# WISCONSIN BADGERCARE PLUS AND MEDICAID SSI REGULATORY REQUIREMENTS

**THESE WISCONSIN BADGERCARE PLUS AND MEDICAID SSI REGULATORY REQUIREMENTS** (these "Medicaid Regulatory Requirements") supplement and are made part of the Provider Participation Agreement ("Agreement") between Medica Self-Insured d/b/a SelectCare ("SelectCare") and the Provider named in the Agreement ("Provider").

## SECTION 1 APPLICABILITY

The provisions of these Medicaid Regulatory Requirements apply with respect to the provision of (a) health care services that Provider provides directly to Covered Persons through Payer's products or benefit plans or (b) other indirect or non-health care related services provided by Subcontractors under the State of Wisconsin BadgerCare Plus and Medicaid SSI programs (collectively, the "State Medicaid Program"), as governed by the State's designated regulatory agencies. In the event of a conflict between these Medicaid Regulatory Requirements and any provision of the Agreement or amendment thereto, the provisions of these Medicaid Regulatory Requirements will control except with regard to benefit contracts outside the scope of these Medicaid Regulatory Requirements or unless otherwise required by law. In the event SelectCare is required to amend or supplement these Medicaid Regulatory Requirements as required by the State and requested by the Payer, Provider agrees that SelectCare will be permitted to unilaterally initiate such additions, deletions or modifications, to be effective immediately unless written notice of such amendment is required under law.

## SECTION 2 DEFINITIONS

Unless otherwise defined in these Medicaid Regulatory Requirements, all capitalized terms will be as defined in the Agreement. For purposes of the State Medicaid Program and these Medicaid Regulatory Requirements, the following terms will have the meanings set forth below; provided, however, in the event any definition set forth in these Medicaid Regulatory Requirements or the Agreement is inconsistent with any definitions under the State Medicaid Program, the definitions will have the meaning set forth under the State Medicaid Program.

2.1 **Agreement:** An executed contract between SelectCare and Provider for the provision of Covered Services to persons enrolled in the State Medicaid Program.

2.2 **BadgerCare Plus:** The Wisconsin State program that merges Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children and families.

2.3 **Clean Claim:** A truthful, complete and accurate claim that does not have to be returned for additional information.

2.4 **Covered Person:** An individual who is currently enrolled with Payer for the provision of Covered Services under the State Medicaid Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.5 **Covered Services:** A health care service or product for which a Covered Person is enrolled to receive coverage under the State Medicaid Contract.

2.6 **Department or DHFS:** The Wisconsin Department of Health and Family Services.

2.7 **Provider:** A hospital, ancillary provider, physician group, or individual physician who has entered into an Agreement.

2.8 **State:** The State of Wisconsin or its designated regulatory agencies.

2.9 **State Medicaid Contract:** Payer's contract with the Wisconsin Department of Health and Family Services for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the BadgerCare Plus and Medicaid SSI programs (collectively, the "State Medicaid Program").

2.10 **Subcontract:** Any written agreement between Payer and another party to fulfill any requirements of the State Medicaid Contract. For purposes of these Medicaid Regulatory Requirements, an Agreement is a Subcontract for the arrangement or provision of Covered Services.

2.11 **Subcontractor:** The party contracting with Payer to fulfill any requirements of the State Medicaid Contract. For purposes of these Medicaid Regulatory Requirements, Provider and SelectCare are both Subcontractors that, respectively, provide and arrange Covered Services.

## SECTION 3
## PROVIDER REQUIREMENTS

The State Medicaid Program, through federal and State statutes and regulations, requires the Agreement to contain certain conditions that SelectCare, Payer and Provider, as applicable, agree to undertake, which are as follows:

3.1 Provider will follow the State Medicaid Contract's provisions for the coverage of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons will be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: Emergency Medical Condition includes all of the following:

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 any of the following:

(i) 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;
(ii) serious impairment of bodily functions; or
(iii) serious dysfunction of any bodily organ or part.

(2) With respect to a pregnant woman who is in active labor:

(i) where there is inadequate time to effect a safe transfer to another hospital before delivery; or
(ii) where transfer may pose a threat to the health or safety of the woman or the unborn child.

