.

The IHCP and the third-party provider may not bill a member for covered services, except in accordance with provisions in Article VI. F. Billing Members.

25. *Member Appeals and Grievances*

The third-party 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 third-party provider treats the member.

The third-party provider agrees to cooperate and not interfere with the members' appeals, grievances and fair hearings procedures and investigations and timeframes in accordance with Article X, Grievances and Appeals.

The IHCP must furnish the following grievance, appeal and 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 a fair hearing, how to obtain a hearing, and 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 continuation of benefits during an appeal or fair hearing filing and, if the IHCP's action 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 IHCP to cover a service.

26. *Prohibited Practice*

a. The IHCP and the third-party provider agree to prohibit communication, activities or written materials that make any assertion or statement, that the IHCP or provider is endorsed by CMS, the Federal or State government, or any other entity, provided that the provider may identify itself as operating on behalf of the IHCP.

b. Marketing/outreach activities or materials distributed by a residential services third-party provider, which claim in marketing its services to the general public, that the Family Care program will pay for an individual to continue to receive services from the third-party provider after the individual's private financial resources have been exhausted are prohibited.

27. *Provider Claim Submission Deadline*

The provider agreement shall specify the number of days that a third-party 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 CFR § 447.45(d) will apply to the submission of claims.

28. *Overpayments*

The third-party provider agreement requires the provider to do all of the following when it has received an overpayment from the IHCP:

a. Report the overpayment to the IHCP when identified;

b. Return the overpayment to the IHCP within sixty (60) calendar days of the date on which the overpayment was identified; and

c. Notify the IHCP in writing of the reason for the overpayment.

The IHCP must report the information in a-b above to the MCO and DHS upon receipt of the information.

29. *Electronic Visit Verification*

The IHCP must require applicable third-party providers to utilize the Department's EVV system or a certified alternate EVV system.

30. *Telehealth or Remote Service Delivery*

The provider may not require the member to receive a service via interactive telehealth or remotely if in-person service is available.

31. *Abuse and Neglect Policies*

The provider agrees to follow the IHCP's policies for IHCP employees and contracted providers that prohibit all forms of abuse, neglect, exploitation and mistreatment of members.

D. Prohibited Provider Agreement Language

In accordance with Wis. Stats. § 46.284(2)(d), IHCPs 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 IHCP any funding that exceeds the cost of those services.

E. Provider Certification and Standards

1. *Provider Standards*

The IHCP shall use only third-party providers that:

a. Are enrolled in Wisconsin Medicaid through the Department centralized provider enrollment system and have a current and valid Medicaid ID allowable for the service to be rendered; or,

b. Are not enrolled in Wisconsin Medicaid through the Department centralized provider enrollment system, but the IHCP has verified the provider meets the following criteria.

c. For waiver services in Addendum IV, Benefit Package Services Definitions. 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. Meet requirements and have been issued a notice of compliance or have an HCBS Compliance / Public Funding Status of Compliant on the provider's profile on https://www.forwardhealth.wi.gov/WIPortal/subsystem/public/DQAProviderSearch.aspx by the overseeing entity regarding the qualities of setting that are eligible for reimbursement for Medicaid HCBS under 42 CFR § 441.301(c)(4) and 42 CFR § 441.710.; and

d. For State Plan services in Addendum IV.B.:

   i. Be 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, or federally recognized equivalent.

   ii. Meet all required licensure and/or certification standards applicable to the service provided.

   iii. Be enrolled with the Department.

e. Meet the DHS provider standards as indicated in the DHS-MCO contract.

2. *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 IHCP and approved by the MCO.

3. *Excluded Providers*

   All third-party providers utilized by the IHCP 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.

The Department or its designee will audit the IHCP for compliance with the above provider standards.

4. Third-Party Delegate

   Upon request by the third-party provider or IHCP, the MCO may choose, but is not required, to act as a third-party delegate as defined in Article I. The third-party provider may request help from the MCO to complete the provider's initial enrollment, re-enrollment, revalidation, demographic maintenance, or make changes to programs or services on the ForwardHealth Portal to establish and/or to maintain the terms of provider enrollment. The MCO may complete the data entry and upload supporting documentation, signed by the third-party provider authorizing the action, to the ForwardHealth Portal. It is the responsibility of the third-party provider to supply the data to the MCO and to ensure the information entered by the MCO is truthful, correct, and accurate.

5. Provider HCBS Settings Rule Compliance for Adult Day, Prevocational, and Group Supported Employment Providers

   a. The IHCP must verify the Notice of Compliance.
   b. The Department posts compliance with the HCBS Settings Rule at the following link: HCBS Settings Rule: Compliance for Nonresidential Services Providers | Wisconsin Department of Health Services
   c. Notices of Compliance are not transferrable between provider locations.
   d. The IHCP must inform the Department if a provider moves locations.
   e. When a provider plans to move to a new location, the IHCP must obtain a Notice of Compliance from the provider prior to authorizing member transfers into the new setting.

F. Access to Providers

1. *Access Standards*

   The IHCP shall ensure all services and all service providers it contracts with comply with access standards provided in Article VI, Services and the access standards in this article.

2. *Assuring Access (Member Access to Care and Services)*

   The IHCP must do the following to assure access:

   a. Meet and require its third-party 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 its 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 third-party 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 its providers, as appropriate, provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

G. Invoking Remedies

If the Department determines that a provider agreement will jeopardize member access to care, the Department may invoke the remedies provided for in Article XV.E., Remedies for Breach or Non-Performance.

H. Health Information System

1. *Accurate and Complete Data*

The IHCP must ensure that data received from third-party 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.

2. *Unique Identifier*

The IHCP must require each physician and other eligible third-party provider to have a unique identifier to the extent required under the HIPAA.

I. Payment

1. *IHCP Payments to Rural Health Clinics (RHCs)*

If the IHCP contracts with a facility or program, which has been certified as an RHC, for the provision of services to its members, the IHCP must provide payment that is not less than the level and amount of payment which the IHCP would make for the services, if the services were furnished by a provider which is not an RHC.

2. *Home and Community Based Waiver Services Rates*

a. The IHCP may negotiate the rates it pays to third-party providers of the Home and Community-Based Waiver Services in Addendum IV, Benefit Package Services Definitions, A.

b. The IHCP must follow all of the procedures specified in Department memo #10-06, if a current community-based residential third-party provider declines to continue providing services to the member at the rate offered by the IHCP and the action results in a member move

(https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta10-06.pdf).

c. Residential Providers: The IHCP must pay residential providers at least the minimum rates as established below.

i. Residential Providers are defined as follows:

a) Certified, corporate-owned 1-2 bed Adult Family Homes ("1-2 bed AFH") as defined in Add. VI.

b) Certified 3-4 bed Adult Family Homes ("3-4 bed AFH") as defined by Wis. Stat. § 50.01(1)(b).

c) Certified Community-Based Residential Facility ("CBRF") as defined by Wis. Stat. § 50.01(1g).

d) Certified Residential Care Apartment Complex ("RCAC") as defined by Wis. Stat. § 50.01(6d).

ii. The minimum payment rates by benefit and by member acuity tier are:

TABLE 1: HCBS RESIDENTIAL PROVIDER BENEFIT AND MINIMUM FEE SCHEDULE RATE

Benefit	Revenue Code	Procedure Code	Modifier Code(s)	Per Diem Rates
AFH 1-2 bed corporate owned	0240	T2031	U1, U6, U7	Tier 1 - $373.80
			U2, U6, U7	Tier 2 – $406.36
			U3, U6, U7	Tier 3 - $423.65
AFH 3-4 bed	0241	T2031	U1, U8	Tier 1 - $203.50
			U2, U8	Tier 2 – $220.79
			U3, U8	Tier 3 - $238.08
CBRF 5-8 members	0242	T2033	U1, U7	Tier 1 - $141.35
			U2, U7	Tier 2 – $158.65
			U3, U7	Tier 3 - $168.31
CBRF 9+ members	0243	T2033	U1, U8	Tier 1 - $100.75
			U2, U8	Tier 2 – $115.07

			U3, U8	Tier 3 - $133.38
RCAC	0670	T2033	U9	$67.41

iii. "Member Acuity Tiers" are defined in Table 2, "Member Acuity Tiers: Criteria", with members being assigned to the highest tier for which they have any single need listed in the acuity tier criteria. Members qualify for Acuity Tier 1 if they do not meet any of the needs listed in the higher acuity tiers.

TABLE 2: MEMBER ACUITY TIERS: CRITERIA		
Tier 1	Tier 2	Tier 3
Wandering = 0 • Does not wander	Wandering = 1 • Daytime wandering but sleeps nights	Wandering = 2 • Wanders at night or day and night
Self-Injurious Behaviors = 0 • No injurious behaviors demonstrated	Self-Injurious Behaviors = 2 • Self-injurious behaviors require interventions 2-6 times per week or 1-2 times per day	Self-Injurious Behaviors = 3 • Self-injurious behaviors require intensive one-on-one interventions more than twice each day
Self-Injurious Behaviors = 1 • Some self-injurious behaviors require interventions weekly or less		
Offensive or Violent Behavior to Others=0 • No offensive or violent behaviors demonstrated	Offensive or Violent Behavior to Others = 2 • Offensive or violent behaviors that require interventions 2-6 times per week or 1-2 times per day	Offensive or Violent Behavior to Others = 3 Offensive or violent behaviors that require intensive one-on-one interventions more than twice each day

Offensive or Violent Behavior to Others = 1 • Some offensive or violent behaviors that require interventions weekly or less		
	Dressing = 2 Help (supervision, cueing, hands-on assistance) needed-helper MUST be present	Uses Mechanical Lift (not a lift chair) selected for Transferring ADL.
	Toileting = 2 Help (supervision, cueing, hands-on assistance) needed-helper MUST be present	Tracheostomy Care selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day
	Transferring = 2 Help (supervision, cueing, hands-on assistance) needed-helper MUST be present	Tube Feedings selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day
	Ostomy – Related Skilled Services selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day	Positioning in Bed or Wheel Chair every 2-3 hours selection is any of the following: 3-4/Day, or 5+/Day

iv. Member acuity tiers are to be calculated or re-calculated according to the timelines found in Articles III.F.4-5.

v. Minimum payment rates for owner-occupied 1-2 bed AFHs:

a) Owner-occupied 1-2 bed Adult Family Homes (AFHs) are not subject to the minimum rate tiers found in Article VIII.L.2.c.ii.

b) The minimum payment rates for owner-occupied 1-2 bed AFHs are to be no less than the equivalent of the 15-minute IHCP-directed supportive home care (SHC) minimum payment rate, as contained in Article VIII.L.2.d.i, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision.

