Definition of an HMO

An HMO is a public or private organization, organized under the laws of the State of Wisconsin, which:

(i) makes services it provides to individuals eligible under Title XIX accessible to such individuals, within the area served by the organization, to the same extent such services are made accessible to individuals (eligible for medical assistance under the state plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the state and which assures that individuals eligible for benefits under Title XIX are in no case held liable for debts of the organization in case of the organization's insolvency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wisconsin

AFDC-RELATED/HEALTHY START HMO PROGRAM

A. General Description of the Program

1. This program is called the AFDC-Related/Healthy Start HMO Program. All Medicaid beneficiaries (as described in Section C) are required to enroll in Health Maintenance Organizations (HMOs). Those described in Section D will not be mandatorily enrolled. (Supplement 1 to Attachment 2.1-A).

2. The objectives of this program are to reduce costs, reduce inappropriate utilization, and assure adequate access to care for Medicaid recipients.

3. This program is intended to enroll Medicaid recipients in HMOs, which will provide or authorize all primary care services and all necessary specialty services. The HMO is responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under this program.

4. The HMO will assist the participant in gaining access to the health care system and will monitor, on an ongoing basis, the participant's condition, health care needs, and service delivery. The HMO will be responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of recipients enrolled in the HMO.

5. Recipients enrolled under this program will be restricted to receive services included under the AFDC-Related/Healthy Start HMO Program either from the HMO or another qualified provider. The recipient's health care delivery will be managed by the HMO. The AFDC-Related/Healthy Start HMO Program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the recipient with a choice of at least two HMOs and a 90-day open enrollment period. The enrollment contractor facilitates this through enrollment counseling and information distribution so that recipients may make an informed decision (see Section E for more details).

6. Non-HMO contractors will act as a central broker, agent, facilitator, and negotiator in assisting eligible individuals in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

7. The State will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments.

8. The State requires recipients to obtain services only from Medicaid-certified providers who provide such services and providers must meet reimbursement, quality, and utilization standards which are consistent with access, quality and efficient and economic provisions of covered care and services.

B. Assurances

1. Consistent with this description, the State assures that all the requirements of Sections 1932 and 1903(m) of the Social Security Act (the Act) will be met.

2. The AFDC-Related/Healthy Start HMO Program is available throughout the State. The AFDC-Related/Healthy Start HMO Program will be implemented statewide. Mandatory enrollment provisions will not be implemented unless a choice of at least two HMOs is available.

3. The State has safeguards in effect to guard against conflict of interest on the part of employees of the State and its agents.

C. Target Groups of Recipients

The AFDC-Related/Healthy Start HMO Program is limited to the following target groups of recipients:

1. Temporary Assistance for Needy Families (TANF), formerly known as Aid to Families with Dependent Children (AFDC).

2. AFDC-related.

3. Healthy Start Recipients, which includes:

   a. Children under the age of six years, income less than or equal to 133% of poverty level (Medical Status Code CC).

   b. Children ages two through six years, income less than or equal to 185% of poverty level (Medical Status Code CM).

   c. Children born after September 1983, income less than or equal to 100% of poverty level (Medical Status Code GC).

   d. Children under the age of two years, income less than or equal to 185% of poverty level (Medical Status Code PC).

e. Pregnant women, income less than or equal to 133% of poverty level (Medical Status Code PW).

f. Pregnant women, income less than or equal to 185% of poverty level (Medical Status Code P1).

g. Pregnant women, IRCA alien, income less than or equal to 185% of poverty level (Medical Status Code A8).

D. <u>Mandatory Enrollment</u>

1. The following groups will not be mandatorily enrolled:

   a. Dual Medicare - Medicaid eligibles.

   b. Indians who are members of Federally-recognized tribes.

   c. Children under 19 years of age who are any of the following:

      (1) Eligible for SSI under Title XIX.

      (2) Described in Section 1902(e)(3) of the Social Security Act.