(3) A psychiatric emergency involving a significant risk of serious harm to oneself or others.

(4) A substance abuse emergency exists if there is significant risk of serious harm to a Covered Person or others, or there is likelihood of return to substance abuse without immediate treatment.

(5) Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma. In all emergency situations, the Provider must document in the Covered Person's dental records the nature of the emergency.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(c) Medically Necessary: A medical service that meets the definition of Wis. Adm. Code HFS 101.03(96m), as may be amended from time to time.

3.2 Provider must be certified by the BadgerCare Plus and/or Medicaid program for State Medicaid Program services required under this Agreement. DHFS reserves the right to withhold retrospectively from the capitation payments the monies related to services provided by any non-Medicaid or BadgerCare Plus-certified physicians or providers, at the Medicaid fee-for-service rate for those services.

3.3 Provider will abide by the terms of the State Medicaid Contract for the timely provision of emergency and urgent care.

3.4 Where applicable, Provider will follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room Memoranda of Understanding (MOU) signed by Payer in accordance with the State Medicaid Contract.

3.5 Provider will submit encounter data in the format specified by Payer, so that Payer can meet the Department's specifications required under the State Medicaid Contract. Payer will evaluate the credibility of data obtained from external databases to ensure that any patient-reported information has been adequately verified. Provider must also submit all reports and clinical information required by Payer including, without limitation, all child and adolescent health check-up reporting, HealthCheck encounters, cancer screening encounters and such other Covered Services as may be required under the State Medicaid Contract.

3.6 Provider will ensure the confidentiality of family planning services in accordance with the terms of the State Medicaid Contract.

3.7 Provider will abide by the terms of the State Medicaid Contract regarding appeals to Payer and DHFS for non-payment by Payer for services rendered to Covered Persons by providers, including:

(a) Payer must accept written appeals from Provider if Provider disagrees with Payer's payment/denial determination as long as Provider submits the dispute in writing and within sixty (60) days of the initial payment/denial notice. Payer has forty-five (45) days from the date of the receipt of the request for reconsideration to respond to Provider in writing. If Payer fails to respond within that time, or if Provider is not satisfied with Payer's response, Provider may seek a final determination from DHFS.

(b) Payer must inform Provider in writing of Payer's payment/denial determinations including:

(i) A specific explanation of the payment amount or a specific reason for the payment denial.

(ii) A statement regarding Provider's rights and responsibilities in appealing to Payer about Payer's initial determination by submitting a separate letter or form: (a) clearly marked "appeal"; (b) containing the provider's name, date of service, date of billing, date of rejection, the Covered Person's name and BadgerCare Plus and/or Medicaid SSI ID number, and reason(s) the claim merits reconsideration; (c) for each appeal; (d) addressed to the person and/or department at Payer that handles provider appeals within sixty (60) days of the initial denial or partial payment.

(iii) A statement advising Provider of its right to appeal to the DHFS if Payer fails to respond to the appeal within forty-five (45) days or if Provider is not satisfied with Payer's response to the request for reconsideration, and that all appeals to the DHFS must be submitted in writing within sixty (60) days of Payer's final decision or, in the case of no response, within sixty (60) days from the forty-five (45) day timeline allotted Payer to respond. In cases where there is a dispute about Payer's payment/denial determination and Provider has requested reconsideration, the DHFS will hear appeals and make final determinations. The DHFS will not exercise its authority in this regard unreasonably. The DHFS will accept written comments from all parties to the dispute before making the decision. Payer and Provider must accept DHFS's determinations regarding appeals of disputed claims. If DHFS's decision is in favor of Provider, Payer will pay Provider within forty-five (45) days of receipt of DHFS's final determination.

3.8 Provider must provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Medicaid Contract including without limitation, appointments for preventative care, urgent care, routine sick care, and well care.

3.9 Provider must cooperate with SelectCare and Payer, as applicable, and provide a Covered Person with continuity of treatment in the event Provider's participation with SelectCare terminates during the course of a Covered Person's treatment by Provider.