For the purposes of enforcement, the Department will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

c) Encounters for owner-occupied 1-2 bed Adult Family Homes (AFHs) are identified with Revenue Code “0240”, procedure code “T2031” and modifier “U5” to indicate owner-occupied.

vi. IHCP-Residential Provider contracts shall include the following:

a) One or more of the following according to the services being contracted for:

1) Tier structure listed in Article VIII.L.c.iii.,
2) The minimum payment rates for owner-occupied 1-2 bed AFHs under Article VIII.L.2.c.v.

b) The Rate per tier listed in Article VIII.L.2.c.ii. for the applicable provider type.

c) Provisions stating that the contracted rate will be no less than that listed in Article VIII.L.2.c.ii. for a member meeting the tier requirements.

vii. IHCP-Supportive home care provider contracts shall include the following:

a) One or more of the following according to the services being contracted for:

1) The requirement in Article VIII.L.2.d., or
2) The requirements in Article VIII.L.2.e.

viii. IHCP-Residential Provider authorization requirements: IHCP-Residential Provider authorizations shall include the following for each member:

a) The acuity tier that is applicable to the member;

b) The date the acuity tier was determined.

c) Whether the member's plan of care requires 1 or more staff dedicated solely to the individual member for 24-hours a day on a daily basis.

d) Changes to member's acuity tier:

1) In the event of a change in the member's acuity tier, the IHCP shall have 60 (sixty) days to implement an updated authorization that reflects the member's updated acuity tier and associated minimum payment rate. The member's updated acuity tier and associated minimum payment rate shall be calculated as of the date of the functional screen result that caused a change to the member's acuity tier.

2) The effective date of the updated rate in the authorization under 1) shall be thirty (30) days following the date of the functional screen result that caused a change to the member's acuity tier.

d. Payment Rates for IHCP-Directed Supportive Home Care (SHC) services

i. IHCPs must pay at least the 15-minute unit SHC minimum rate of $6.38 when the services are IHCP-directed. IHCPs must pay SHC daily or hourly rates that are greater than or equal to what the IHCP would pay if it was paying the 15-minute unit SHC minimum rate, as contained in Article VIII.L.2.d.i, multiplied by the 15-minute units of time needed to provide care and active

supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision.

ii. For the purposes of enforcement, the Department will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

iii. SHC minimum rates apply to the following medical codes when used for SHC services.

a) 15-Minute Codes: S5120, S5125, S5130, S5135

b) Per Diem Codes: S5121, S5126, S5131, S5136

e. Payment Rates for Self-Directed Supportive Home Care (SHC) services

i. The IHCP shall increase self-directed services budgets of members so that all members have sufficient budget authority to pay the 15-minute unit self-directed SHC minimum fee rate of $4.08 and an additional $0.48 of state and federal payroll taxes and workers compensation for all units of supportive home care they receive through self-direction.

ii. The IHCP shall pay at least $4.56 per 15-minutes for self-directed supportive home care for the sum of supportive home care worker wages, state and federal required payroll taxes, and workers compensation.

a) Members who are self-directing supportive home care services must pay their supportive home care workers at least the $4.08 per 15-minute minimum rate unless a worker voluntarily opts out of the minimum rate. Members must pay SHC daily or hourly rates that are greater than or equal to what the member would pay if they were paying the 15-minute unit self-directed SHC minimum rate, as contained in Article VIII.L.2.e.i, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the

member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision. For the purposes of enforcement, the Department will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

iii. SDS supportive home care workers may voluntarily opt out of the minimum rate payment requirement.

a) If an SDS supportive home care worker voluntarily opts out of the IHCP minimum rate payment requirement, they must sign a form designated by the Department confirming their decision to do so and the self-directing member and IHCP must retain the signed form.

f. Encounter data requirements

i. IHCPs and MCOs must include in their adult family home encounters the following Department-assigned modifiers:

a) "U1" to indicate Acuity Tier 1, "U2" to indicate Acuity Tier 2, or "U3" to indicate Acuity Tier 3 as the first modifier.

b) "U5" to indicate owner-occupied or "U6" to indicate corporate owned as the second modifier.

c) "U7" to indicate 1-2 bed adult family home or "U8" to indicate 3-4 bed adult family home as the third modifier.

d) "U4" to indicate the member received 24-hour 1-on-1 (or greater) care, when applicable, as the fourth modifier.

ii. IHCPs and MCOs must include in their community based residential facility encounters the following Department-assigned modifiers:

a) "U1" to indicate Acuity Tier 1, "U2" to indicate Acuity Tier 2, or "U3" to indicate Acuity Tier 3 as the first modifier.

b) "U7" for community based residential facilities with 5-8 beds or "U8" for community based residential facilities with 9 or more beds as the second modifier.

c) "U4" to indicate the member received 24-hour 1-on-1 (or greater) care, when applicable, as the third modifier.

iii. IHCPs and MCOs must include in their residential care apartment complex encounters the following Department-assigned modifiers:

a) "U9" to indicate residential care apartment complex as the first modifier.
b) "U4" to indicate the member received 24-hour 1-on-1 (or greater) care, when applicable, as the second modifier.

iv. IHCPs and MCOs must include the Department-defined self-direction indicator for all self-directed supportive home care encounters.

g. After a member's Long Term Care Functional Screen is calculated or re-calculated and the Functional Screen Information Access (FSIA) generates an acuity tier report, the IHCP must provide to the provider upon request the first page of the acuity tier assignment report from FSIA which contains:

i. Applicant's name;

ii. Agency that calculated residential acuity tier;

iii. Date residential acuity tier was determined;

iv. Residential Acuity tier, if applicable.

h. The HCBS minimum fee schedule state-directed payment will be submitted annually to CMS for review and approval.

i. The IHCP must update all provider agreements to comply with Article VIII.L.2.c-g. The IHCP will be subject to all requirements and reporting set forth by the Department.

j. Failure to Meet Minimum Fee Schedule Requirements

i. The IHCP may be subject to financial penalty of up to $10,000 for each payment to a provider that fails to meet the provisions in Article VIII.L.2.c-i.

ii. If the IHCP is found to have failed to meet the provisions in Article VIII.L.2.c-g. for payments made to a provider, the IHCP will reprocess payments to that provider such that the reprocessed payments meet the provisions in Article VIII.L.2.c-g.

iii. The IHCP may be placed on a corrective action plan (CAP) as a result of the Department finding the IHCP out of compliance with Article VIII.L.2.c-i.

For the purposes of enforcing the requirements under Article VIII.L.2.c-i, the Department shall compare the IHCP's reimbursement to the provider to the sum of the member's minimum payment rate and the member's room and board obligation.

3. *Medicaid Rates*

a. Negotiated Rates

Except as provided in sub b., if the IHCP can negotiate such agreements with third-party providers, the IHCP may pay third-party providers less than Medicaid fee-for-service rates.

b. The Medicaid Rate for Nursing Home Services

In determining the payment rate for nursing home services, the IHCP must employ the Medicaid fee-for-service nursing home rate methodology in effect for the dates of service, and any retroactive adjustments. IHCPs must apply nursing home retroactive rate adjustments within 90 days of the Department posting an updated rate for the nursing home, utilizing provider submitted member acuity information. The Department 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.

The IHCP must pay the nursing home 95% of the nursing home hospice rate when the member is enrolled in hospice and residing in the nursing home.

c. Medicaid Fee-For-Service Rates

The IHCP shall not pay itself or its third-party 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 others.

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. IHCP Notification of Payment Above the Medicaid Fee-For Service Rate

In the event that an IHCP contracts at a rate above the Medicaid fee-for-service rate, the IHCP must submit a notification to the MCO and Department.

i. The IHCP must submit a single comprehensive report to the MCO and the Department at DHSLTCFiscalOversight@dhs.wisconsin.gov in April and October of each year. The information will be reported to the Department on a form provided by the Department.

ii. The MCO must submit encounter data for expenditures on the services paid for above the Medicaid Fee-For-Service Rate.

4. *Payments* for *Court-Ordered Services*

The IHCP will pay for covered court-ordered services that are in the benefit package in accordance with Article VI.H., Court-Ordered Services.

J. MCO Payment to the IHCP

The MCO shall pay the IHCP for services in the benefit package provided to Indian members who are eligible to receive services from the IHCP, either:

1. At a rate negotiated between the MCO and the provider, or
2. 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 IHCP.

The MCO shall pay the IHCP promptly in accordance with this section and the timely payment requirements under 42 CFR. § 447.45 and § 447.46.

K. IHCP Cost Settlement

1. *Family Care IHCP Cost Report*

   The IHCP is required to complete a Family Care IHCP Cost Report annually and prior to any interim wraparound payment.

