Medicare Dual Advantage, Family Care, and Family Care Partnership Provider Manual 2026

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Contents

For information on Medicaid BadgerCare+ or Supplemental Security Income (SSI) programs, reference the Molina Healthcare of Wisconsin, Inc. Provider Manual: molinahealthcare.com/providers/wi/medicaid/manual/provman.aspx.

SECTION 1: INTRODUCTION

My Choice Wisconsin by Molina Healthcare (MCW) welcomes you to our provider network! As a contracted provider, please use our provider handbook as your primary resource for policies, procedures, claims processing guidelines, benefits information, service authorizations requirements as well as using our MIDAS Provider Portal and Claims Web Portal, as applicable.

In addition to the provider handbook information, we recommend you and your staff review additional sources for Family Care information including:

- Family Care Guide for Wisconsin Medicaid-Certified Providers
- Wisconsin Medicaid All-Provider Handbook
- Wisconsin Medicaid service-specific handbooks
- Wisconsin Administrative Code, Chapters DHS 101-108

Additional information can also be found by visiting these websites and/or calling Wisconsin's Department of Health Services (DHS) below:

WI Aging and Disability Resource Centers:	www.dhs.wisconsin.gov/adrc/consumer/index.htm
Wisconsin Medicaid website:	www.dhs.wisconsin.gov/medicaid
Long-Term Care website:	www.dhs.wisconsin.gov/LTCare
Wisconsin Medicaid's Provider Services:	Toll Free: (800) 947-9627 or (608) 221-9883

If you have questions or need help with this handbook, please call Customer Service at (800) 963-0035.

About My Choice Wisconsin

My Choice Wisconsin is a Managed Care Organization (MCO) and Health Maintenance Organization (HMO) with a passion for putting our members first. Members receive long-term care and health services to help them live their best lives independently in their own communities through Family Care, Family Care Partnership, and/or Medicare Dual Advantage programs.

My Choice Wisconsin works collaboratively with local agencies and health care providers to ensure our members have ample choice and high-quality support and services from a diverse network. We provide seamless care for each member based on their own needs, goals, and abilities.

Our Mission

We are committed to the improved health of our members and the betterment of our communities. As trusted stewards of public funds, we care for the whole person and well-being of all by offering services that promote independence, value diversity, and inspire self-advocacy.

Our Core Values

Service – We are committed to service excellence through continuous improvement.
Equity – We believe everyone deserves fair and impartial treatment.
Respect – We value the rights, wishes and traditions of others. We are accountable and stand behind our commitments**.**
Vision – We aspire to a sustainable future through innovation and a commitment to quality.
Empowerment – We help our members take ownership of their health and embrace self-advocacy.

Our Programs

Family Care

- The Family Care program helps frail elders and adults with disabilities coordinate their home and community-based long-term care needs.

Family Care Partnership (Partnership)

- The Partnership program helps frail elders and adults with disabilities with higher care needs coordinate their medical, health, and long-term care services.

Medicare Dual Advantage

Medicare Dual Advantage (HMO SNP) is a Medicare Advantage plan for people who qualify for both Medicaid and Medicare. This plan helps coordinate healthcare needs with no monthly premiums or deductibles. This plan includes prescription medications and access to unique program benefits like dental and vision coverage and a monthly allowance to spend on covered items and services such as over-the-counter products, hearing aids, utilities and transportation for qualifying members.

Our Special Needs Plans

Medicare Special Needs Plans (SNPs) are specially designated Medicare Advantage plans with custom designated benefits to meet the needs of a specific population. Enrollment in a SNP is limited to Medicare beneficiaries within the target SNP population. Qualified enrollees for the My Choice Wisconsin Medicare Dual Advantage and Partnership Programs are members of My Choice Wisconsin's Special Needs Plans.

Our SNP goals are to improve and assure the member's receipt of:

- Access to affordable care and medical, mental health, social and preventive health services
- Coordinated care through an identified point of contact
- Transition of care across health care settings and practitioners
- Appropriate utilization of services
- Cost-effective services
- Overall improved member health outcomes

Our Model of Care (MOC)

My Choice Wisconsin is committed to offering a Model of Care (MOC) that meets the unique needs of our SNP members. SNP members face chronic and often co-occurring physical and behavioral health conditions. These members also face complex psychosocial issues (poverty, homelessness, addiction, and lack of resources) that impact their ability to effectively manage their care. Through the integration of physical, behavioral, social, medical, and community resources, the SNP MOC aims to address barriers that impact the members' ability to self-manage their care and coordinate needs.

By developing and implementing a SNP MOC, members can experience improved health outcomes, access to essential services, coordination and seamless transitions of care, appropriate utilization of services, and satisfaction.

The My Choice Wisconsin SNP Model of Care is a service delivery mechanism that contains the following elements:

- Description of the SNP-specific target population
- Measurable goals
- Staff structure and care management roles
- Interdisciplinary care team
- A network having special expertise and use of clinical practice guidelines
- Model of care training for personnel and provider network
- Health risk assessment (HRA)
- Individualized care plan
- Communication network
- Care Management for the most vulnerable subpopulations
- Performance and health outcome measurements

Providers are required to participate in, and comply with, the CMS Model of Care (MOC) training requirements as applicable. This includes completing My Choice's initial and annual MOC training and submitting attestation documentation upon completion. My Choice's MOC Provider training and attestation documents are found on the My Choice Provider website at mychoicewi.org/providers/provider-forums-and-trainings/.

Our Provider Network

Giving our members access to an extensive network of high-quality providers is "mission critical" for My Choice Wisconsin (MCW). MCW is proud to work with the dedicated Primary Care Physicians (PCPs), specialists, behavioral health providers, residential services, nursing home, hospitals, home care and hospice facilities, home health care agencies, durable medical equipment providers and more which comprise our network.

We contract with more than 500 healthcare clinics throughout Wisconsin, covering more than 1,700 primary care providers. In addition, we connect members with a range of services depending on program, including pharmacy, transportation, employment, day care, residential facilities, and more.

Our provider network consists of quality providers who have agreed to:

- MCW rates.
- Follow contractual requirements.
- Maintain ongoing communications with MCW.
- Meet or exceed quality assurance expectations of MCW.

The Health and Community Supports Contract and HFS 10 require MCW to continually monitor the Provider Network to ensure that service capacity and access are managed in accordance with current and anticipated Member service demands. MCW is not required to contract with providers beyond the number necessary to meet the needs of Members. For current Provider Network availability, see website: Become a Healthcare Provider - How to Join our Network | My Choice Wisconsin.

Thank you for being part of our provider network and helping us to improve the health outcomes of our members.

Out of Network Providers

MCW is not required to add providers to our network simply because Members request them. Non-contracted providers must meet a specific need outside the established Provider Network, meet our qualifying standards and accept the service rate(s) set by MCW.

SECTION 2: PROVIDER RESPONSIBILITIES

Introduction

This section of the Provider Manual addresses the responsibilities of providers participating in our provider network. "Providers" are individuals or organizations that are contracted to participate in My Choice Wisconsin's provider network and offer health, medical, and long-term care services to My Choice Wisconsin members.

My Choice Wisconsin ensures members have access to qualified providers who have agreed to a number of member protections and other legal requirements in the provider contract. Therefore, My Choice Wisconsin members are required to obtain services from network providers except in an emergency. Our goal is to offer My Choice Wisconsin members a broad range of providers who can help them achieve their individual outcomes. Whenever possible, My Choice Wisconsin wants to offer members choices among available providers.

My Choice Wisconsin may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his/her patient, including any of the following:

- For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- For any information the member needs in order to decide among all relevant treatment options.
- For the risks, benefits, and consequences of treatment or non-treatment.
- For the member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Becoming a Network Provider

If you are interested in participating in the MCW Provider Network, please visit the following link - Join Our Network, scroll down to "**Step One - Connect**", and click Contract Request on our online provider portal to complete a request for an application.