3.10 Provider will not create barriers to access to care by imposing requirements on Covered Persons that are inconsistent with the provision of Medically Necessary and covered BadgerCare Plus and/or Medicaid SSI benefits (e.g., coordination of benefits recovery procedures that delay or prevent care).

3.11 Provider must look solely to Payer for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Medicaid Contract and hold the State and Covered Persons harmless in the event that Payer cannot or will not pay for such Covered Services. Provider will not bill BadgerCare Plus and/or Medicaid SSI Covered Persons for Medically Necessary services covered under the State Medicaid Contract and provided during the Covered Person's period of enrollment with Payer, pursuant to Section 1128(B)(d)(1) of the Social Security Act. Provider also will not bill a Covered Person for any missed appointments while the Covered Person is eligible under the BadgerCare Plus – Standard Plan and/or Medicaid SSI programs; provided, however, Covered Persons eligible under the BadgerCare Plus – Benchmark Plan (as described in the State Medicaid Contract) may be billed for missed appointments. In addition, a Covered Person eligible under the BadgerCare Plus – Standard Plan (as described in the State Medicaid Contract) or the BadgerCare Plus – Benchmark Plan may be billed for

applicable copayments and/or premiums for Medically Necessary services provided during the Covered Person's enrollment with Payer. Provider may not bill a Medicaid SSI Covered Person for copayments or premiums for Medically Necessary services provided during the Covered Person's enrollment with Payer. This provision will remain in effect even if Payer becomes insolvent.

Notwithstanding the foregoing, if a Covered Person agrees in writing to pay for a non-covered service, then Provider or Payer can bill the Covered Person for the service. The standard release form signed by the Covered Person at the time of services does not relieve Provider or Payer from the prohibition against billing a BadgerCare Plus – Standard Plan or Medicaid SSI Covered Person in the absence of a knowing assumption of liability for a non- covered service. The form or other type of acknowledgment relevant to BadgerCare Plus or Medicaid SSI Covered Person liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus or Medicaid SSI.

3.12 Provider will cooperate with SelectCare and Payer, as applicable, in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy.

3.13 In addition to the amount, duration, and scope of Covered Services to be provided by Provider as specified in the Agreement and the State Medicaid Contract, Provider must continue to provide Covered Services through the duration of the Provider's Agreement with SelectCare including, without limitation, the applicable capitation or premium payment period for which the State has paid to Payer.

3.14 Provider must promptly inform SelectCare and Payer, as applicable, when the number of Active Covered Persons from all populations serviced under the Agreement reaches 3,000 Active Covered Persons. Provider must also submit to SelectCare and Payer, as applicable, by January 31st of each calendar year, an attestation indicating the number of Active Covered Persons from all populations serviced by Provider as of the date of the submission. For the purposes of this provision, "Active Covered Person" means a Covered Person who is seen by the same primary care physician, or by a physician assistant or advanced nurse practitioner under the supervision of the primary care physician, at least three (3) times within a calendar year.

3.15 Provider will prominently display a consumer assistance notice in all Covered Person reception areas or other conspicuous areas as required by State law or the State Medicaid Contract. The notice must include the addresses and toll-free numbers of the State agency charged with enforcing the State Medicaid Contract, the phone number for any Covered Person assistance program, and any other applicable regulatory agency that is responsible for addressing Covered Person issues. The notice must also clearly state that the address and toll-free number of the Payer grievance and appeals department will be provided upon request.

3.16 Provider must offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid fee-for-service beneficiaries.

3.17 Provider will comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination.

3.18 In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Provider will assure maximum health outcomes for such Covered Persons.

3.19 Provider will not make referrals for designated health services to health care entities with which the Provider or a member of the Provider's family has a financial relationship.

3.20 Provider will contract with only BadgerCare Plus and/or Medicaid SSI-certified providers in accordance with the State Medicaid Contract for purposes of the State Medicaid Program.