      (3) In foster care or other out of home placement.

      (4) Receiving foster care or adoption assistance.

      (5) Receiving services through a family centered, community-based coordinated care system receiving grant funds under Section 501(a)(1)(d) of Title V. Recipients that are not mandatorily enrolled under this subsection are defined as children with special health-care needs (CSHCN) that are receiving direct financial assistance from the State's Maternal and Child Health Care program. These recipients will be identified using appropriate medical status codes from the Medicaid Management Information System. Any additional recipients that would be affected by this subsection will be requested to self identify themselves in the enrollment process.

   d. Recipients who are residing in a nursing facility or ICF/MR.

   e. Recipients who have to travel more than 20 miles to the nearest primary care provider contracted by the HMO.

f. Recipients who have an eligibility period that is less than three months.

g. Recipients who have an eligibility period that is only retroactive.

2. Medicaid recipients may be excluded from mandatory enrollment:

   a. If they are patients of certified nurse midwives or nurse practitioners.

   b. If they are patients with AIDS or HIV-positive with anti-retroviral drug treatment.

   c. If they are patients of Federally Qualified Health Centers (FQHC)or a Rural Health Clinic (RHC).

   d. If they are recipients who have commercial HMO insurance, they may be eligible for exemption from mandatory enrollment if the commercial HMO does not participate in Medicaid.

   e. If they are recipients who have a recurrent or persistent psychosis and/or a major disruption in mood, cognition, or perception.

   f. If they are recipients who have a major impairment in functioning in personal or social roles; e.g., self care/activities of daily living, and if they need extraordinary human service programming which is best provided by the social/human service system and who will be receiving these medical and non-medical services with emphasis on the need for a comprehensive and coordinated program.

   g. If they are recipients who participate, or they have been determined to need participation, in a Methadone treatment program.

E. Enrollment and Disenrollment

1. With the exception of where the rural exception described in section EE. applies, all recipients will be given the opportunity to chooose from at least two HMOs. If a recipient has a prior provider relationship that they wish to maintain, through one-on-one enrollment counseling and informing services, the enrollment broker will assist the recipient in choosing an HMO that will maintain this relationship.

   Specifically, the enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

a. Supplies an enrollment, packet to the recipient which includes individuals' HMO informing materials and information supplied by the State.

b. Provides enrollment counseling which includes:

(1) Inquires about patient/provider experience and/or preference.

(2) Provides information on which HMO's are available to maintain a prior patient-provider relationship.

(3) Discusses any mandatory or voluntary exemption possibilities.

(4) Facilitates direct contact with individual HMOs, as necessary.

(5) Provides any information and education concerning the enrollment process, individual HMO's, benefits offered, enrollment packet and any of the other information provided for in this section.

If the recipient fails to choose an HMO within two months after receiving enrollment materials, the State will assign the recipient to an HMO. These recipients are automatically assigned, where it is not possible to determine prior patient/provider relationship, on a rotational basis to HMOs that have openings to ensure equitable distribution to individual HMOs.

2. Any selection or assignment of an HMO may be changed at the request of the recipient for the following reasons:

a. During the first 90 days of the enrollment period of up to 12 months, and annually thereafter, the recipient can change from one HMO to another for any reason.

b. Enrollees will be provided notification 60 days prior to the end of a lock-in period of their opportunity to make a new choice of HMOs.

c. Enrollees will be given an annual opportunity to change HMOs and will be sent a notice to that effect.

d. Recipients may disenroll at any time for good cause as defined in Section E.7.

3. There will be an annual 90-day open enrollment period during which the HMO will accept individuals who are eligible to enroll.

4. HMOs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

5. The HMO will not terminate enrollment because of an adverse change in the recipient's health.

6. An enrollee who is terminated from an HMO solely because the enrollee has lost their Medicaid benefits for a period of two months or less will automatically be re-enrolled into the same HMO.