2. *IHCP Cost Allocation Plan and Department Review of Cost Reports*

   a. The IHCP is required to submit a policy and procedure to support the allocations for shared direct expenses and shared overhead expenses between all programs or other lines of business to support the Family Care service costs reported in the annual Family Care IHCP cost report.

      i. A direct staff cost allocation plan will outline the time reporting capture system for staff expense charging to Family Care services reporting.

      ii. A cost allocation plan for other shared expenses will identify the allocation process and cost drivers for the shared expenses and allocated overhead expenses.

      iii. The policy and procedure will support the purpose and process to accumulate and summarize costs reported in the IHCP cost report.

   b. The Department will evaluate actual cost allocations in the Family Care IHCP cost report for consistency against the approved cost allocation plans prior to payment of additional cost based funding. The Department will also monitor the costs for waiver services, to include self-directed services, in the Family Care IHCP cost report, against statewide program experience for similar services to evaluate whether costs are reasonable and to identify areas of concern.

   c. The Department may require additional supporting documentation or perform specific procedures to verify consistency and accuracy of reporting in the IHCP cost report.

d. The IHCP shall provide the Department additional supporting documentation and access to staff and required records as requested.

3. *IHCP Annual Audit*

The IHCP is required to demonstrate annually through a financial audit by an independent certified public accountant the reasonable assurance that the financial statements are free from material misstatement in accordance with Generally Accepted Accounting Principles (GAAP) and satisfy Wisconsin State audit requirements outlined in Wisconsin Stat. § 46.036. The audit report should demonstrate to the Department the internal controls, related reporting systems and cost allocation plan are operational and sufficient to ensure the integrity of the financial reporting systems.

The annual audit submission should follow the requirements of Wisconsin Stat. § 46.036 for submission, required due date, and specific audit guidelines.

See https://www.dhs.wisconsin.gov/business/audit-reqs.htm for more information.

4. *IHCP Indian Member Reporting*

The IHCP will provide the Department with a list of all Indian members whose costs for Family Care services are reported on the Family Care IHCP Cost Report. The IHCP will provide the list of Indian members quarterly and with their submission of the Family Care IHCP Cost Report. The list will include sufficient information for the Department to uniquely identify each Indian member and the encounter records the MCO submitted for services provided to the Indian member. The IHCP will submit an attestation that all of the Indian members on the list were eligible for 100% FFP at the time of service.

5. *Wrap around payments*

IHCPs will receive wraparound payments or recoupments from the Department for all Family Care services the IHCP provides to Indian members. The amount of the wraparound will be calculated as follows:

a. The Department will calculate the amount of the direct and indirect services costs reported by the IHCP on the Family Care IHCP Cost Report plus an allocation of overhead services for providing Family Care covered services. The allocation of overhead services shall not exceed 7.0% of total service costs for Family Care services provided by the IHCP.

b. The Department will subtract from the amount in a. all payments by or due from Medicare Part C, Medicare fee-for-service, Family Care members, and other third parties for the Family Care services the IHCP provided.

c. The Department will pay or recoup from the IHCP an amount equal to the difference between what the MCO paid the IHCP for Family Care services the IHCP provided and the costs calculated in b.

6. *Timing of wraparound payments to the IHCP*

a. The Department will make annual wraparound payments to the IHCP.

b. The Department agrees to make one interim wraparound payment during the first year of this agreement. In future years, at the request of the IHCP, the Department may make one interim wraparound payment prior to the annual wraparound payment.

c. The Department will make wraparound payments no more than three (3) months after the IHCP submits the interim or annual Family Care Cost Report.

7. *IHCP Billing*

The IHCP shall act as the billing provider for all Family Care services the IHCP provides to Family Care Indian members, who have an accepted referral, whether the IHCP is the direct provider or the IHCP contracts for the provision of the service. The IHCP may not provide, bill the MCO, or include in their Family Care IHCP Cost Report services in excess of the amounts authorized for the Family Care Indian member.

The IHCP shall ensure accurate claims submission and processing in order for the MCO to provide DHS with accurate encounter data.

8. *IHCP Documentation for Federal Financial Participation*

The IHCP shall maintain all documentation necessary for the Department to claim enhanced federal financial participation for Family Care services the IHCP or the MCO provides to Indian members receiving care management from the IHCP.

L. Standards for IHCP Staff

1. *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 services.

Relatives or legal guardians may 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 IHCP interdisciplinary team ensures both of the following:

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 IHCP interdisciplinary team monitors and manages any real or potential conflicts of interest 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.

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).

h. For spouses, the individual will either:

i. Provide an amount of service that exceeds 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.

2. *Intimate Care Services*

If the IHCP 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 IHCP in choice and assignment of attendant(s) that provide the service;

b. Members are involved with training the IHCP 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 IHCP attendant(s); and

e. Members are involved in the supervision of IHCP attendant(s) along with the IHCP attendant supervisor (if desired by the member and to the extent of the member's abilities).

3. *Caregiver Background Checks*

The IHCP shall comply with Wis. Admin. Code Chapters DHS 12 and 13 related to caregiver background and other checks for all SDS workers, providers, and MCO employees who do not meet VIII.E.1.a., including:

a. The IHCP shall establish and implement a policy consistent with Wis. Admin. Code Chapters DHS 12 and 13 to appropriately respond to an IHCP 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 IHCP 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. The IHCP shall ensure that subcontractors perform background checks on caregivers in compliance with Wis. Stat. § 50.065 and Wis. Admin. Code Chapter DHS 12;

d. The IHCP maintains the ability to not pay or contract with any provider if the IHCP deems it is unsafe based on the findings of past criminal convictions stated in the caregiver background check.

The IHCP 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 IHCP shall take all appropriate steps the IHCP deems necessary to assure the health and safety of the member.

4. Contracting with 1-2 Bed AFH's

a. Placing IHCPs are required to notify a 1-2 bed certifying agency of all new placements in a 1-2 bed AFH.

b. Placing IHCPs are required to notify the certifying agency of any incidents, identified in Article IV.H.2.b., c., and e., that occur in a 1-2 bed AFH within 24 hours.

c. Certifying MCOs are required to inform all placing agencies (agencies can be MCOs, IRIS, IHCPs, or Counties) of any incidents that may jeopardize the health and safety of residents residing in a 1- 2 bed AFH they certify within 24 hours.

d. Certifying MCOs and placing agencies are responsible for assuring that 1-2 bed AFHs are notifying both the placing agencies and certifying agency of all incidents, identified in Article IV.H.2. b., c., and e.

e. Certifying MCOs must inform contracting agencies immediately if the certification will be revoked or the certifying MCO plans to let the certification lapse without renewal.

VIII. Member Materials

A. Member materials

1. *General Requirements*

   a. Within ten (10) business days of a member selecting IHCP care management, the Indian Health Care Provider (IHCP) shall provide new members or their legal decision makers the MCO member handbook, the IHCP supplement to the MCO member handbook and information about how to obtain an electronic copy of the MCO's provider network directory and the list of providers the IHCP is contracting with. A paper copy of the MCO's provider network directory and list must be provided upon request within five (5) business days.

   b. IHCPs are responsible for disseminating the materials to new members:

      i. MCO member handbooks and Department-approved IHCP supplement to the handbooks;

      ii. List of IHCP providers;

      iii. MCO provider network directories; and

      iv. Self-directed supports guidebook.

   c. If a potential member requests member materials prior to enrollment, the Resource Center can refer the potential member to the MCO website, IHCP or directly to the MCO.

   d. IHCPs are responsible for providing the list of IHCP's contracted providers and Department-approved IHCP supplement to the MCO Member Handbook to the ADRCs.

   e. Model member notices and templates developed by DHS shall be used by the IHCP.

   f. Member materials must be provided in a manner and format that may be easily understood and is readily accessible. All materials produced and/or used by the IHCP must be understandable and readable for the average consumer and reflect respect to the diverse cultures served. Materials shall take into account individuals who are visually limited and limited English proficient.

2. *IHCP Specific Member Supplement*

   a. The IHCP must provide members with an up-to-date IHCP Department-approved Member Supplement upon initial enrollment and upon request within five (5) business days.

   b. The supplement will be considered to be provided if the IHCP:

i. Posts the information on the IHCP'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

ii. 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.

c. The IHCP Member Supplement, at a minimum, will include information about:

i. The location of the IHCP facility or facilities;

ii. The hours of service;

iii. Using after hours services and obtaining services out of the IHCP service area;

iv. The telephone numbers including:

a) The 24 hour a day toll free telephone number that can be used for assistance in obtaining urgent and emergency care; and

b) A toll free telephone number where members can acquire information about the requirements and benefits of the program.

v. Any additional information that is available upon request, including the following the structure and operation of the IHCP.

d. When significant changes occur, the IHCP must distribute an updated IHCP member supplement, an addendum to the supplement or other written notification at least thirty (30) calendar days in advance of the effective date.

e. Annually, the IHCP must distribute to its members the IHCP member supplement or notify members of their right to request and obtain a copy of the member supplement. The IHCP must offer to discuss the Member Handbook Supplement with the member annually or upon request.

IX. Member Rights and Responsibilities

A. Protection of Member Rights

The language and practices of the Indian Health Care Provider (IHCP) shall recognize each member as an individual and emphasize each member's capabilities. IHCP 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.

Member rights specified in this section include but are not limited to:

1. Being treated with respect and with due consideration for the enrollee's 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 the enrollee's medical records, and to request that they be amended or corrected, as specified in 45 CFR § 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, IHCPs 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.
8. Support from the IHCP 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 IHCP and its providers or any state agency treat the enrollee.

12. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

C. Member Rights and Responsibilities Education

The IHCP shall provide education to members on the grievance and appeal process within ninety (90) calendar days of IHCP accepted referral for care management. 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 MCO's member handbook, including information about the availability of the MCO Member Rights Specialist.

D. Advance Directives

1. The IHCP 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 IHCP 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 IHCP shall:

   a. Document in the member record whether or not the member has executed an advance directive.

   b. 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.

   c. Provide referral to appropriate community resources, for any member or individual seeking assistance in the preparation of advance directives.