If you are an existing contracted provider, please log in to access your account to add a service or rendering location to your contract. All links and additional information may be found on our website. As there are requirements and expectations for our network providers, please note that completing a request to Join Our Network does not constitute a contract nor guarantee that a contract will be offered.

Our Contracting team will review your information and reach out with confirmation of acceptance or denial of your request. We perform a rigorous quality review of all organizations to ensure that we not only meet, but exceed, the regulatory requirements of our funding agencies, Medicaid and Medicare. Safety, quality, and member happiness are our priorities.

MCW considers requests for contracting based on the following criteria:

- Proposed services are within our Program benefit package(s)
- Provider meets applicable licensing and credentialing standards

- Provider has been in business for a minimum of one year
- Provider type & services are needed to meet network adequacy
- Medicaid and Medicare certified when applicable
- Is not on the excluded provider lists available at: Exclusions Database

Credentialing of Providers

My Choice Wisconsin (MCW) credentialing standards are established to meet the requirements of MCW's contract with CMS and DHS. Although MCW delegates some credentialing activities to recognized credentialing programs, MCW always retains the right and the obligation to accept or reject the recommendations of our credentialing delegates.

When a provider contracts with MCW, the provider will be advised whether the credentialing application must be completed. Failure to provide credentialing information to MCW will delay the credentialing, or re-credentialing, process and may affect your status as a plan provider.

Information acquired through the credentialing and re-credentialing processes is considered confidential. MCW staff with access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law. The release of any information acquired through these processes is prohibited without a provider's written consent. If a law enforcement agency or other government agency seeks provider information, a legal opinion is sought prior to the release of such information.

MCW may not contract with, or use any providers, including their employees and subcontractors, who are excluded from participation in any federal or state health care programs. Upon obtaining information or receiving information from CMS, DHS or from another verifiable source, MCW is required to exclude from participation all persons or entities that could be included in any of the following categories:

- Entities That Could Be Excluded Under s. 1128(b)(8) of the Social Security Act.
- Entities That Have a Direct or Indirect Substantial Contractual Relationship with an Individual or Entity Listed which could be excluded under s. 1128(b)(8) of the Social Security Act.
- Entities That Employ, Contract With, or Contract Through Any Individual or Entity That is Excluded from Participation in Medicaid under ss. 1128 or 1128A, for the Provision (Directly or Indirectly) of Health Care, Utilization Review, Medical Social Work, or Administrative Services.

Providers will keep provider enrollment documentation, and all personnel files related to persons providing direct care to members for no less than ten (10) years from the final date of the contract period or from the date of completion of any audit.

My Choice Wisconsin monitors Medicare and Medicaid sanctions and grievances against health care professionals. MCW also monitors those who opt out of accepting federal reimbursement from Medicare and resolution of beneficiary grievances. Further, MCW checks the Wisconsin Department of Regulation and Licensing website monthly to determine if any plan providers have had actions taken against their licenses. If MCW becomes aware of conditions at a site that suggest compromised safety or other concerns related to the delivery of care, MCW conducts a site visit to assess the site and identify corrective action.

My Choice Wisconsin will adopt any change in legal, regulatory, or accreditation requirements automatically as of the requirement's effective date and such changes will be effective for all new and existing providers upon that date.

Department of Health Services Provider Enrollment Agreement

My Choice Wisconsin verifies that all potential providers who must be enrolled with the WI Department of Health Services have the appropriate enrollment agreement. Providers will utilize the WI Department of Health Services' Centralized Provider Enrollment System to submit all necessary information to become and maintain Medicaid certification through the ForwardHealth Portal.

Residential providers or providers of services at a fixed-site facility must:

- Be enrolled in Wisconsin Medicaid, and
- Have a unique Medicaid Provider ID for each physical location of the service.

This includes:

- Waiver Residential Services providers:
    - 1-2 bed adult family home (AFH)
    - 3-4 bed adult family home (AFH)
    - Community-based residential facility (CBRF)
    - Residential care apartment complex (RCAC)
- Waiver Aging and Disability Support Agency providing:
    - Adult day care
    - Day habilitation services – facility based
- Waiver Non-residential Day and Vocational Services facility providing:
    - Adult day care
    - Day habilitation services – facility based
    - Prevocational services – facility based.

Exemption: Community Transportation providers that meet the definition of mass transit system under Wis. Stat. § 85.20(1), are exempt from the requirement to enroll in Wisconsin Medicaid through the Department's centralized provider enrollment system. The MCO must verify these providers:

- Meet the provider standards in Wisconsin's approved s. 1915(c) home and community-based waiver.
- Meet all required licensure and/or certification standards applicable to the service provided.

Compliance with the Home and Community-Based Setting Requirements

Providers must maintain compliance with the Home and Community-Based Setting Requirements under 42 C.F.R. § 441.301(c)(4) as outlined in Article VIII.G.1.a. iv. of the DHS-MCO contract.

Insurance Coverage

My Choice Wisconsin verifies that all potential providers have appropriate insurance, depending on provider type. Providers are required to provide MCW with a Certificate of Insurance.

Insurance Coverage Minimums are noted below.

Provider Type	Automobile Liability	General Liability	Umbrella Liability	Professional Liability	Workers Compensation
Adult Day Care- Less than 25 Employees	$500,000	$500,000	Not required	$500,000	Required
Adult Day Care- More than 25 Employees	$1,000,000	$1,000,000	$1,000,000	$1,000,000	Required
AFH- 1-4 Bed- Non-Owner Occupied	$1,000,000	$1,000,000	Not required	$500,000	If workers are contracted WC, may be required
AFH- 1-4 Bed- Owner Occupied	$100,000 (Leased) $300,000 Owned	$500,000	Not required	$500,000	Not required
CBRF- Less than 100 beds	$1,000,000	$1,000,000	$1,000,000	$1,000,000	Required
CBRF- More than 100 beds	$1,000,000	$1,000,000	$2,000,000	$1,000,000	Required
DMS/DME/Pharmacy - Less than 25 employees	$500,000	$500,000	Not required	$500,000	Required
DMS/DME/Pharmacy - More than 25 employees	$1,000,000	$1,000,000	Not required	$1,000,000	Required
Home Health- Less than 25 employees	$500,000	$500,000	Not required	$500,000	Required
Home Health- More than 25 employees	$1,000,000	$1,000,000	$1,000,000	$1,000,000	Required
Lawn and Snow	$1,000,000	$1,000,000	Not required	Not required	If Applicable
Personal care- Less than 25 employees	$500,000	$500,000	Not required	$500,000	Required
Personal care- More than 25 employees	$1,000,000	$1,000,000	$1,000,000	$1,000,000	Required

Prevocational - Less than 25 employees	$500,000	$500,000	Not required	$500,000	If workers are contracted and not full employees, WC may not be required
Prevocational - More than 25 employees	$1,000,000	$1,000,000	$1,000,000	$1,000,000	Required
RCAC- Less than 100 Beds	$1,000,000	$1,000,000	$1,000,000	Not required	Required
RCAC- More than 100 Beds	$1,000,000	$1,000,000	$2,000,000	Not required	Required
Skilled Nursing Facility- Less than 25 employees	$500,000	$500,000	Not required	$500,000	Required
Skilled Nursing Facility- More than 25 employees	$1,000,000	$1,000,000	$1,000,000	$1,000,000	Required
Supportive Home Care- Less than 25 employees	$1,000,000	$1,000,000	Not required	$1,000,000	If workers are contracted and not full employees, WC may not be required

Insurance Coverage Minimums are continued below.