7. As stated in section F.2.a., an enrollment period shall not exceed 12 months. An enrollee may disenroll following the 90th day of any period of enrollment if all of the following circumstances occur:

a. The enrollee submits a request for disenrollment to the State citing good cause for disenrollment.

b. The request cites the reason or reasons why the recipient wishes to disenroll, such as poor quality of care, lack of access to special services or other reasons satisfactory to the State.

c. The State determines good cause for disenrollment exists. Cause will include, but not be limited to any of the following:

(i) When the recipient moves out of the managed care entity's service area.

(ii) If the plan does not, because of moral or religious objections, cover the service that the recipients seeks.

(iii) If the recipient needs related services to be performed at the same time; not all related services are available within the network; and the recipient's primary care provider or another provider determines that receiving the services separately would subject the recipient to unnecessary risk.

(iv) If the State imposes sanctions on the plan under the authority in 42 CFR 438.702(a)(3).

8. The recipient will be informed at the time of enrollment of the right to disenroll.

9. An enrollee will be allowed to choose his or her health professional in the HMO to the extent possible and appropriate and will be allowed to change his or her health professional twice a year without cause and more often with cause.

10. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women health specialists.

EE. Rural Exception to Right to Choose From at Least Two HMOs

1. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in an MCO will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3). The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs.

2. Where the rural exception to the right to choose is imposed on recipients, the recipient is entitled to the following protections:

a. A recipient is permitted to choose from at least two physicians or case managers.

b. A recipient may obtain assistance from any other provider in an emergency or other appropriate circumstances established by the State of Wisconsin.

c. A recipient may obtain assistance from any other provider of the service or type of provider is not available within the MCO network.

d. A recipient may obtain services from a provider who is not part of the network, but is the main source of a service to the recipient, provided that–

(i) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO network as other network providers of that type.

(ii) If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 days after being given an opportunity to select a provider who participates.

e. A recipient may obtain services from an out of network provider if the only plan or provider available to the recipient does not, because of moral or religious objections, provide the service the enrollee seeks.

f. A recipient may obtain services from an out of network provider if the recipient's primary care provider or other provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

g. A recipient may obtain services from an out of network provider if the State determines that other circumstances warrant out-of-network treatment.

F. Maximum Payments

Section 1902(a)(30) of the Act and implementing regulations prohibit payments to a contractor from exceeding the cost to the agency of providing these same services on a fee-for-service (FFS) basis to an actuarially equivalent nonenrolled population.

G. Non HMO Covered Services

All Medicaid covered services will be provided by Medicaid HMOs without Medicaid prior authorization under the AFDC-Related/Healthy Start HMO Program with the exception of the following services:

1. Dental services (optional for HMOs).

2. Common carrier transportation (optional for HMOs).

3. Chiropractic services (optional for HMOs).

4. Prenatal care coordination (obtained on a fee-for-service basis).

5. Tuberculosis-related services (obtained on a fee-for-service basis).

6. Targeted case management (obtained on a fee-for-service basis).

7. Community support program services for the chronically mentally ill (obtained on a fee-for-service basis).

8. Prescription drugs and medical supplies listed in the Department's Prescription Drug Index or Disposable Medical Supplies Index (and obtained on a fee-for-service basis), that are not reimbursable as part of the rate paid for a physician office visit or a stay in a hospital or nursing home.

H. Covered Services

1. Services not covered by the AFDC-Related/Healthy Start HMO Program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the AFDC-Related/Healthy Start HMO Program, the process for obtaining such services, and the information noted in Section M.1 and 7. In order to ensure the coordination of non-restricted preventive and primary care services, HMOs will be encouraged to work with Local Public Health Agencies (LPHA) and additional organizations in the collection and integration of immunization data, upon request of local providers, as a condition of contracting with the Medicaid program. As a condition of Medicaid certification, providers will be required to share immunization data with HMOs.

2. HMOs will be required to work with schools, school districts, and Cooperative Educational Services Agencies when such organizations are certified to provide school based services.