4. 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.

E. Legal Decision Makers

The IDT 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 IDT 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. Members shall have full and confidential access to an ombudsman or other advocate, and may have this contact with or without the legal decision-maker's knowledge. The IHCP must cooperate with advocates as requested by the member, as indicated in Article X.C.2, "Cooperation with Advocates", and as indicated by statute.

X. Grievances and Appeals

A. Purpose and Philosophy

Members have the right to appeal IHCP adverse benefit determinations and to grieve any action or inaction of an IHCP that the member perceives as negatively impacting the member.

Members are encouraged to attempt to informally resolve their issues before filing a grievance or 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 IHCP 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 E of this article.
3. Department Review is the final process in resolving members' grievances. For more information about the Department Review process see Section F 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 G of this article.
5. Other remedies available to members, depending on the circumstance or issue, may include Wis. Admin. Code § 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 IHCP's administration of the LTCFS, indicated by one of the following:
            a) A change from nursing home level of care to non-nursing home level of care; or
            b) A change in level of care from nursing home level of care or non-nursing home level of care to functionally ineligible.
        ii. The denial or limited authorization of a requested service that falls within the benefit package specified in Addendum IV, Benefit

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

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 failure to provide services and support items included in the member's MCP in a timely manner, as defined by the Department.

vii. The failure of the IHCP to act within the timeframes of this article for resolution of grievances or appeals.

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.

b. An adverse benefit determination is not:

i. A change in non-residential provider;

ii. A change in the rate the IHCP 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 IV.K.3.; 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 they are 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 IV, Benefit Package Services Definitions.

vi. The denial of authorization for remote delivery of a waiver service or a state plan service delivered via interactive telehealth.

vii. The denial of a member's request to self-direct a service or the limitation of a member's existing level of self-direction.

2. *Appeal*

An "appeal" is a request for review of an "adverse benefit determination." If a member is dissatisfied with the MCO's appeal decision, the member 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 appeal decision, the member can request a State Fair Hearing.

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 MCO's Member Rights Specialist. The IHCP shall assist the MCO for the full conduct of the grievance process. 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" is used to refer to the overall system that includes grievances and appeals handled at the MCO level and the DHS level, as well as the processes to collect and track them, and access to the State Fair Hearing process.

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 adverse benefit determination by the Department, a county agency, a Resource Center or an MCO.

C. Overall Policies and Procedures for Grievances and Appeals

1. *The IHCP shall assist the MCO for the full conduct of the grievance and appeal processes.*

2. *Cooperation with Advocates*

IHCPs must make reasonable efforts to cooperate with all advocates a member has chosen to assist the member 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 the member's 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.

i. Advocacy agencies with statutory authority to obtain HIPAA related information may receive information from the IHCP or MCO with the verbal consent of the member. Written consent must be provided as soon as possible. Verbal and written consent may be provided by any member, including those with a legal decision maker.

3. *Reversed Appeal Decisions*

If the MCO appeal process or the State Fair Hearing process reverses a decision to deny, limit, or delay services that were not furnished during the appeal, the IHCP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the decision.

If the MCO appeal process or a State Fair Hearing reverses a decision to deny authorization of services, and the member received the disputed services during the appeal, the IHCP must pay for those services.

4. *Continuation of Benefits While an MCO Appeal or State Fair Hearing are Pending*

a. Services shall be continued by the IHCP 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 G.2. 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 IHCP 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 IHCP 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 IHCP 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 IHCP'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 or IHCP contracted provider due to contracting changes; however, in such a situation the member does have a right to appeal dissatisfaction with her/his MCP.

ii. When grieving adverse actions 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 they are a member of the group impacted by the change.

d. If the final disposition of the appeal and or State Fair Hearing is adverse to the member and upholds the IHCP's adverse benefit determination, the IHCP may recover the cost of services continued solely because of the requirements of this section. The Department or the IHCP may waive or reduce the member's liability if the Department or the IHCP determines that the member would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided.

5. *Information to Providers*

In its subcontracts with providers, the IHCP shall furnish providers with information regarding the MCO's 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 Adverse Benefit Determination*

The IHCP must provide written notice of adverse benefit determination in the situations listed below.

The IHCP must use the Department-issued notice of adverse benefit determination form for Family Care members: 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 IHCP 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 IHCP intends to deny in whole or in part a request for a service included in the benefit package.

Although the IHCP may cover a service that is outside of the benefit package, an IHCP is not required to provide a notice of adverse benefit determination when it denies a member's request for such a service. The IHCP is however required to inform members in writing when a request for a service outside the benefit package is denied. The IHCP 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 or medical supplies shall be treated by the IHCP 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 IHCP.

b. Reduction, Suspension or Termination of a Previously Authorized Service

The IHCP 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 IHCP 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 IHCP 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:

i. The IHCP denies a member's request for payment of an item or service included in the benefit package.; or

ii. A provider's claim remains unpaid, in whole or in part, after the provider has completed the provider appeals process with the MCO and Department and the unpaid claim is a clean claim as defined under 42 CFR § 447.45(b). In this situation, the adverse benefit determination must inform the member that the member is not liable for the unpaid claim.

Although the IHCP may pay for a service that is outside of the benefit package, an IHCP 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 IHCP is however required to inform members in writing when a request for payment of a service outside of the benefit package is denied. The IHCP 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.

d. Denial of payment for an item meeting the definition of medical equipment or appliances or medical supplies shall be treated by the IHCP 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 IHCP.

2. *Documentation of Notice of Adverse Benefit Determination*

The IHCP is required to maintain a copy of any notice of adverse benefit determination required in Article X.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 X.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 CFR. § 438.10(d) and 42 CFR. § 438.404 to ensure ease of understanding.

4. *Content of Notice of Adverse Benefit Determination*

The IHCP will use the DHS issued notice of adverse benefit determination form (https://www.dhs.wisconsin.gov/library/f-00232.htm) required in Article X.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 IHCP or its contractor has taken or intends to take, including the effective date of the adverse benefit determination and the date the adverse determination was made.

b. The reasons for the adverse benefit determination.

c. Any laws that support the adverse benefit determination.

d. The right of the member, legal decision maker, or authorized person 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 IHCP's adverse benefit determination and receives notice that the adverse benefit determination has been upheld by the MCO or the MCO does not complete the appeal in a timely manner, with the result being that 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 IHCP must mail or hand-deliver the notice of adverse benefit determination required in Article X.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 IHCP must mail or hand deliver notice of adverse benefit determination within fourteen (14) calendar days of the request unless the IHCP extends the timeframe. The IHCP 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 IHCP must mail or hand deliver the following written notification of extension to the member no later than the fourteenth day after the original request. Extension notice for Family Care:
https://www.dhs.wisconsin.gov/forms/f0/f00232b.docx

a) If the IHCP denies a member's request for an alternate service, as described in Article VI. Section A.5., the IHCP 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 IHCP 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 IHCP 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.

For Family Care Medicaid-only, if the IHCP denies a request for an expedited service authorization decision, the IHCP must provide the member with a written notice that explains the reason for the decision not to expedite and the member's right to file a grievance if the member disagrees with that decision.

When the IHCP denies a request for expedited resolution, it must reach a decision on the service authorization within the standard timeframe.

The IHCP must request the necessary information from a non-network provider within 24 hours of the request for an expedited service authorization, if the IHCP must receive information from a non-network provider in order to make its decision.

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 IHCP justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest.

For an extension not required by the member, the IHCP must:

a) Make a reasonable effort to give the member prompt oral notice of the delay;

b) Mail or hand deliver the following written notification of extension to member no later than seventy-two (72) hours after the original request; Extension notice for Family Care: https://www.dhs.wisconsin.gov/forms/f0/f00232b.docx; 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. 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 IHCP must send a notice of action 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 IHCP must mail or hand deliver notice of adverse benefit determination (https://www.dhs.wisconsin.gov/library/collection/f-00232) 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 action ten (10) days before the effective date of the action.

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 or DHS.

ii. No Advance Notice of Adverse Benefit Determination Is Required.

In the following circumstances, the IHCP may take action to immediately reduce or terminate a member's service. The IHCP 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 they understand termination or reduction of services 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 IHCP 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 IHCP must mail or hand-deliver 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 appeals with the MCO and the member's rights 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 Section F of this Article. 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 LTCFS that results in a reduction of the member's level of care from "nursing home" to "non-nursing home," as identified in Section B of this Article.

The MCO does not need to provide notification of change in level of care if the member is found to no longer meet any eligible 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/library/f-00232b.htm

c. Involuntary Disenrollment of the Member from the MCO at the MCO's Request

MCO-requested disenrollments must be approved by the Department. 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 Section B of this Article. 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 section F of this Article.

2. *Documentation of Notification of Appeal Rights*

The IHCP is required to maintain a copy of any notification of appeal rights required in Article X.E., in the member's paper or electronic record.

3. *Timing of Notification of Appeal Rights*

a. Adverse MCO Grievance or Appeal Decision

i. Grievances

The IHCP must mail or hand-deliver a written decision regarding a grievance to the member and the member's legal decision maker, if applicable, as expeditiously as a member's health requires but no later than twenty (20) business days after the date of receipt of the grievance. When the MCO's decision is entirely or partially adverse to the member, the decision must include the reason for the decision and any further rights the member's right to request Department review of the MCO's grievance decision.

ii. Appeals

The IHCP 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 Section C. When the MCO's decision is entirely or partially adverse to the member, the decision must include notification of any further appeal rights 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.

b. Other Actions Adverse Benefit Determinations

A member has the right to appeal the other actions identified in Article X.D.1. On the date it becomes aware of any such adverse benefit determination, the IHCP shall mail or hand deliver to the member a written notification of the right to appeal these adverse benefit determinations.