Provider Type	Automobile Liability	General Liability	Umbrella Liability	Professional Liability	Workers Compensation
Supportive Home Care- More than 25 employees	$1,000,000	$1,000,000	Not required	$1,000,000	If workers are contracted and not full employees, WC may not be required
Transportation- Less than 25 employees	$1,000,000	$1,000,000	Not required	Not required	If workers are contracted and not full employees, WC may not be required
Transportation-More than 25 employees	$1,000,000	$1,000,000	Not required	Not required	If workers are contracted and not full employees, WC may not be required
Health Care – Facility Level		$1,000,000 (Occurrence) / $3,000,000 (Aggregate)		$1,000,000 (Occurrence)/ $3,000,000 (Aggregate)	Required
Health Care Practitioner Level				$1,000,000 (Occurrence)/ $3,000,000 (Aggregate)	
Financial Management/ Rep Payee /	$500,000	$500,000	Not required	$500,000	Required
Financial Management/ Rep Payee / Guardianship – More than 25 employees	$1,000,000	$1,000,000	Not required	$1,000,000	Required
Other- Counseling and Therapeutic Resources – Less than 25 employees	$500,000	$500,000	Not required	$500,000	Required
Other- Counseling and Therapeutic Resources – More than 25 employees	$1,000,000	$1,000,000	Not required	$1,000,000	Required

Reporting Changes to My Choice Wisconsin

Providers are required to notify MCW of changes in tax identification numbers, addresses, loss of liability insurance and any other change which would impact their status with My Choice Wisconsin.

Report changes to Provider Services:

- Complete forms available online at: My Choice Wisconsin Resource Library

Change in Ownership

Providers Have 35 Days to Report a Change in Ownership.

Medicaid-enrolled providers are required to notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change, in accordance with the Centers for Medicare & Medicaid Services Final Rule 42 C.F.R. 455.104(c)(1)(iv). In addition, providers are also required to notify My Choice Wisconsin of this change and complete the online LTSS Provider Change of Ownership Notification Form found under Frequently Used Forms, after which they will be advised of next steps, including going through re-credentialing.

Failure to report a change in ownership within 35 calendar days may result in denial of payment, per 42 C.F.R. 455.104(e).

Written Notification and a New Enrollment Application Are Required

Any time a change in ownership occurs, providers are required to do **one** of the following:

- Mail a change in ownership notification to ForwardHealth. After mailing the notification, providers are required to complete a new Medicaid provider enrollment application on the Portal.
- Upload a change in ownership notification as an attachment when completing a new Medicaid provider enrollment application on the Portal.

ForwardHealth must receive the change in ownership notification, which must include the affected provider number (National Provider Identifier [NPI] or provider ID), within 35 calendar days **after** the effective date of the change in ownership.

Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Written Notification and a New Enrollment Application are required any time a change in ownership occurs, providers are required to do **one** of the following:

- Mail a change in ownership notification to ForwardHealth. After mailing the notification, providers are required to complete a new Medicaid provider enrollment application on the Portal.
- Upload a change in ownership notification as an attachment when completing a new Medicaid provider enrollment application on the Portal.

ForwardHealth must receive the change in ownership notification, which must include the affected provider number (National Provider Identifier [NPI] or provider ID), within 35 calendar days **after** the effective date of the change in ownership. Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Special Requirements for Specific Provider Types

The following provider types require Medicare enrollment and/or Wisconsin Division of Quality Assurance certification with current provider information before submitting a Medicaid enrollment change in ownership:

- Ambulatory surgery centers
- Community health centers
- End-stage renal disease services providers
- Home health agencies
- Hospice providers
- Hospitals (inpatient and outpatient)
- Nursing homes
- Outpatient rehabilitation facilities
- Rehabilitation agencies
- Rural health clinics
- Tribal federally qualified health centers

Events That ForwardHealth Considers a Change in Ownership

ForwardHealth defines a change in ownership as an event where a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility.

The following events are considered a change in ownership and require the completion of a new provider enrollment application:

- Change from one type of business structure to another type of business structure. Business structures include the following:
    - Sole proprietorships
    - Corporations
    - Partnerships
    - Limited Liability Companies
- Change of name and tax identification number associated with the provider's submitted enrollment application (for example, Employer Identification Number).
- Change (addition or removal) of names identified as owners of the provider.

Examples of a Change in Ownership

Examples of a change in ownership include the following:

- A sole proprietorship transfers title and property to another party.
- Two or more corporate clinics or centers consolidate, and a new corporate entity is created.
- There is an addition, removal, or substitution of a partner in a partnership.
- An incorporated entity merges with another incorporated entity.
- An unincorporated entity (sole proprietorship or partnership) becomes incorporated.

Repayment Following a Change in Ownership
Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them. If necessary, ForwardHealth will hold responsible for repayment to the provider to whom a transfer of ownership is made prior to the final transfer of ownership. The provider acquiring the business is responsible for contacting ForwardHealth to ascertain if they are liable under this provision. The provider acquiring the business is responsible for full repayment within 30 days after receiving such a notice from ForwardHealth.

Providers may send inquiries about the determination of any pending liability to the following address:

Office of the Inspector General
PO Box 309
Madison WI 53701-0309

ForwardHealth has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to Wis. Stat. § 49.45(21) for complete information.

New Prior Authorization Requests Must Be Submitted After a Change in Ownership. Medicaid-enrolled providers are required to submit new prior authorization (PA) requests when there is a change in billing providers. New PA requests must be submitted with the new billing provider's name and billing provider number. The expiration date of the new PA request will remain the same as the original PA request. The provider is required to send the following to ForwardHealth with the new PA request:

- A copy of the original PA request, if possible
- The new PA request, including the required attachments and supporting documentation indicating the new billing provider's name, address, and billing provider number
- A letter requesting to end date the original PA request (may be a photocopy), which should include the following information:
    - The previous billing provider's name and billing provider number, if known
    - The reason for the change of billing provider (The new billing provider may want to verify with the member that the services from the previous billing provider have ended. The new billing provider may include this verification in the letter.) new billing provider's name and billing provider number

      The requested effective date of the change

Billing for a Hospital Stay That Spans a Change in Ownership
When a change in hospital ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A patient stay has dates of service from June 26 to July 2. The hospital submits the claim using the NPI effective July 1.

Providers with further questions about changes in ownership may call ForwardHealth Provider Services.

Reporting of Primary Care Provider Status Change

Primary Care Providers must notify My Choice Wisconsin of status changes by calling the My Choice Wisconsin Customer Service Department at 1-800-963-0035, so that My Choice Wisconsin can fulfill its obligations under its contract with CMS. Status changes include changing from an open to closed practice, retirement, transfer, resignation, termination, or leave of absence, relocation, and the like.

A status change may require a Primary Care Provider to assist My Choice Wisconsin in transitioning member care. The provider (or practice) is responsible for informing members that care will be transferred to another Primary Care Provider, and for transferring records and treatment plans to the new Primary Care Provider.

My Choice Wisconsin will assist members in transferring care and will notify members of material provider status changes.

Provider Directory

The My Choice Wisconsin Provider Directory contains a listing of our network providers for all Programs. You may use the searchable online Provider Directory on our website.

Please note that a listing in the Provider Directory does not necessarily mean that all of a provider's services are covered under a member's benefit plan. My Choice Wisconsin cannot guarantee continued affiliation with any provider. If a member requires services that a provider is unable to render, the member should be referred only to another My Choice Wisconsin network provider. It is important to always contact My Choice Wisconsin before coordinating services for a member with another provider in order to assure the services are a covered benefit.

Cultural Competency

The U.S. Department of Health and Human Services defines cultural and linguistic competence as a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals and enable effective work in cross-cultural situations. Delivering quality and sensitive care to a diverse cross-cultural population promotes respectful and responsive healthcare without cultural communication differences hindering the relationship. Cultural competency occurs in both clinical and non-clinical areas of My Choice Wisconsin. In the clinical area, it is based on the patient-provider relationship. In the non-clinical arena, it involves organizational policies and interactions that impact healthcare services.