3. HMOs will be encouraged to develop subcontracts or Memoranda of Understandings with LPHAs, HealthCheck providers, and other specific community-based organizations, such as family planning clinics.

4. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's HMO is not required. Recipients will be informed that emergency and family planning services are not restricted under the AFDC-Related/Healthy Start HMO Program. "Emergency services" and "emergency/post stabilization services" are defined in the managed care contract.

5. A State-determined limit on the number of recipients which can be managed by a physician in an HMO will be in effect under the AFDC-Related/Healthy Start HMO Program. A limit will be chosen in order to guarantee access to appointments within acceptable time parameters for urgent and illness-related conditions as well as non-symptomatic preventive care. The number of Medicaid recipients would also allow for the provider to serve a sufficient number of private pay and commercially insured patients to create a mixture of patients reflective of the insurance status of the community may be required.

I. Mandates

Qualifications and requirements for HMOs will be noted in the provider agreements. In addition, HMOs shall meet all of the following requirements:

1. An HMO shall be a Medicaid qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

2. The HMO shall sign a certification agreement which explains the responsibilities HMOs must comply with.

3. The HMO shall have a State-approved grievance and complaint process.

4. The HMO shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the HMO.

5. The HMO shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

6. The HMO shall make available 24-hour, 7 day a week access by telephone to a live voice (an employee of the HMO or a representative) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours.

7. The HMO shall not refuse an assignment or disenroll a participant or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition except when that illness or condition can be better treated by another provider type.

8. The HMO shall only request reassignment of the participant to another HMO if the patient/HMO relationship is not mutually acceptable. All reassignments must be State approved.

9. All subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.

10. The HMO shall be licensed by the Wisconsin Office Commissioner of Insurance (OCI) in order to ensure financial stability (solvency) and compliance with regulations.

J. Comprehensive Risk Contracts

The State will enter into comprehensive risk contracts with the HMOs, procured in a competitive manner. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, rural health clinic (RHC), laboratory, x-ray, skilled nursing facility, FQHCs, physician, home health, early periodic screening, diagnosis and treatment, family planning services and all other Medicaid optional services except for those described in Section H. All contracts will comply with Sections 1932 and 1903(m) of the Act.

K. Additional Requirements

1. Any marketing materials available for distribution under the Act and state statutes shall be provided to the State for its review and approval.

2. The HMO shall certify that no recipient will be held liable for any HMO debt as the result of insolvency or for services the State will not pay for.

3. The HMO shall include safeguards against fraud and abuse, as provided in state statutes.

4. The HMO shall allow the State to take sanctions as prescribed by federal or state statutes. Also, the HMO shall provide assurance that due process will be provided.

L. FQHC and RHC Services

FQHC and RHC services will be mandatory and the recipients are provided reasonable access to these services under the program.

M. Process for Enrollment in an HMO

The following process is in effect for recipient enrollment in HMOs:

1. The recipient shall be provided by the State with all of the following:

   a. A brochure explaining the program and comparing HMOs in a chart-like format including benefits, services covered and not covered, and quality and performance indicators. Quality and performance indicators include disenrollment rates and enrollee satisfaction.

   b. A form for enrollment in the plan and selection of a plan.

   c. A list of HMOs serving the recipients geographical service area.

   d. A toll-free number which can be used to pose questions by telephone.

   e. Enrollee rights and responsibilities.

   f. Information explaining the grievance and complaint procedure.

   g. Information on how to obtain Medicaid services not covered by the HMO.

2. All materials will be translated into languages other than English as necessary (at a minimum into Spanish and Hmong) and will be in an easily understood format (6th grade or less reading level). Materials will be translated into languages other than English if there is 5% of the population or 1,000 people in a service area that speak a language other than English as their first language.

3. Each recipient shall notify the State by mail, telephone or in person, of his or her choice of plans.

4. As indicated in Section E.1, if the recipient does not choose a plan, the State will assign the recipient to a plan and notify the recipient of the assignment.