F. 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 IHCP 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 grievances 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 all of the following:

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 IHCP failed to act within the requirements of this agreement, the Department may order the IHCP to take corrective action. The IHCP shall comply with any corrective action required within the timeframes established by the Department.

f. The IHCP 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 Department Review within forty-five (45) calendar days of the action that is the subject of the member's grievance or appeal.

h. The Department will mail or hand-deliver to the member and the MCO its 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 (DHA) 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, and DHS-MCO contract non-compliance.

c. If, during the course of its informal review, the Department determines that the IHCP failed to act within the requirements of the DHS-MCO

contract or ensure a member's health and safety, the Department may order the IHCP to take corrective action. The IHCP shall comply with any corrective action required within the timeframes established by the Department.

G. The State Fair Hearing Process

The IHCP 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 in section B.1.a. of this Article after the member has received written notice that the MCO is upholding the IHCP's adverse benefit determination or after the MCO has failed to issue a decision within the applicable timeframe (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 Section D.5., within ninety (90) calendar days from the date the applicable timeframe expires.

3. *IHCP Response*

The IHCP shall assist the MCO for the full conduct of the hearing process. When the IHCP is notified by the Wisconsin Department of Administration, DHA that a member has requested a State Fair Hearing, the IHCP 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, the MCO and to the Department if requested by the Department.

4. *Participation of IHCP Representative at State Fair Hearing*

The IHCP will assure that a representative of the IHCP participates in State Fair Hearings if:

a. Any IHCP action described in Article X.B is being appealed; or

b. The IHCP has knowledge that the issue being appealed concerns the member's cost share and the IHCP has relevant information likely to help the Administrative Law Judge reach a decision.

c. The IHCP representative will be prepared to:

i. Represent the IHCP's position;

ii. Explain the rationale and authority for the IHCP action that is being appealed;

iii. Accurately reference and characterize any policies and procedures in this agreement related to the action that is being appealed; and

iv. Accurately reference and characterize any specific MCO's DHS-approved policies and procedures related to the action that is being appealed.

5. *Timeline for Resolution of State Fair Hearing*

The Wisconsin Department of Administration, 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 the member's legal decision maker;

b. The legal representative of a deceased member's estate;

c. The IHCP;

d. The Department; and

e. 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, IHCP and the MCO in considering the appeal.

8. *Access to Services*

If the IHCP's decision to deny or limit a service is reversed through the State Fair Hearing process, the IHCP shall authorize or provide the service promptly and as expeditiously as the member's situation or health condition requires, but no later than seventy-two (72) hours from the date it receives the State Fair Hearing decision reversing the determination.

H. Documentation and Reporting

1. *Confidentiality of Grievance and Appeal Records*

The IHCP shall keep grievance and appeal records confidential in accordance with Article XII.

2. *Retention of Grievance and Appeal Records*

The IHCP shall retain the documents related to each grievance and appeal in accordance with Article X.C. and shall immediately provide the MCO with copies of all grievance and appeal documents.

XI. Quality Management

A. Cooperation with Department Review

The IHCP is subject to, at a minimum, an annual external independent review of timeliness of, and access to, the services covered in the benefit package.

The IHCP 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 IHCP staff, providers, and members it serves.

B. Response to Department Findings

1. In the event that a review by the Department or the EQRO results in findings that concern the Department, IHCP will cooperate in further investigation or remediation, which may include:
2. Revision of a care plan or any of its elements for correction, if found to be incomplete or unsatisfactory;
3. Corrective action within a time frame to be specified in the notice, if the effect on the member is determined to be serious;
4. Additional review by the Department or by the MCO to determine the extent and causes of the noted problems; or
5. Action to correct systemic problems that are found to be affecting additional members.

XII. Administration

A. Member Records

The IHCP shall utilize the MCO's electronic case management system or other Department approved electronic case management system for maintaining member records and for monitoring compliance with policies and procedures. The IHCP shall scan any paper records and upload them immediately into the MCO's electronic case management system. The MCO must assure the IHCP only has access to records of members the IHCP actively provides care management to.

1. *Confidentiality of Records and HIPAA Requirements*

The IHCP 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 the (HIPAA of 1996 and its implementing regulations, the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E (Privacy Rule) and 45 CFR Parts 160 and 164, Subparts A and C ("Security Rule"); 45 CFR Part 164, Subpart D ("Breach Rule"); the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII, Subtitle D of the American Reinvestment and Recovery Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (2009) ("ARRA"); and the "Part 2" requirements for confidentiality of substance use disorder treatment records under 42 CFR Part 2.

a. Duty of Non-Disclosure and Security Precautions

The IHCP 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 agreement. The IHCP 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 IHCP's obligations under this agreement. The IHCP 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 IHCP shall be responsible for the breach of this agreement in the event any of the IHCP's directors, officers, employees, or agents fail to properly maintain any confidential information.

b. Limitations on Obligations

The IHCP's obligation to maintain the confidentiality of confidential information shall not apply to the extent the IHCP 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 IHCP shall promptly notify the MCO and 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 IHCP 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 agreement by the IHCP;

iii. Is or becomes generally known on a non-confidential basis, through no wrongful act of the IHCP;

iv. Was known by the IHCP 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 IHCP's knowledge, is not required to maintain its confidentiality;

vi. Was independently developed by the IHCP;

vii. Is the subject of a written agreement whereby the Department consents to the disclosure of such confidential information by the IHCP on a non-confidential basis; or

viii. Was a permitted or required use or disclosure, in accordance with HIPAA and its implementing regulations, the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E (Privacy Rule) and 45 CFR Parts 160 and 164, Subparts A and C ("Security Rule"); 45 CFR Part 164, Subpart D ("Breach Rule"); the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII, Subtitle D of the American Reinvestment and Recovery Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (2009) ("ARRA"); and the "Part 2" requirements for confidentiality of substance use disorder treatment records under 42 CFR Part 2

c. Unauthorized Use, Disclosure, or Loss

If the IHCP becomes aware of any threatened or actual use or disclosure of any confidential information that is not specifically authorized by this agreement, or if any confidential information is lost or cannot be accounted for, the IHCP shall notify the MCO and the Privacy Officer in the Department's Office of Legal Counsel within one day of the IHCP becoming aware of such use, disclosure, or loss. The notice shall include, to the best of the IHCP's understanding, the persons affected, their identities, and the confidential information that was disclosed.

The IHCP shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. IHCP shall reasonably cooperate with the MCO and 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.

d. Equitable Relief

The IHCP 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 MCO or Department, which injury will not be compensable by money damages and for which there is not an adequate remedy at law. Accordingly, the IHCP agrees that the MCO or 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 agreement or under applicable law.

e. Remedies for non-compliance

In the event of an unauthorized use, disclosure, or loss of confidential information, the Department may pursue remedies for non-compliance in Article XV.E.

f. Compliance Reviews

The Department will work with the IHCP to review the IHCP'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 IHCP shall use best efforts to assist a member, the member's legal decision maker, and others designated by the member to obtain records within ten (10) business days of the request. The IHCP shall identify an individual who can assist the member and the member's 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. *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 the MCO to submit as encounter data to the Department and for administrative purposes.

4. *Professional Standards*

The IHCP shall maintain, or require the IHCP's providers to maintain, individual member records in accordance with any applicable professional and legal standards.

5. *Provision of Records*

The IHCP shall make all pertinent information relating to the management of each member's medical and long-term care readily available to the Department and/or MCO. The IHCP shall provide this information to the Department and/or MCO at no charge. The IHCP 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 IHCP and other providers receiving referrals.

6. *Record Retention*

Records must be retained in accordance with the requirements in Article XIII.C.

7. *Continuity of Records*

The IHCP shall have adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

8. *Contents of Member Records*

A member record shall contain at least all of 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 IHCP 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. For an adverse service authorization, third-party records relied upon (if applicable).

p. For a favorable service authorization, third-party records or summaries of records relied upon (if applicable).

q. Copy or documentation of member's most up to date DVR coordination plan (if applicable).

r. Notification of the results or outcomes of an investigation described by Article IV. J.5.b.xii. (added in item 18.)

Minimum member record documentation per chart entry or encounter must conform to the applicable provisions of Wis. Admin. Code § DHS 106.02(9).

B. Subcontracting and Entering Provider Agreements

1. *IHCP Responsibility and Accountability for Subcontracts and Provider Agreements*

The IHCP retains responsibility for fulfillment of all terms and conditions of this agreement 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. The IHCP 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 IHCP must assure that:

a. All subcontractors and providers agree to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance, and agreement provisions.

b. The IHCP evaluates the prospective subcontractor or provider's ability to perform the activities to be delegated; and

c. The IHCP 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.

2. *MCO Responsibility for 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.

3. *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 DQA.

The MCO shall have specific SOD review processes in place to address SODs with significant enforcement action, such as: provider visit verification, 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.

iii. Each MCO shall monitor the quality improvement of any of its DQA-cited providers.

4. *Additional Requirements for Provider Agreements*

Article VII provides additional Department requirements for provider agreements.

C. Ineligible Organizations and Individuals

In implementing this section the IHCP 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), as required by 42 CFR § 455.436, as well as any other databases that may be required by the federal DHSS or the Department, for all providers that do not meet VIII.E.1.a.. Upon obtaining information from a database of excluded entities or individuals receiving information from the Department or from another verifiable source, the IHCP shall disclose to the Department, and the IHCP may not contract with any excluded individuals or organizations, 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 (the 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 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 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 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 IHCP attests by signing this agreement that it excludes from participation in the IHCP all individuals and organizations which could be included in any of the above categories.