My Choice Wisconsin has a strong commitment to diversity in its members, providers, employees and the communities it serves. My Choice Wisconsin and participating network providers shall honor and support member beliefs and be sensitive to cultural diversity. This includes members with limited English proficiency and diverse cultural and ethnic backgrounds. Contracted providers shall collaborate with My Choice Wisconsin in fostering staff/provider attitudes, equity and inclusion and interpersonal communication styles to respect member cultural backgrounds.

To further support providers in delivering culturally and linguistically appropriate care, My Choice Wisconsin offers access to a comprehensive list of trainings and resources on our website. Providers can find information on Culturally and Linguistically Appropriate Services (CLAS) as well as other relevant training opportunities by visiting the following link: Provider Forums & Trainings - My Choice Wisconsin. These resources are designed to help providers enhance their skills and ensure respectful, quality care for all members.

Contact Info for the Contracting Department

Should you have any questions and/or concerns relating to provider service need, your application, and/or contract, please contact My Choice Wisconsin at:

Phone: (414) 287-7640
Toll-free: (877) 489-3814
Email: MHWIProviderNetworkManagement@MolinaHealthcare.com.

You will be directed to your respective Contracting Representative.

Contact Info for Providers in the My Choice Wisconsin Network

My Choice Wisconsin's Provider Relations team develops and maintains relationships with thousands of Wisconsin providers; from acute and primary care providers at major health systems to small, community-based organizations.

If you're a contracted provider and have general questions or are requesting authorizations, please reach out to our Customer Service team at (800) 963-0035, Monday - Friday, 8:00 a.m. to 4:30 p.m.

If you have a specific billing and/claims inquiry, please reach out directly to the claims center. A dedicated claims representative will assist you.

For Medicare Dual Advantage & Family Care Partnership Claims, please contact: My Choice Wisconsin Dual Advantage & Partnership Provider Help Desk:
Toll-Free at (855) 878-6699

- For Family Care Claims, please contact:

  My Choice Wisconsin WPS Family Care Customer Service
  Toll – Free at (800) 223-6016

For additional contact information, such as email addresses or program locations, please check out the contact information on the My Choice Wisconsin website. Go to MCW Contact Us Page for a complete list of contact information as well as access to our quick reference guide.

Other Important Contacts

ForwardHealth Portal: www.forwardhealth.wi.gov/WIPortal/

- Providers should use the ForwardHealth Portal for any eligibility or enrollment questions.

ForwardHealth Portal Help Desk: (866) 908-1363

- Providers and trading partners may call the ForwardHealth Portal Help Desk with technical questions on Portal functions.

WiCall Automated Voice Response (AVR) System: (800) 947-3544

- Available 24 hours a day, seven days a week. WiCall is an AVR system that allows providers direct access to enrollment verification.

Member Incidents

My Choice Wisconsin encourages open communication. If you have a member-related concern or incident, including Member Incidents, call My Choice Wisconsin's Customer Service team at (800) 963-0035 to be directed to the member's Interdisciplinary Care Team or other designated Care Management Staff. For after-hours inquiries, please call the toll-free number above. Our on-call staff will be glad to assist you.

Providers receive training on their contractual obligations related to member incidents and incident reporting during provider onboarding.

Providers are required to report a member incident within one (1) business day after the incident is discovered and to provide all information related to the incident to the care team, so that a thorough investigation can be completed. The priority is always to assure the safety of the members. The provider must identify, respond to, document, and report member incidents to MCO as outlined in Article V.J.5 of the DHS-MCO contract.

Provider Advisory Committee

My Choice Wisconsin organizes and hosts a Provider Advisory Committee (PAC) for and made up of providers to discuss topics of mutual importance with the goal of strengthening the partnership between MCW and our providers. This collaborative, strategic, and solutions focused group works together to improve services to our members and the provider network.

Authorizations

Our programs require prior authorization for certain services and claims for some services will not be paid in the absence of correct prior authorization. Providers must verify member eligibility and benefits prior to rendering non-emergency services. For the full list of prior authorization requirements, forms, and instructions for submission, see our Claims & Authorizations information on our website.
Go to www.mychoicewi.org/providers/authorizations/ for a complete list of prior authorization requirements, as well as forms and instructions for submission.

Partnership and Medicare Dual Advantage Authorizations

To submit a request for prior authorization for Partnership or Medicare Dual Advantage, use the My Choice Wisconsin form appropriate to the service and fax it to (608) 210-4050. Go to www.mychoicewi.org/providers/authorizations/ and search the document library.

Family Care Authorizations

All Family Care Benefit services must be provided by a contracted provider and be pre-authorized by the Member's Interdisciplinary Team (IDT). Contact (800) 963-0035 to obtain the IDT's contact information. My Choice Wisconsin IDTs make the final decision on Member eligibility for services and number of services to be provided.

Care teams will enter all authorizations and providers will be able to see and/or print the authorization from the MIDAS portal for these members. Go to www.mcfc-midas.com for the MIDAS portal. This excludes Partnership and Medicare Dual Advantage.

Providers will not be reimbursed for unauthorized services provided to Members or provided in amounts that exceed those authorized.

Providers should review that all information within the authorization is correct prior to rendering service. Verification can be completed via MIDAS.

Examples of areas/data to verify:

Date of Service Span:	Does the authorized service date span match or cover the expected service period?
Place of Service	Does the authorized place of service match the service location?
Units of Service:	Is the total number of authorized units equal to the number of units needed for the current service period?
Service Codes:	Are all the applicable service codes, HCPCS and/or revenue codes authorized?

If a discrepancy is identified, immediately request a correction to the service authorization from the My Choice Wisconsin IDT. Untimely requests will result in claim denial and no reimbursement.

Drug Coverage Requests or Authorizations

For drug coverage requests or authorizations, you may request a Coverage Determination by phone, fax, or mail.

Phone: 800-963-0035
Fax: 866-290-1309

My Choice Wisconsin by Molina Healthcare
Pharmacy Services Department
7050 Union Park Center Drive Suite 600
Midvale, Utah 84047

Inpatient Admissions Notification

My Choice Wisconsin requires notification of all inpatient admissions. Providers should fax My-Choice-Wisconsin-Pre-Service-Request-Form.pdf to 608-210-4050.

Medical Record Standards

My Choice Wisconsin providers shall ensure medical records are accurately maintained for each member. It shall include the quality, quantity, appropriateness, and timeliness of services performed under the provider's Agreement for Services.

Medical records shall be maintained for a period of no less than ten (10) years, including after termination of the Agreement and retained further if records are under inspection, evaluation, or audit, until such is completed.

Upon request, My Choice Wisconsin, or any federal or state regulatory agency, as permitted by law, may obtain copies and have access to any medical, administrative, or financial record of physician related and medically necessary covered services to any member. The provider further agrees to release copies of medical records of members discharged from the provider to My Choice Wisconsin for retrospective review.

A medical record documents a member's medical treatment, current and past health status, and current treatment plans. A member's medical record is an essential component in the delivery of quality health care.

Primary Care Provider Responsibilities

The following are some of the responsibilities of participating Primary Care Providers of My Choice Wisconsin's provider networks:

- Establish and maintain a strong provider/patient relationship; assume responsibility for the healthcare of members who select you as their primary care provider.
- Review and monitor member's compliance with medication and prescribed treatments.