3.21 Provider will comply with all non-discrimination requirements as set forth in the State Medicaid Contract, including but not limited to: (i) complying with all applicable federal and State laws relating to non-discrimination and equal employment opportunity, including s. 16.765 Wis. Stats., the Federal Civil Rights Act of 1964 and regulations issued pursuant to that Act, and the provisions of Federal Executive Order 11246 dated September 26, 1985; (ii) assuring physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794); (iii) complying with all requirements imposed by the applicable State and federal regulations (45 C.F.R. part 84) and all guidelines and interpretations issued pursuant thereto; and (iv) complying with the provisions of the Age Discrimination and Employment Act of 1967 and the Age Discrimination Act of 1975.

3.22 Provider must maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Provider will comply with all record retention requirements under the State Medicaid Contract and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements. Provider must maintain records for a period of not less than ten (10) years from the close of the State Medicaid Contract, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete. Payer or SelectCare, as applicable, will request and obtain prior approval from Provider for the disposition of records under review or inspection. Provider must safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224, as may be amended from time to time.

3.23 Provider will provide representatives of Payer and, as applicable, SelectCare, as well as duly authorized agents or representatives of the Department and the U.S. Department of Health and Human Services, access to its premises and its contracts and/or medical records. Provider will otherwise preserve the full confidentiality of medical records in accordance with the State Medicaid Contract and pursuant to: Chapter 19, Subchapter II, Wis. Stats., Wis. Admin. Code HFS 108.01, and 42 C.F.R. 431 Subpart F. Except as otherwise required by law, rule, or regulation, access to such information must be limited by Payer, SelectCare and the Department to persons who, or agencies which, require the information in order to perform their duties related to the State Medicaid Contract, including the U.S. Department of Health and Human Services and such others as may be required by the Department.

Provider will also make available to the Department, the Department's authorized agents and appropriate representatives of the U.S. Department of Health and Human Services any financial records of Provider that relate to the services performed and amounts paid or payable under the State Medicaid Contract.

3.24 Provider will abide by all requirements for maintenance and transfer of medical records pursuant to the terms of the State Medicaid Contract. Minimum medical record documentation per chart entry or encounter must conform to Wis. Admin. Code, Chapter HFS 106.02, (9)(b), as may be amended from time to time.

3.25 Provider will clearly specify referral approval requirements to its providers and in any sub-subcontracts.

3.26 Within fifteen (15) days of Payer's request, Provider must forward to Payer medical records related to grievances. If Provider does not meet this fifteen (15) day requirement, Provider must explain why and indicate when the medical records will be provided.

3.27 Provider will abide by Payer's and, as applicable, SelectCare's marketing/information requirements. Provider will forward to Payer and SelectCare for prior approval all flyers, brochures, letters, and pamphlets Provider intends to distribute to Covered Persons concerning its or Payer affiliation(s), or changes in affiliation, and other information that relates directly to the BadgerCare Plus and/or Medicaid SSI population. Provider will not distribute any marketing or Covered Person informing materials without the consent of Payer, SelectCare, as applicable, and DHFS.

3.28 Provider must maintain during the term of the Agreement general liability insurance, workers' compensation insurance and, if applicable, professional liability insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance will comply with State Workers' Compensation Law. Such comprehensive general liability insurance and professional liability insurance will provide coverage in an amount established by SelectCare pursuant to the Agreement or as required under the State Medicaid Contract.

3.29 Provider must indemnify and hold the State and Covered Persons harmless from and against all claims, damages, causes of action, costs or expense, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising in connection with the Agreement. This clause survives the termination of the Agreement, including breach due to insolvency. The State Medicaid Program reserves the right to waive this requirement for itself, but not Covered Persons, for damages in excess of the statutory cap on damages for public entities if Provider is a public health entity with statutory immunity. All such waivers must be approved in writing by the State Medicaid Program.

3.30 Provider will perform all tasks under the Agreement in accordance with the State Medicaid Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves Payer of its responsibility under the State Medicaid Contract. If any provision of the Agreement is in conflict with provisions of the State Medicaid Contract, the terms of the State Medicaid Contract will control.

3.31 Provider must comply with Payer's cultural competency program consistent with the terms of the State Medicaid Contract.

3.32 Provider will participate in and contribute required data to Payer's Quality Assessment/Performance Improvement programs.