4. *Disclosure of Excluded Individuals or Entities*

The IHCP shall disclose to the Department any relationship with an excluded individual or entity described under C.3. 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 IHCP 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 CFR § 438.602(i), the State is prohibited from contracting with an IHCP located outside of the United States. In the event an IHCP moves outside of the United States, this agreement will be terminated.

b. IHCP Wraparound Payment

Claims paid by an IHCP to a network provider, out-of-network provider, subcontractor or financial institution outside of the United States shall be reported as non-reimbursable expenditures on the IHCP's cost report to the Department.

D. Compliance with Applicable Law and Cooperation with Investigations

The IHCP shall observe and comply with all applicable federal and state law in effect when this agreement is signed or which may come into effect during the term of this agreement, which in any manner affects the IHCP's performance under this agreement.

To the extent permitted by law, the IHCP shall fully cooperate with any member-related investigation conducted by the MCO, Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity.

The IHCP must have conflict of interest safeguards in place at least equal to applicable federal safeguards.

E. IHCP Insurance

1. *If not self-insured:*

The IHCP agrees that in order to protect itself as well as the Department under the indemnity agreement provision set forth in the preceding paragraph, the IHCP will at all times during the terms of this agreement keep in force a liability insurance policy issued by a company authorized to do business in the State of Wisconsin and licensed by the Office of Commissioner of Insurance. In the event of any action, suit, or proceeding against the Department upon any matter herein indemnified, the Department shall, within five (5) working days, notify the IHCP by certified mail, addressed to its post office address, of the action.

2. *If self-insured:*

The IHCP shall be responsible for any loss or expense (including cost and attorney fees) incurred by or attributed to any act, error, or omission of its agent or agents.

F. Access to Premises and Information

1. *Access to Premises*

All records the IHCP maintains pursuant to this agreement shall be made available to the Department upon request with adequate notice for inspection, examination, or audit. Except when the Department determines that unusual circumstances exist, the Department will give the IHCP at least five (5) business days written notice to produce the requested records, unless the IHCP consents to a shorter time frame.

Notwithstanding the above, nothing in the agreement shall be construed to limit, modify, or extinguish any federal or state agency's legal authority to inspect, audit, or have access to any records, financial statements or other reports maintained by the IHCP; or to modify or limit the IHCP's legal obligation to maintain any record or report required by state or federal laws, rules, or regulations.

2. *Access to and Audit of Agreement Records*

Throughout the duration of this agreement, and after termination of this agreement, the IHCP shall provide duly authorized agents of the MCO, state or federal government access to all records and material relating to the agreement's provision of and reimbursement for activities contemplated under this agreement. 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 agreement. All information so obtained will be accorded confidential treatment as provided under applicable law. The rights to access, inspect, and audit premises and agreement records described in Article XIII exist for 10 years from the final date of the agreement period or from the date of completion of any audit, whichever is later. If the MCO, 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.

3. *Suspension of Provider Payments*

a. The IHCP shall suspend payments to a sub-contracted third-party provider pursuant to 42 CFR § 455.23 if the Department or MCO informs the IHCP that the Department has suspended fee-for-service Medicaid payments to the provider because of a credible allegation of fraud, unless the third-party provider believes there is good cause for not suspending its payments or the IHCP believes that doing so would jeopardize member health and safety. If the third-party provider or IHCP demonstrates based on the criteria under 42 CFR § 455.23 (e) or (f) that there is good cause for not suspending its payments or for only suspending them in part, the provider shall submit written documentation to the Department's Office of Inspector General describing the basis for such a good cause exception to suspending payment. The Department's Office of Inspector General shall approve or disapprove the third-party provider's request for a good cause

exception. If the Department's Office of Inspector General disapproves the request the IHCP shall suspend payments to the third-party provider.

b. If the IHCP suspends its payments in whole or in part to a third-party provider because the Department has determined that there is a credible allegation of fraud and the third-party provider fails to demonstrate good cause to not suspend payments, the IHCP shall:

i. Provide notice to the third-party provider that meets the timeframe and content requirements of 42 CFR § 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 CFR § 455.23(e).

c. 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 CFR § 455.23(g).

4. *Investigations*

The IHCP shall cooperate with any investigation of fraud and abuse, including directly conducting investigations as needed. The IHCP 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.

G. Resource Center Conflict of Interest Policies and Procedures

The IHCP shall have written conflict of interest policies and procedures that prohibit IHCP 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.

H. Interoperability and Access to Health Information – Patient Access Application Programming Interface (API, Provider Directory API, and Payer-to-Payer Data Exchange)

The IHCP must follow the MCO's policies and procedures implementing requirements from the CMS "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers" final rule (85 FR 25510).

I. Care Management Conflict of Interest Policy

The IHCP must administratively separate its care management function from its direct service provider functions. Staff that perform assessments and develop member-centered plans may not provide direct services.

XIII. Reports and Data

A. Reports: Regular Interval

1. *General*

The IHCP must furnish information from its records to the MCO or Department, and to the MCO's or Department's authorized agents and upon request to CMS, which may be required to administer this agreement.

2. Daily Report

The IHCP must provide the MCO with information to complete the self-directed support worker's file. The MCO must complete the contracted self-directed support workers file and submit daily or use the available web service to send new SDS worker information to ForwardHealth and receive a Medicaid ID for the SDS worker and updated information for any existing SDS workers. The MCO must submit the report electronically through the Secure File Transfer Portal (SFTP) or by using the Web Service functionality. The MCO is not required to file a report if there are no new or updated SDS worker information to submit.

3. *Monthly Report*

The IHCP must provide the MCO with information to complete the monthly IHCP network file. The monthly network file is due on the 10th. The MCO must submit the report electronically through the SFTP site. The file will include all Medicaid-enrolled providers who are contracted with the IHCP.

4. *Quarterly Restrictive Measures Reporting*

Approved restrictive measures reporting is due quarterly. The report shall be submitted to the MCO no later than thirty (30) calendar days after the end of the reporting period. The reporting shall be submitted electronically through the Restrictive Measures database: (https://ltcareies.forwardhealth.wi.gov/restrictiveMeasures/#/login).

5. *Quarterly Competitive Integrated Employment Data Report*

The IHCP shall cooperate with the MCO to assist in reporting employment data for members working in CIE. The MCO is required to file reports on a quarterly basis 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 competitive integrated employment data to them; however, the MCO will be responsible for the uploading and certification of the competitive integrated employment data sent to DHS. The tool the MCO will use for competitive integrated employment data collection and submission of these reports will be the IES through the SAS EDW.

6. *Semiannual IMD Report*

The IHCP shall track all IMD stays and submit a Semiannual IMD Report that includes all IMD stays within the applicable reporting period (January 1 through

June 30, or July 1 through December 31). Stays at state, county, and privately operated IMDs must be reported. A list of county and privately operated IMDs in Wisconsin can be found in section 27.11 of the Medicaid Eligibility Handbook.

The Semiannual IMD Report is due forty-five (45) calendar days after the reporting period or, if the forty-fifth day falls on a holiday or weekend, the following business day. The IHCP shall complete the report using an excel spreadsheet that the Department will e-mail to the IHCP. The report spreadsheet shall be returned, password-protected, via encrypted e-mail to DHS at DHSIMDRI@dhs.wisconsin.gov.

7. *Quarterly Report*

The Quarterly Report is due to the MCO thirty (30) 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 IHCP 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. Payments the IHCP received for enhanced services and donations directly received by the IHCP from members, the member's family or significant others as specified in Article VI.G.3.

b. 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.

c. Total overpayments recovered, split out by those retained by the IHCP, those returned to the MCO because the IHCP is not permitted to retain them, and those due to potential fraud, waste and abuse.

d. Overpayments identified but not recovered.

8. *Semi-Annual Employment Data Report*

The IHCP shall, in its provider agreements, require employment services providers to report employment data in May and November of each year for pre-populated lists of members provided by MCO. The IHCP shall report employment data in May and November of each year to the MCO for pre-populated lists provided by the MCO of members who do not have a service provider. The IHCP shall provide this data on an MCO provided template.

B. Reports: As Needed

The IHCP must furnish to the Department and the Department's authorized agents reports that may be required to administer this agreement or the DHS-MCO contract, to the MCO or Department and the MCO's or Department's authorized agents.

C. Records Retention

The IHCP shall retain, preserve and make available upon request all records or documents relating to the performance of its obligations under this agreement, including paper and electronic claim forms, for not less than ten (10) years following the end of this agreement period. Records and documents that must be retained include, but are not limited to, the following:

1. Claims data;
2. As described by 42 CFR §§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 agreement, including all federal and state requirements;
    c. Notifications regarding changes in members' circumstances which may impact eligibility;
    d. Verification that services that were represented to have been delivered were actually received by members;
    e. Compliance with the False Claims Act;
    f. Compliance with requirements regarding the enrollment of providers with the state as Medicaid providers;
    g. Disclosure of any prohibited affiliations, including individuals or entities excluded from participation in any federal health program under section 1128 or 1128A of the Social Security Act.

The IHCP 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 agreement 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 IHCP, to a provider, including specifically recoveries of overpayments due to fraud, waste, or abuse.

D. Access to CARES Data

The IHCP 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 IHCP 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 IHCP query access to certain data in the CARES mainframe computer system and the CARES Worker Web

system. The types of data to which the IHCP 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 the member 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 the member's annual Medicaid eligibility review.

b. The Department shall designate a data steward for providing the IHCP with access to CARES data who shall be responsible for:

i. Approving or denying requests from the IHCP 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 IHCP staff with access to data found in CARES; and

iii. Coordinating any other CARES data exchange requests between the Department and the IHCP for data that it is unable to obtain using the limited access to CARES under this agreement. The Department has sole discretion as to whether to grant such requests. The IHCP may be required to reimburse the Department for the costs incurred in obtaining this data for the IHCP.