- Assist members with Advance Directives, if necessary.
- Avoid duplication of services.
- Evaluate and treat acute and chronic illness.
- Provide preventive care, screening services and routine maintenance checks as appropriate and indicated.
- Communicate with specialists involved in a members' care.
- Ensure that the exchange of member healthcare information among treating providers is handled in a confidential manner.
- Use respectful communication in all interactions with My Choice Wisconsin members and Care Management staff.
- Recognize that conflict may occasionally arise between My Choice Wisconsin and providers, or My Choice Wisconsin and members, and that conflict should be resolved within the parameters of the grievance or appeals processes outlined in the applicable My Choice Wisconsin document.
- Ensure that My Choice Wisconsin members with limited English proficiency or reading skills, diverse cultural or ethnic backgrounds, or physical or mental disabilities understand any treatment plans.
- Refrain from comments or advice on payment or insurance coverage issues. Refer members with coverage questions or concerns to the My Choice Wisconsin Customer Service Department.
- Ensure that My Choice Wisconsin members receive information needed to participate fully in their own care (e.g., medication management, use of medical equipment, potential complications, and symptoms that should be communicated to provider, patient education, etc.).

Specialist Provider Responsibilities

The following describes some of the responsibilities of participating specialty providers of My Choice Wisconsin's provider networks:

- Coordinate all member care through the Primary Care Provider.
- Provide advice and recommendations to member, member's family, and Primary Care Provider.
- Work with My Choice Wisconsin Care Management staff to ensure appropriate utilization of healthcare services and improve quality of care.
- Actively facilitate care coordination by communicating openly and directly with the member's Primary Care Provider and the My Choice Wisconsin Care Management Staff, as appropriate.
- Avoid duplication of services, including diagnostic and laboratory testing.
- If the need arises for consultation with another network provider, coordinate through the Primary Care Provider.

Hospital Responsibilities - Medicare Outpatient Observation Notice (MOON)

All My Choice Wisconsin participating hospitals and critical care hospitals (CAH) must comply with the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) 42 U.S.C. §1395cc(a)(1)(Y), which requires hospitals to provide written and oral notice, within 36 hours, to patients who are in observation or other outpatient status for more than 24 hours. The notice must explain the reason that the patient/member is an outpatient (and not an admitted inpatient) and describe the implications of that status both for cost-sharing in the hospital and for subsequent "eligibility for coverage" in a skilled nursing facility (SNF). For a copy of the final rule and guidance for implementation, visit: Federal Register-IPPS-NOTICE Act Final Rule federalregister.gov/articles/2016/08/22/2016-18476/medicare-programs-hospital-inpatientprospective-payment-systems-for-acute-care-hospitals-etc.

Requests for Testimonials and Letters of Support

It is My Choice Wisconsin's policy to refrain from providing testimonials and other kinds of letters of support requested by contracted and non-contracted providers. MCW values the providers in its provider networks, in addition to any out of network providers that may provide services to its members.

Some exclusions may apply as there may be times when MCW is interested in promoting the efforts of a group of provider types because those efforts may lead to improved outcomes for members. For example, My Choice Wisconsin might choose to support employment providers' grant applications for expanded services to the target group served. In these cases, MCW may choose to respond to a provider's request for a testimonial or letter of support so long as it supports MCW's mission and is in compliance with all regulatory and contractual requirements.

SECTION 3: MEMBER ELIGIBILITY & BENEFITS

Member Eligibility

The following table illustrates the eligibility requirements for each My Choice Wisconsin program. Eligibility commonalities and differences are noted below.

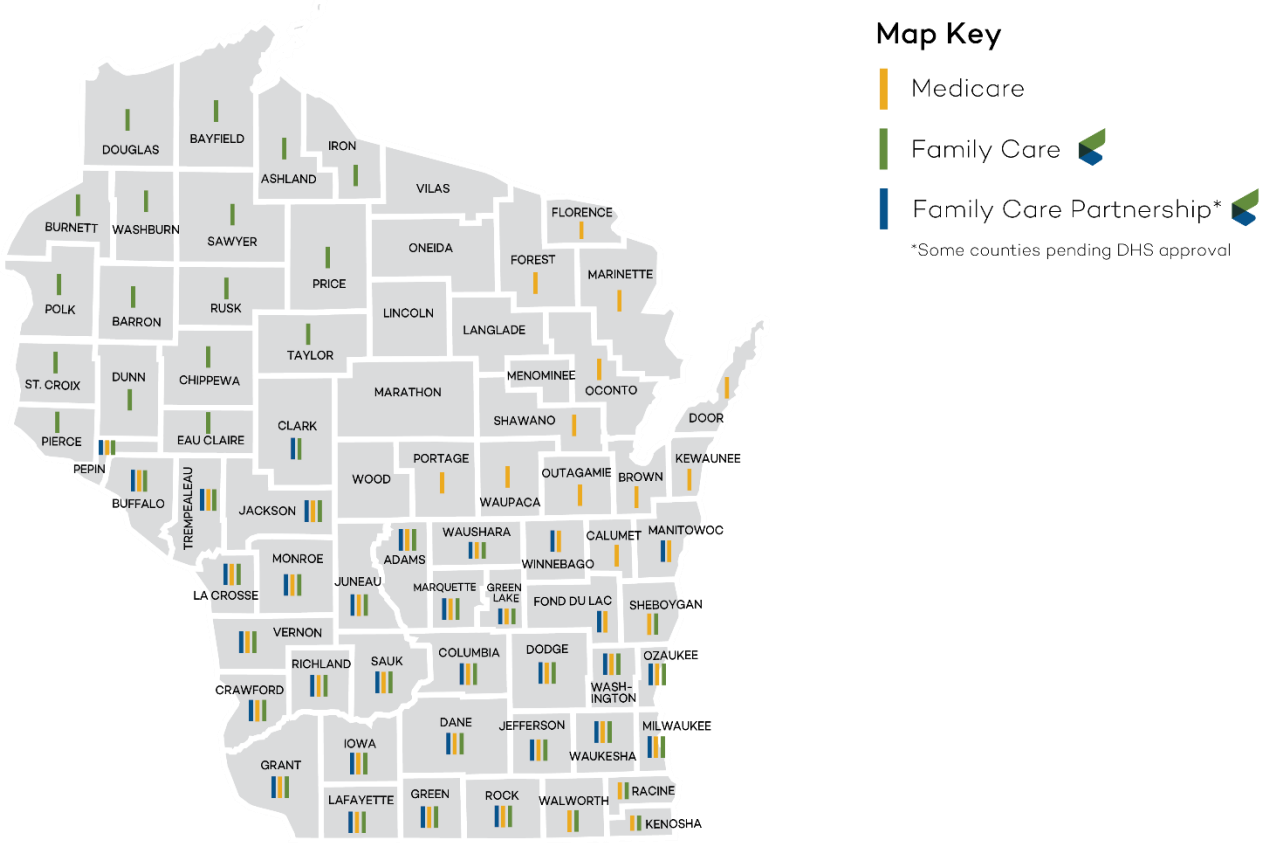
<table>
<tr><th>Family Care</th><th>Partnership</th><th>Medicare Dual Advantage</th></tr>
<tr><td>Must be eligible for Medicaid</td><td>Must be eligible for Medicaid and may also be eligible for Medicare

If eligible for Medicare, must be enrolled in MCW's Medicare plan when choosing Partnership.</td><td>Must be eligible for both Medicaid and Medicare</td></tr>
<tr><td colspan="2">Must be a frail adult, age 65 or older, or 18 or older with physical, intellectual or developmental disabilities*</td><td>Family Care Members Eligible for Medicare Can Also Join Medicare Dual Advantage</td></tr>
<tr><td colspan="2">Meet functional requirements which mean that a person needs help performing other activities such as bathing, dressing, or eating.</td><td></td></tr>
</table>