3.33 Provider must comply with Physician Incentive Plans ("PIPs") in accordance with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Payer nor SelectCare may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

3.34 Payer will provide monitoring and oversight and SelectCare must assure that all licensed medical professionals are credentialed in accordance with the applicable State Medicaid Contract credentialing requirements as Payer has delegated credentialing to SelectCare.

3.35 If Provider delegates any functions of the Agreement, the delegation agreement must include all of the requirements of these Medicaid Regulatory Requirements, and applicable requirements of the State Medicaid Contract.

3.36 Provider will comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time.

3.37 Provider will comply with all applicable federal and State statutes and rules and regulations that are in effect when the State Medicaid Contract is signed, or that come into effect during the term of the State Medicaid Contract. This includes, but is not limited to Title XIX of the Social Security Act, Title XXI, SCHIP, and Title 42 of the CFR.

3.38 Provider is subject to all State and federal laws and regulations relating to fraud, abuse or waste in health care and the State Medicaid Program. Provider must cooperate and assist the State Medicaid Program and any other State or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste. Provider must provide originals and/or copies of any and all information, allow access, wherever Provider maintains such books, to premises and provide records, to the State Medicaid Program's fraud and abuse designee, CMS, the U.S. Department of Health and Human Services, the Federal Bureau of Investigation (FBI), or any other unit of State or federal government upon request, and free-of-charge.

3.39 Provider acknowledges that no terms of these Medicaid Regulatory Requirements or the Agreement are valid which terminate the legal liability of Payer.

3.40 Provider will comply, as applicable, with Payer's Civil Rights Compliance Plan.

## SECTION 4
## SELECTCARE AND PAYER REQUIREMENTS

4.1 Provider will not be prohibited from discussing treatment or non-treatment options with Covered Persons that may not reflect SelectCare's or Payer's position, as applicable, or may not be covered by Payer.

4.2 Provider will not be prohibited, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the Covered Person's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered. Provider will also not be prohibited from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

4.3 SelectCare and Payer, as applicable, will not discriminate with respect to participation, reimbursement, or indemnification of a Provider who is acting within the scope of his/her/its license or certification under applicable State law, solely on the basis of such license or certification. This provision will not be construed to prohibit SelectCare from including providers to the extent necessary to meet the needs of Covered Persons or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities.

4.4 SelectCare and Payer, as applicable, will not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments.

4.5 SelectCare will require Payer to pay Provider pursuant to the State Medicaid Contract, applicable State law and regulations, and 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims will be determined in accordance with federal and/or State third party liability law and the terms of the State Medicaid Contract. Unless Payer otherwise requests assistance from Provider, Payer will be responsible for third party collections in accordance with the terms of the State Medicaid Contract.

4.6 To the extent applicable under the State Medicaid Contract and in the case of newborns, Payer will be responsible for any payment owed to Provider for services rendered prior to the newborn's enrollment with Payer.

4.7 Payer will not be responsible for any payments owed to Provider for services rendered prior to a Covered Person's enrollment with Payer, even if the services fell within the established period of retroactive eligibility.

4.8 If Payer delegates selection of providers to SelectCare, Payer retains the right to approve, suspend, or terminate any Provider selected by SelectCare.

## SECTION 5
## OTHER REQUIREMENTS

5.1 To the extent applicable and required by law or the terms of the State Medicaid Contract, any notice of termination by Payer to Subcontractor will be furnished to the State or its designated government agencies.

5.2 In addition to its termination rights under the Agreement, Payer will have the right to revoke any functions or activities Payer delegates to Subcontractor under the Subcontract or impose other sanctions consistent with the State Medicaid Contract if in Payer's reasonable judgment Subcontractor's performance under the Subcontract is inadequate.

5.3 Payer will perform ongoing monitoring of Subcontractor and will subject Subcontractor to formal review at least once a year, consistent with the requirements of State and federal law and the State Medicaid Contract. As a result of such monitoring activities, Payer will identify to Subcontractor any deficiencies or areas for improvement and Subcontractor will take appropriate corrective action.