5. The HMO will be informed electronically of the recipient's enrollment in that HMO.

6. The recipient will be notified of enrollment and issued an identification card.

7. Additionally, each HMO will provide the following information within five days after notice of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

   c. Names and locations of current network providers including those providers not accepting new patients.

   d. Any restrictions on freedom of choice.

   e. The extent to which there are any restrictions concerning out of network providers.

   f. Policies for specialty care and services not furnished by the primary care providers.

   g. Grievance and complaint process.

N. <u>Quality of Health Care and Services, Including Access</u>

To assure quality of health care services in this document, the State shall perform the actions listed in this section.

1. The State shall require, by contract, all HMOs and providers to meet certain State-specified standards for Internal Quality Improvement Programs (QIP's).

2. On a periodic or continuous basis, the State shall monitor the adherence to these standards by all HMOs, through the following mechanisms:

   a. Review of the written QIP for each HMO to monitor adherence to the State's QIP standards. Such review shall take place prior to the State's execution of the contract with the HMO and each contract renewal period thereafter. The contract renewal period is every two years.

   b. Periodic review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the State on at least a semi-annual basis.

   c. Monitoring of the implementation of the QIP shall be conducted to assure compliance with the State's QIP standards. This monitoring shall be conducted on-site at both the HMO administrative offices and the care delivery sites. At least two such monitoring visits shall occur per year.

d. Monitoring through the use of State Medicaid agency personnel and contracted staff.

3. The State will arrange for an independent, external review of the quality of services delivered under each HMO's contract with the State. The review will be conducted for each HMO contractor on an annual basis. The entity which will provide the annual external quality reviews shall not be a part of the State government, HMOs, or an association of any HMOs.

4. Recipient access to care will be monitored as part of each HMO's internal QIP and through the annual external quality review for HMOs. The periodic medical audits described in par. 1., the State monitoring activities described in par. 2, and the external quality review described in par. 2, shall all derive the following information:

   a. Periodic comparisons of the number and types of Medicaid services before and after the institution of the AFDC-Related/Healthy Start HMO Program.

   b. Recipient satisfaction surveys managed by State staff.

   c. Periodic recipient surveys which contain questions concerning recipient access to services which the HMOs will conduct.

   d. Measurement of waiting periods to obtain health care services; including standards for waiting time and monitor performance against these standards.

   e. Measurements of referral rates to specialists.

   f. Assessment of recipient knowledge about how to obtain health care services.

   g. A requirement that HMOs submit utilization and encounter data.

O. Access to Care

In addition to the above processes, the AFDC-Related/Healthy Start HMO Program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating HMOs in the service areas. The State will make available an HMO-certified service area map that is updated each contracting period. In addition, as per 42 CFR 434.29, within an HMO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the AFDC-Related/Healthy Start HMO Program.

3. State-specified access standards for distances and travel miles to obtain services for recipients under the AFDC-Related/Healthy Start HMO Program have been established. Specifically, the HMO must have a primary care provider within 20 miles, and a dental provider, mental health provider, and substance abuse provider within a 35-mile distance from any enrollee residing in the HMO service delivery area.

4. The number of providers to participate under the AFDC-Related/Healthy Start HMO Program is expected to increase.

5. Primary care and health education are provided to enrollees by a chosen or assigned HMO. This fosters continuity of care and improved provider/patient relationships.

6. Pre-authorization is precluded for emergency/post stabilization and family planning services under the AFDC-Related/Healthy Start HMO Program.

7. Recipients have the right to change plans if good cause is shown.

8. HMOs are required to provide or arrange for coverage 24 hours a day/7 days a week.

9. The same state hearing appeals system in effect under the Medicaid fee-for-service program will be in effect under the AFDC-Related/Healthy Start HMO Program. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E.

10. The state assures that state-determined access standards are maintained by use of a Geographic Mapping program.