Our Service Area*

**As of March 1, 2026. Pending DHS regulatory approval.*

Medicare, Family Care & Family Care Partnership



Map Key

- Medicare
- Family Care
- Family Care Partnership*

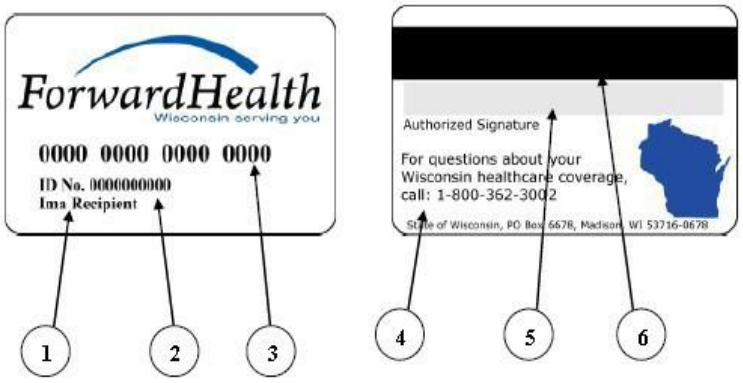
*Some counties pending DHS approval

Member Identification

Family Care

My Choice Wisconsin issues an identification card for our Family Care members. The Family Care ID Cards are sent to each member in their New Member Welcome Kit. The Welcome Kits are sent within three days of enrollment. Members are encouraged to keep their My Choice Wisconsin Family Care ID Card with their ForwardHealth ID Card. Members are issued a ForwardHealth ID card by the Wisconsin Medical Assistance Program, which is used for non-Family Care items and services, specifically acute and primary services such as medical appointments, hospitalizations, eyeglasses, podiatry, and dentistry. See example of Forward ID card below. Verify member eligibility at each member encounter via the ForwardHealth Portal and Medicare's MARx User Interface for members eligible for Medicare. Please note, members of the My Choice Wisconsin Family Care program that are Medicare eligible may enroll in the My Choice Wisconsin Medicare Dual Advantage program. Please see Medicare Dual Advantage for eligibility and member identification information.

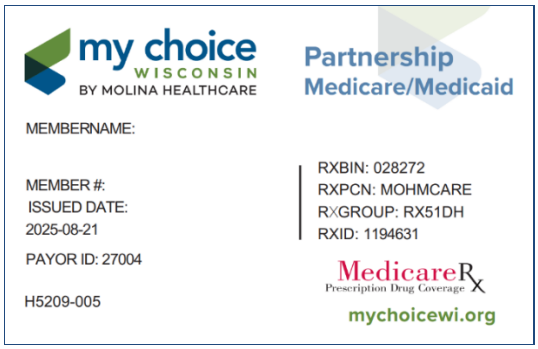
DHS ForwardHealth ID Card Example

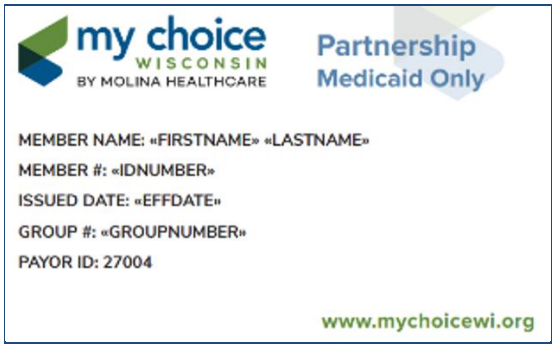


1. Recipient Name
2. Medicaid Identification Number
3. Unique Card Number (for internal use only)
4. Medicaid Recipient Services Telephone Number
5. Signature Space
6. Magnetic Strip

Family Care Partnership "Partnership"

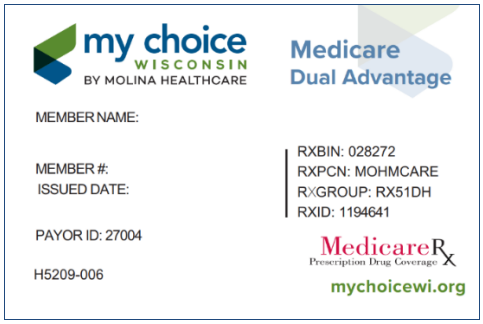
Verify member eligibility at every member encounter via the ForwardHealth Portal. My Choice Wisconsin issues members of the Partnership program a My Choice Wisconsin identification card, see below. Partnership members are not issued a ForwardHealth ID Card by the Wisconsin Medical Assistance Program, as the My Choice Wisconsin identification card replaces that.





Medicare Dual Advantage

Members are issued a My Choice Wisconsin identification card, see below. Verify member eligibility via Medicare's MARx User Interface. Members of Medicare Dual Advantage may receive Medicaid benefits with other insurers. Verify member eligibility in ForwardHealth at each encounter.



Member Benefits

Family Care Benefits

My Choice Wisconsin's Family Care Program provides long-term care services covered by Wisconsin Medicaid, as well as services covered by Wisconsin's Home and Community-Based Waiver (HBCW) and other waiver services. Family Care is a comprehensive and flexible long-term care program for seniors and adults with physical, intellectual, and developmental disabilities.

By combining services otherwise covered separately through Medicaid and long-term care, Family Care improves the coordination of the services, is cost–effective, and most importantly, assists individuals in living more active and independent lives.

Family Care Partnership Benefits

My Choice Wisconsin's Family Care Partnership Program provides all the benefits covered in Family Care, plus Wisconsin Medicaid-covered services, including primary and acute care. For Family Care Partnership members who are dually eligible for Medicare (Part A and Part B) and Medicaid, My Choice Wisconsin also covers all Medicare Part A, B and D services through its fully integrated Medicare Advantage Special Needs Plans (SNPs). Family Care Partnership Medicare-covered services include CMS's national coverage decisions and published coverage decisions of local carriers and intermediaries. My Choice Wisconsin informs health care providers, in writing, of new coverage decisions.

Family Care and Family Care Partnership Member Benefits Chart

The Family Care and Family Care Partnership member benefit chart can be found at: Comparison of services in IRIS, Family Care, Partnership, and PACE, P-00570. For complete definitions of the services listed in the member benefit chart, see the Benefit Package Service Definitions addendum of the MCO Contract at: https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm.

Home & Community Based Waiver Covered Services under the Partnership and Family Care program are subject to prior authorization through the Member's Care Team. Contact the Member's Care Team for prior authorization. If you require assistance in connecting with the Member's Care Team, contact the My Choice Wisconsin Customer Service Center at (800) 963-0035.

All health care services must be medically necessary and provided in accordance with professionally recognized standards of care.

Contact Customer Service to verify member-specific benefits.

For information on Medicaid BadgerCare+ or Supplemental Security Income (SSI) programs, reference the Molina Healthcare of Wisconsin, Inc. Provider Manual: molinahealthcare.com/providers/wi/medicaid/manual/provman.aspx.

Medicare Dual Advantage Benefits

The My Choice Wisconsin Medicare Dual Advantage Program member is eligible for all Medicare covered services under Medicare Parts A, B, and D, as appropriate. To learn more about an individual member's covered benefits, please use one of these three (3) resources:

1. Reference the members' Summary of Benefits and Evidence of Coverage at https://mychoicewi.org/medicare-dual-advantage/member-resources/
2. Contact Customer Service to verify member-specific benefits.
3. Medicare: Search the CMS Medicare Coverage Database available online at: MCD Search. Below is a summary of covered services by Medicare.

Summary of Medicare Part A Covered Services

Inpatient Care (see restrictions in Medicare coverage database)

- Anesthesia
- Chemotherapy
- Room and board
- All meals and special diets
- General nursing
- Medical social services
- Physical, occupational, and speech-language therapy
- Drugs except for some self-administered drugs
- Blood transfusions
- Other diagnostic and therapeutic items and services
- Medical supplies and use of equipment
- Inpatient alcohol or substance abuse treatment
- Part A blood (see the restrictions under non-covered services)
- Clinical trials (Inpatient)
- Kidney Dialysis (Inpatient)

Summary of Medicare Part B Covered Services

Medically Necessary Outpatient Services (see restrictions in Medicare coverage database)

- Durable Medical Equipment (DME)
- Home health services
- Outpatient physical, speech, and occupational therapy services
- Chiropractic care
- Outpatient mental health services
- Part B blood
- Physician services
- Prescription drugs
- Preventive care services
- Radiology and laboratory services

Summary of Medicare Part D Covered Services

For a complete plan formulary (list of Part D prescription drugs) and any restrictions, go to our website at Formulary Search.