2. *IHCP Responsibility*

a. The IHCP shall identify an IHCP security and data exchange coordinator who shall be responsible for:

i. Forwarding to the Department's data steward all requests from the IHCP 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 IHCP staff that will have access to data found in CARES; and

iii. Coordinating any other data exchange requests between the Department and the IHCP in accordance with this agreement.

iv. The IHCP will use the Agency Data Security Staff User Agreement (https://www.dhs.wisconsin.gov/library/collection/f-00639) to notify the Department of new designations or changes to the primary or secondary IHCP Security and Data Exchange Coordinator.

b. The IHCP 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 IHCP 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 IHCP 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 IHCP attests that all of its staff members with access to any CARES data the IHCP obtains shall be required to follow all of the policies and procedures of the Department and of the IHCP that apply to and protect the confidentiality of this data.

c. The IHCP 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 IHCP 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 agreement.

The IHCP 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 IHCP to make sure that the IHCP 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 IHCP uses any data that it obtains under this agreement for a purpose not specified in this article;

b. The IHCP fails to protect the confidentiality of CARES data that it obtains or to protect it against unauthorized access or disclosure; or

c. The IHCP fails to allow on-site inspections as required in this article.

Any suspension shall last until the Department is satisfied that the IHCP is capable of complying with the responsibilities specified in this article.

XIV. 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 the IHCP and other portions of the Department and the Department's contract agencies responsible for the administration and implementation of the Family Care program.

B. Reports from the IHCPs

The MCO will acknowledge receipt of the reports required in Article XIII. The MCO shall have systems in place to ensure that reports and data required to be submitted by the IHCP shall be reviewed and analyzed by the MCO in a timely manner. The MCO shall offer technical assistance to help the IHCP correct any reporting problems.

C. 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.

D. Capitation/Interim Payment Reporting

The Department provides MCOs with Capitation Payment Reports on a weekly basis. The MCO and IHCP will coordinate to ensure the list accurately reflects all enrolled members. The capitation payment report provides a detailed listing of each member and the member's enrollment and disenrollment date that is associated with each monthly capitation/interim payment for that member. ForwardHealth interChange creates monthly capitation/interim payments and reports on the first Friday of each month for that month. Capitation/interim adjustments and reports are also created each week for members whose eligibility and/or enrollment information changed after a regular monthly capitation/interim 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.

E. Review of Study or Audit Results

1. *Release to the Public*

The Department shall submit to the IHCP 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 IHCP and Medicaid.

2. *Plan of Correction*

Under normal circumstances, the Department will not implement a plan of correction prior to the IHCP'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).

F. Provider Certification

The MCO shall give the IHCP access to the names and contact information for all Medicaid certified providers in the MCO's service area; in the alternative, the MCO shall continue to give the IHCP timely responses to the IHCP's requests for confirmation of particular providers' Medicaid certification status.

G. Technical Assistance

The MCO and Department shall review reports and data submitted by the IHCP and shall share results of this review with the IHCP. In conjunction with the IHCP, the MCO and 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 and IHCP, shall develop a technical assistance plan and schedule to assure compliance with all terms of this agreement and quality service to members of the MCO.

H. 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.

XV. Relationship Under This Agreement

A. Agreement

This agreement is drafted in accordance with the requirements of Wis. Stat. §§ 46.2803 to 46.2895 and Wis. Admin. Code § DHS 10. This document, the Agreement between the MCO, IHCP and the Department, constitutes the entire agreement between the MCO, IHCP and the Department and no other expression, whether oral or written, constitutes any part of this agreement.

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 agreement;
3. Applicable DHS-MCO contract;
4. DHS numbered memos (including Contract Interpretation Bulletins and Technical Assistance Series documents); and
5. Certification documents.

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 agreement.

2. *Dispute Resolution*

   The parties shall use their best efforts to cooperatively resolve disputes and problems that arise in connection with this agreement. When a dispute arises that the MCO and the IHCP have been unable to resolve, the Department reserves the right to determine the final resolution.

3. *Audit Dispute Resolution*

   If the IHCP is dissatisfied with the Department's interpretation of an audit related issue, the IHCP may pursue the review process used for audits to resolve the dispute.

4. *Performance of Agreement Terms During Audit Dispute*

   The existence of a dispute notwithstanding:

   a. All parties agree to continue without delay to carry out all their respective responsibilities which are not affected by the dispute; and

b. The MCO and IHCP further agrees to abide by the interpretation of the Department regarding the matter in dispute while the MCO or IHCP seeks further review of that interpretation.

D. IHCP Certification

1. *Certification*

The IHCP is required to demonstrate that it meets certification standards as defined by the Department.

2. *Certification Information and Documents*

The IHCP shall provide to the Department whatever information and documents the Department requests so that the Department can determine whether the IHCP is meeting these standards.

The IHCP agrees to submit the requested information by the deadlines identified in the request.

E. Remedies for Breach or Non-Performance

The Department may work with the IHCP to create and implement a corrective action plan, withhold payment, or terminate the agreement, as set forth in this article, if it determines the IHCP has failed to meet the substantive requirements of this agreement.

1. *Remedies*

a. Bases for Imposing Remedies

The Department may impose remedies if it determines the IHCP has failed to meet any of the following expectations:

i. The IHCP shall provide all necessary services that the IHCP is required to provide, under law or under this agreement to any member covered under the agreement.

ii. The IHCP shall not impose premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program.

iii. The IHCP 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, refusing to serve an Indian member for any unlawful reason other than case management capacity.

iv. The IHCP shall not misrepresent or falsify information that it furnishes to the MCO, CMS or to the Department.

v. The IHCP shall not misrepresent or falsify information that it furnishes to a member, potential member, subcontractor, or a provider.

vi. The IHCP shall not violate any of the other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

vii. The IHCP shall meet the quality standards and performance criteria of this agreement such that members are not at substantial risk of harm.

viii. The IHCP shall not distribute directly or indirectly through any agent or independent contractor, any materials which describe or provide information regarding the Family Care program, which have not been approved by the Department.

ix. The IHCP shall meet all obligations described in Article XII in order to prevent the unauthorized use, disclosure, or loss of confidential information.

x. The IHCP must not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising on behalf of a member who is the provider's 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 the member's health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

xi. The IHCP shall meet all other obligations described in federal law, state law, or the agreement, not otherwise specifically described, above.

b. Types of Remedies

The Department may impose the following remedies for the violations described in Article E.1.a.:

i. Decertification as a Family Care case manager.

ii. Suspension of all new selection of IHCP for case management the effective date of the sanction.

iii. 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 agreement as provided under Article XVI.

iv. Suspension of MCO and Department payment for recipients of IHCP case management until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

v. Withholding of MCO and Department payments.

vi. Termination of the agreement.

vii. Notice of Remedies to IHCP. Except as provided in Article XV.E.1. or 42 CFR § 438.706(c), before imposing any of the remedies described in Article XV.E.1., the Department must give the affected IHCP written notice that explains the basis and nature of the required remedy.

c. Corrective Action Plan (CAP)

d. If the IHCP fails to meet the substantive terms of this agreement, the Department may work with the IHCP to develop a CAP to ensure that the IHCP thereafter meets all of the requirements of this agreement. Right to Withhold Payments

i. Amount of payment to be withheld

In the event the IHCP does not fulfill its obligations under the corrective action plan, the Department or MCO may withhold future payments otherwise due to the IHCP

ii. Notice to IHCP

In the event the Department intends to withhold payments as described in this Article, the Department shall include as part of its notice described in Article XV.E.1.b.vii., documentation of:

a) The basis for withholding payments; and

b) The amount of payments that will be withheld and the length of time in which payments will be withheld.

2. *Termination of Agreement*

The Department has the authority to terminate this agreement and decertify the IHCP from providing case management if the Department determines that the IHCP has failed to do either of the following:

a. Carry out the substantive terms of this Agreement; or

b. Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

F. Modification and Termination of the Agreement

1. *Modification*

   a. This agreement may be modified at any time by written mutual consent of the MCO, IHCP and the Department.

   b. The Department may unilaterally modify this agreement will be modified if changes in federal or state laws, rules, regulations or amendments to Wisconsin's CMS approved waivers, state plan or DHS-MCO Family Care contract require modification to the agreement. In the event of such change, the Department will notify the MCO and IHCP in writing. If the change materially affects the MCO's or IHCP's rights or responsibilities under the agreement and the MCO or IHCP does not agree to the modification, the MCO or IHCP may provide the Department with written notice of termination at least six (6) months prior to the proposed date of termination.

2. *Mutual Consent for Termination*

   This agreement may be terminated at any time by mutual written consent of the MCO, IHCP and the Department.

3. *Unilateral Termination*

This agreement may be unilaterally terminated only as follows:

   a. Termination for Convenience

      Any party may terminate this Agreement at any time, without cause, by providing a written notice to the other parties. The party initiating the termination must notify the other party in writing at least six (6) months prior to the proposed date of termination of its intent to terminate this contract.

   b. Changes in Federal or State Law

      This agreement may be terminated at any time, by any party, due to modifications mandated by changes in federal or state law or regulations that materially affect any party's rights or responsibilities under this agreement.

      In such case, the party initiating the termination must notify the other parties in writing, at least six (6) months prior to the proposed date of termination, of its intent to terminate this agreement.

   c. Termination for Cause

      If any party fails to perform under the terms of this Agreement, the other parties may terminate this Agreement by providing written notice of any defects or failures to the non-performing party. The non-performing party

will have thirty (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 thirty (30) days of the non-performing party receiving the notice, the other parties may terminate the Agreement. The Agreement may be terminated by the Department earlier than the time period specified in this paragraph if the Department finds that member health or welfare is jeopardized by continued enrollment in the IHCP or MCO.

d. Termination when Federal or State Funds are Unavailable

i. Permanent Loss of Funding

This agreement may be terminated by any party, in the event federal or state funding of services under this agreement rendered by parties' becomes permanently unavailable and such lack of funding would preclude reimbursement for the performance of the parties' obligations. In the event it becomes evident state or federal funding of claims payments or services under this agreement rendered by the parties will become unavailable, the Department shall immediately notify the MCO and IHCP, 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 agreement will terminate without termination costs to any party.

ii. Temporary Loss of Funding

In the event funding will become temporarily suspended or unavailable, the Department will suspend the parties' performance of any or all of the parties' obligations under this agreement 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 parties' 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 parties will resume the suspended services within thirty (30) days from the date the funds are reinstated. The agreement will not terminate under a temporary loss of funding.