Benefit Exclusions

Some services are excluded from coverage under My Choice Wisconsin's programs. For information and questions on service exclusions, please contact the members of My Choice Wisconsin care team or Customer Service. In addition to specific excluded services, My Choice Wisconsin may deny coverage if:

- The service is not medically necessary;
- The service is not a covered benefit; or
- The member is not enrolled in a My Choice Wisconsin program at the time the services are provided.

Family Care Benefit Package Exclusions

Medical Services, including acute and primary care services, physician visits, hospital stays, and medications are not included in the Family Care Benefit Package. For those members who are Medicaid eligible, these services can be accessed with their Forward Card.

Emergency Services

When included as a benefit under a member's program, medically necessary emergency services are covered within and outside of My Choice Wisconsin's service area. In the event of an emergency, the member should seek immediate care or call 911. Prior authorization is not required.

Emergency Services are defined as covered inpatient and outpatient services that are: (a) furnished by a provider who 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. An emergency medical condition is 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:

- 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.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Post-Stabilization Care Services

When included as a benefit under the member's program, My Choice Wisconsin covers post-stabilization care services. Post-stabilization care services are services related to an emergency medical condition that are either provided after a member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the member's condition. All health care services must be medically necessary and provided in accordance with professionally recognized standards of care.

Urgently Needed Care

When included as a benefit under the member's program, My Choice Wisconsin covers urgent care services. Urgent care is medically necessary care that is required by an illness or accidental injury that is not life-threatening and will not result in further disability but has the potential to develop such a threat if treatment is delayed longer than twenty-four (24) hours. Urgent care services are typically provided when a member is temporarily absent from My Choice Wisconsin's service area or, under unusual and extraordinary circumstances, provided when the member is in the service area but My

Choice Wisconsin's provider network is temporarily unavailable or inaccessible and when the services are medically necessary and immediately required a) as a result of an unforeseen illness, injury, or condition; and b) it was not reasonable, given the circumstances, to obtain the services through My Choice Wisconsin's contracted provider network.

Notification of Emergency Services and Urgently Needed Care

Members are encouraged to notify My Choice Wisconsin as soon as possible after receiving urgently needed, emergency, or post-stabilization health services. Hospitals that contract with My Choice Wisconsin are required to notify My Choice Wisconsin when a member is admitted to the hospital.

Renal Dialysis Services

For Family Care Partnership and Medicare Dual Advantage members who are within the service area, My Choice Wisconsin covers renal dialysis services provided by a network provider. Out-of-area renal dialysis services are also covered within the United States if furnished by a Medicare-certified renal dialysis facility while a member is temporarily outside of the service area.

Use of Network Providers

Members must use My Choice Wisconsin network providers to get covered services, except in limited cases. Examples of when it is permissible to use out-of-network provider include:

- Emergency care,
- Urgently needed care when our network is not available,
- Out of service area dialysis, or
- American Indian or Alaskan Native members in the Partnership program obtaining primary care services from an out-of-network Indian Health Service, Tribal, or Urban Indian (I/T/U) health care provider, or
- American Indian or Alaskan Native members who obtain covered services in the benefit package from an out-of-network Indian Health Service, Tribal, or Urban Indian (I/T/U) health care provider that meets the state's provider certification and standards.

Tribal Liaison

My Choice Wisconsin maintains a designated Tribal Liaison who serves as the primary point of contact regarding all tribal matters. The Tribal Liaison acts as the main conduit between the Managed Care Organization (MCO), the Department of Health Services (DHS), and each individual tribe. This role is established to ensure effective communication, collaboration, and resolution of tribal issues in a timely and culturally respectful manner.

For any questions or concerns related to tribal issues, the Tribal Liaison can be reached at infowi@molinahealthcare.com

Member Rights and Responsibilities

My Choice Wisconsin must honor Member Rights and must ensure those rights when furnishing services. My Choice Wisconsin members receive a list of their rights and responsibilities upon enrollment and in the Member's program Member Handbook.

Family Care Member Rights

Go to the MIDAS Provider Portal's User Documents. There you will find Member Handbooks in a variety of languages that describe Member Rights under the Family Care program.

Direct Access to Preventive Care

My Choice Wisconsin members have direct access to preventive health care services when coverage is provided by My Choice Wisconsin. Members have access to the following services from a Network Provider without the need for a referral:

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests and pelvic exams as long as the member gets them from a network provider.
- Flu shots **and** pneumonia vaccines, as long as the member gets them from a network provider.
- Urgently needed care from in-network providers, or from out-of-network providers when network providers are temporarily unavailable or inaccessible, (e.g., when a member is temporarily out of the plan's service area.)
- Family planning services.

Member Rights

We must provide information in a way that works for the member, including information provided in the member handbook or any provider handouts or documentation (in languages other than English, in Braille, in large print, or other alternate formats, etc.). A member can call My Choice Wisconsin Customer Service to get information on what works for them at (800) 963-0035 (TTY users should call Wisconsin Relay System 711).

Members also have the right to ask for an interpreter and have one provided to them during any covered service. Our plan has free interpreter services available to answer questions from non- English-speaking members. We can also give members information in Braille, in large print, or other alternative formats if needed.

If a member is eligible for Medicare because of a disability, My Choice Wisconsin is required to give the member information about the plan's benefits that is accessible and appropriate for the member. To get appropriate information about what works for the members, please contact Customer Service at (800) 963-0035.

If a member has any trouble getting information from our plan because of problems related to language or a disability, and the member has Medicare, the member can call Medicare and ask to file a complaint at 800-MEDICARE ((800) 633-4227), 24 hours a day, 7 days a week. TTY users can call (877) 486-2048.

1.) **We must treat a My Choice Wisconsin member with fairness, dignity, and respect with the need for privacy always**. Members have the right:

- To get compassionate, considerate care from My Choice Wisconsin staff and providers.
- To get care in a safe, clean environment.
- To not have to do work or perform services for My Choice Wisconsin.
- To be encouraged and helped in talking to My Choice Wisconsin staff about changes in policy that the member thinks should be made or services that the member thinks should be provided.
- To be encouraged to exercise rights as a member of My Choice Wisconsin.
- To be free from discrimination. My Choice Wisconsin and providers must obey laws to protect members from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, sexual orientation, health, ethnicity, creed (beliefs), age, national origin, or source of payment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. This means a member has the right to be free from being restrained or forced to be alone in order to make the member behave in a certain way or to punish because someone finds it useful.
- To be free from abuse, neglect, and financial exploitation.
    - **Abuse** can be physical, emotional, financial, or sexual. Abuse can also be if someone gives the member a treatment such as medication, or experimental research without their informed consent.
    - **Neglect** is when a caregiver fails to provide care, services, or supervision which creates significant risk of danger to the individual. Self-neglect is when an individual who is responsible for his or her own care fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.
    - Providers and MCW employees will adhere to all MCO policies which prohibit any form of abuse, neglect, exploitation, or mistreatment of members.
    - **Financial exploitation** can be fraud, enticement or coercion, theft, misconduct by a fiscal agent, identity theft, forgery, or unauthorized use of financial transaction cards including credit, debit, ATM, and similar cards.

What can a member do if they are experiencing abuse, neglect, or financial exploitation? The member's care team, or other care management staff, is available to talk with a member about issues that members may feel may constitute abuse, neglect, or financial exploitation. They can help members with reporting or securing services for safety. Members should always call 911 in an emergency.

If anyone feels that they, or someone they know, is a victim of abuse, neglect, or financial exploitation, they can contact Adult Protective Services. Adult Protective Services help protect the safety of seniors and adults-at-risk who have experienced abuse, neglect, or exploitation. They also help when a person is unable to look after their own safety due to a health condition or disability.