4. *Automatic Termination of Foreign Entity*

This agreement will terminate immediately upon the MCO or IHCP becoming located outside of the United States.

5. *Transition Plan*

In the case of this agreement being terminated, the IHCP shall submit a written plan that receives the Department's approval, to ensure uninterrupted delivery of services to MCO

members and their successful transition of care management to the MCO. The plan will include provisions for the transfer of all member related information held by the IHCP or its providers and not also held by the Department.

a. Submission of the Transition Plan

The IHCP must submit the plan within ten (10) business days of notice of termination by the Department; or along with the IHCP's notice of termination.

b. Management of the Transition

The IHCP 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.

6. *Declaration of National or State Emergencies or Disasters:*

In the event of a federal or state declared emergency or disaster, the Department has the ability to modify or waive contractual obligations and regulations that are necessary to address the emergency or disaster. The Department will maintain documentation of any modifications to or waivers of contract requirements.

IHCPs must follow all relevant ForwardHealth Updates and other Department communications issued during a federal or state emergency or disaster.

7. *Obligations of Parties*

When termination of this agreement 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; and

b. Outstanding Claims

The IHCP be responsible for any outstanding Medicaid claims.

G. Delegations of Authority

The IHCP 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. 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.

2. Before any delegation, the IHCP shall evaluate the prospective subcontractor's or provider's ability to perform the activities to be delegated.
3. The IHCP 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.
4. The IHCP shall maintain oversight of subcontractors' and providers' quality of services.
5. If the IHCP identifies deficiencies or areas for improvement, the IHCP and the subcontractor or provider shall take corrective action.
6. If the IHCP delegates selection of subcontractors or providers to another entity, the IHCP retains the right to approve, suspend, or terminate any subcontractor or provider selected by that entity.

H. Indemnification

To the extent provided by federal and tribal law, the IHCP will be liable for, and will indemnify the Department against, all loss, damages, and expenses the Department may sustain, incur, or be required to pay by reason of any eligible client's suffering personal injury, death, or property loss resulting from the IHCP's acts or omissions while any eligible client is participating in or receiving care and services furnished by the IHCP under this agreement. The provisions of this paragraph shall not apply to liabilities, losses, charges, costs, or expenses caused by the Department.

The IHCP shall indemnify the Department and MCO for any federal fiscal sanction taken against the Department or any other state agency which is attributable to action or inaction by the IHCP, its officers, employees, agents, providers or subcontractors that is contrary to the provisions of this agreement.

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 IHCP shall cooperate in that defense to the extent requested by the Department.

Upon notice of a threatened federal fiscal sanction, the Department and MCO may withhold payments otherwise due to the IHCP to the extent necessary to protect the Department against potential federal fiscal sanction. The Department will consider the IHCP's requests regarding the timing and amount of any withholding adjustments.

I. Independent Capacity of the IHCP

The Department, IHCP and the MCO agree that the IHCP and any agents or employees of the IHCP, in the performance of this agreement, shall act in an independent capacity, and not as officers or employees of the MCO or Department.

J. Omissions

In the event that any party hereto discovers any material omission in the provisions of this agreement that is essential to the successful performance of this agreement, said party

may so inform the other parties 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 agreement.

K. Choice of Law

This agreement shall be governed by and construed in accordance with the laws of the State of Wisconsin. The IHCP shall be required to bring all legal proceedings against the Department or MCO in the state courts in Dane County, Wisconsin.

L. Waiver

No delay or failure by the MCO, IHCP or the Department to exercise any right or power accruing upon noncompliance or default by the other parties with respect to any of the terms of this agreement 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 agreement is declared or found to be illegal, unenforceable, invalid or void, then the 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 agreement 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

The parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this agreement 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 agreement is not assignable by the MCO or IHCP either in whole or in part, without the prior written consent of the Department.

Q. Survival

The terms and conditions contained in this agreement 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 agreement. This specifically includes, but is

not limited to recoupments and confidentiality provisions. All rights and remedies of the parties provided under this agreement, including but not limited to any and all sanctions for violation, breach or non-performance survive the completion of the performance, expiration or termination of the agreement.

XVI. Specific Agreement Terms

A. Program

This agreement covers the Family Care Program.

B. Agreement Contingencies

1. Agreement is contingent upon the IHCP being certified by the Department as a care management provider.
2. This Agreement is contingent upon continued approval from CMS of the Family Care waiver.

C. Signatures

In WITNESS WHEREOF, the State of Wisconsin, Tribal Nation and MCO have executed this agreement:

Executed on behalf of
Department of Health Services

William Hanna
Medicaid Director

Date

Executed on behalf of
Tribal nation

Authorized Signer
Title

Date

Executed on behalf of
MCO

Authorized Signer
Title

Date

ADDENDUM

I. Requirements for Memoranda of Understanding

The IHCP is required to abide by the following MCO MOUs, as applicable:

Title	Purpose	Party
Aging & Disability Resource Center	The MCO must execute an Urgent Services Agreement (F-02130), and may voluntarily elect to implement an accompanying MOU 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. In the event of conflict between the Urgent Services Agreement and the contents of an accompanying, voluntary MOU or other written agreement between the MCO and ADRC, the Urgent Services Agreement shall prevail.	All ADRCs within the MCO's service areas
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
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 the individual's needs.	All counties within the MCO's service areas
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
General MOU	An MCO may enter into an MOU with a business, provider or similar entity. Such an MOU may not	A business, provider or similar entity

Title	Purpose	Party
	violate any of the requirements found in this contract concerning contracts, subcontracts, or agreements between the MCO and a business, provider or similar entity	

ADDENDUM

II. IHCP Quality Indicators

This addendum lists the quality indicators the IHCP will report directly to the MCO as required by the Department.

The following quality indicators pertain to Family Care:

A. Care Management (IDT Staff) Turnover

B. Influenza Vaccinations

C. Pneumococcal

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).

ADDENDUM

III. 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

IV. 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.

Family Care program benefits include the services defined in Appendix C of Wisconsin's s. 1915 (c) home and community-based waiver services waiver #0367.00 https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83601

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 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 ninety (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).

    a. 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.

    b. 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 five (5) day stays in a nursing home.

    c. 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.

    d. 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 the member's own home. Long-term care services in a nursing home may be authorized only:

        i. 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

        ii. 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

ADDENDUM

V. Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

A. Purpose of Addendum; Supersession

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the Family Care Agreement by and between the State of Wisconsin Department of Health Services, Division of Medicaid Services (herein "State"), MCO (herein "Managed Care Plan") and the Tribal Nation (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Family Care Agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

B. Definitions

For purposes of this Addendum, the following terms and definitions shall apply:

1. "Indian" means any individual defined at 25 U.S.C. § 1603(13), (28), or § 1679(a), or who has been determined eligible as an Indian, under 42 CFR § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

    a. 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;

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

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

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

    The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or 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.

2. "Indian Health Care Provider (IHCP)" means 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).

3. "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.
4. "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).
5. "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42 CFR 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.
6. "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).
7. "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).
8. "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

C. Description of IHCP

The IHCP identified in this Addendum is (check the appropriate box):

/_/ IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§ 450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

D. Cost-Sharing Exemption for Indians; No Reduction in Payments

The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 CFR § § 447.53 and 457.535.

This is not applicable to cost share post eligibility treatment of income.

E. Agreement to Pay IHCP

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act and 42 CFR §§ 438.14 and 457.1209.

F. Persons Eligible for Items and Services from IHCP

Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 CFR Part 136.

No term or condition of the Family Care Agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

G. Applicability of Federal Laws not Generally Applicable to other Providers

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix A.

H. Non-Taxable Entity

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

I. Licensure and Accreditation

Pursuant to 25 USC 1621t and 1647a, the State and the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. In addition, the State and the managed care organization shall not require the licensure of a health professional

employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

J. Dispute Resolution

In the event of any dispute arising under the Family Care Agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Family Care Agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

K. Governing Law

The Family Care Agreement and all addenda thereto shall be governed and construed in accordance with federal and state law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the Family Care Agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

L. Medical Quality Assurance Requirements

To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

M. Hours and Days of Service

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

N. Purchase/Referred Care Requirements

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan. The IHCP shall comply with coordination of care and referral obligations of the Managed Care Plan issuer except only in specific circumstances in which such obligations would conflict with requirements applicable to Purchased/Referred Care at 42 CFR Part 136. The IHCP will notify the Managed Care Plan issuer when such circumstances occur.

O. Sovereign Immunity

Nothing in the Family Care Agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

P. Endorsement

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

VI. APPENDIX A

(a) The IHS as an IHCP:
- (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
- (2) ISDEAA, 25 U.S.C. § 450 et seq.;
- (3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 CFR Part 5b;
- (6) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:
- (1) ISDEAA, 25 U.S.C. § 450 et seq.;
- (2) IHCIA, 25 U.S.C. § 1601 et seq.; (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Privacy Act, 5 U.S.C. § 552a, 45 CFR Part 5b.

(c) An urban Indian organization that is an IHCP:
- (1) IHCIA, 25 U.S.C. § 1601 et seq.
- (2) Privacy Act, 5 U.S.C. § 552a, 45 CFR Part 5b.