You may call the following numbers to report incidents of witnessed or suspected abuse:

- If there is a life-threatening emergency, call 911.
- Call the Care Team at (800) 963-0035, 8:00 a.m. to 4:30 p.m., Monday-Friday.
    - For assistance after-hours, on weekends and holidays, call the same number.

2.) **We must ensure members receive assistance in a prompt, courteous, appropriate, and culturally competent manner.**

3.) **We must ensure that My Choice Wisconsin members get timely access to covered services and drugs as provided for in Federal and State law. When medically appropriate, services must be available 24 hours a day, 7 days a week**. As a member of our plan, a member has the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for covered services. Members can call Customer Service to learn which doctors are accepting new patients. Members also have the right to go to a women's health specialist, such as an Obstetrician and Gynecologist (OB/GYN), nurse midwife, or licensed midwife, without a referral in addition to choosing from their primary care physician.

My Choice Wisconsin members have the right to get appointments and covered services from the plan's network providers *within a reasonable amount of time*. This includes the right for members with prescription benefits to get prescriptions filled or refilled at any of our network pharmacies without long delays.

If a member thinks they are not getting medical care or prescription drugs within a reasonable amount of time, they can refer to their Evidence of Coverage to learn what to do or contact Customer Service. (If My Choice Wisconsin has denied coverage for a member's medical care or drugs, and a member does not agree with our decision, a member can refer to their Evidence of Coverage, or contact Customer Service to learn what to do.)

4.) **We must protect the privacy of a member's personal health information**. Federal and state laws protect the privacy of our members' medical records and personal health information. We protect members' personal health information as required by these laws.

- A member's "personal health information" includes the personal information they gave the health plan upon enrollment, as well as their medical records and other medical and health information.
- The laws that protect a member's privacy give the member rights related to getting information and controlling how the information is used. My Choice Wisconsin gives members a written notice, called a "Notice of Privacy Practice," that tells the member these rights and explains how we protect the privacy of the member's health information.

A member can contact My Choice Wisconsin Customer Service at (800) 963-0035 (TTY users should call Wisconsin Relay System 711) for questions or concerns about the privacy of their personal health information.

Rights included in the My Choice Wisconsin "Notice of Privacy Practice" include the right for a member to:

- Get a copy of their health and claims records
- Correct their health and claims records
- Request confidential communication

- Ask us to limit the information we share
- Get a list of those with whom we've shared their information
- Get a copy of our privacy notice
- Choose someone to act for them
- File a complaint if they believe their privacy rights have been violated

The above is not a complete description of My Choice Wisconsin's Privacy Practices. Contact the Privacy Officer at (608) 245-3073 or dlfamcprivacyofficer@mychoicefamilycare.org, or send USPS mail Attn: Privacy Officer to 10201 W Innovation Drive Ste 100 Wauwatosa, WI 53226.

5.) **A member has the right to receive their records and information that pertains to them within a timely manner**.

6.) **We must give members information about the plan, its network of providers, and their covered services**. A member of My Choice Wisconsin has the right to get several kinds of information from us such as:

- Information about our plan
- Information about our network providers, including our network pharmacies
- Information about their coverage and the rules members must follow when using their coverage
- Information about why something is not covered and what they can do about it

7.) **We must support a member's right to make decisions about their care**. A member has the right to know their treatment options and participate in decisions about their health care.

A member has the right to get full information from their doctors and other health care providers when they go for medical care. Providers must explain a member's medical condition and their treatment choices in a way that they can understand.

Members also have the right to participate fully in decisions about their health care. To help them make decisions with their doctors about what treatment is best for them; their rights include the following:

- **To know all about all their choices.** This means that members have the right to be told about all the treatment options that are recommended for their condition, no matter what they cost or whether they are covered by our plan, including the right to request a second opinion. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **Consent to treatment.** A member has the right to have their medical provider request their consent for all treatment, except in the case of an emergency where the member's life is in serious danger and the member is unable to sign a consent form.
- **To know about the risks.** Members have the right to be told about any risks involved in their care. Members must be told in advance if any proposed medical care or treatment is part of a research experiment. Members always have the choice to refuse any experimental

treatments.

- **The right to say "no."** Member has the right to refuse any recommended treatment and to be advised of the probable consequences of the refusal. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. Member also has the right to stop taking their medication. Of course, if they refuse treatment, or stop taking medication, members accept full responsibility for what happens to their body as a result.
- **Advance Directive**. A member has the right to choose an Advance Directive to designate the kind of care the member prefers to receive if the member becomes unable to express their wishes.
- **To receive an explanation if a member is denied coverage for care.** Members have the right to receive an explanation from us if a provider has denied care that they believe they should receive. To receive this explanation, members will need to ask My Choice Wisconsin for a coverage decision. The member's Evidence of Coverage provides an explanation of how to do this, or member can contact Customer Service for assistance.

A member has the right to give instructions about what is to be done if they are not able to make decisions for themselves. A member can refer to the Evidence of Coverage for additional help or contact Customer Service on how to do this.

8.) **A member has the right to make complaints, file a grievance or appeal and to ask us to reconsider decisions we have made without fear of retaliation, and to receive a response in a timely manner**. A member can refer to the Evidence of Coverage for information about what to do if they have any problems or concerns about their covered services or care. It gives the details about how to deal with all types of problems and complaints. Members may also contact Customer Services for assistance.

9.) **What can a member do if they believe they are being treated unfairly, or their rights are not being respected?**

If it is about discrimination, call the Office for Civil Rights.
If the member believes they have been treated unfairly, or their rights have not been respected due to their race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, they should call the Department of Health and Human Services' Office for Civil Rights at 800368-1019 or TTY (800) 537-7697 or call their local Office for Civil Rights.

Is it about something else?
If member believes they have been treated unfairly, or their rights have not been respected, *and* it's *not* about discrimination, they can get help dealing with the problem they are having:

- Members can **call My Choice Wisconsin Customer Service** at (800) 963-0035 (TTY users should call Wisconsin Relay System 711).
- Members can **call the State Health Insurance Assistance Program.** Members can find details about this organization and how to contact it in their Evidence of Coverage.
- Or, members **can call Medicare** at 1-800-MEDICARE ((800) 633-4227), 24 hours a day, 7

days a week. TTY users should call (877) 486-2048.

10.) **We must provide an option of referral to another provider if a provider objects to providing treatment to a member based on religious or moral grounds**.

11.) **How can members get more information about their rights?** There are several places where a member can go to get more information about their rights:

- Members can **call My Choice Wisconsin Customer Service** at (800) 963-0035 (TTY users should call Wisconsin Relay System 711).
- Members can **call the State Health Insurance Assistance Program.** Members can find details about this organization and how to contact it in their Evidence of Coverage.
- Members can contact **Medicare.**
  - Member can visit the Medicare website to read or download the publication "Your Medicare Rights and Protections." (The publication is available at: https://www.medicare.gov/pubs/pdf/11534-medicare-rights-and-protections.pdf).
  - Or, members can call 800-MEDICARE ((800) 633-4227), 24 hours a day, 7 days a week. TTY users should call (877) 486-2048.

Member Rights & Responsibilities

Please reference the member's Evidence of Coverage on My Choice Wisconsin's website: Medicare Advantage Info & Resources for Current Members | My Choice Wisconsin.

Member Rights for Appeal and Grievance

We are committed to providing quality service to our members. If you or the Member has a concern that you are unable to resolve, contact the Member's IDT or call My Choice Wisconsin' Member Rights Specialist at (800) 963-0035 ext. 3448.

Members have the right to file a grievance or appeal against a decision made by My Choice Wisconsin and to receive a prompt and fair review. The Member Rights Specialist can tell the Member about their rights, attempt to informally resolve their concerns, and help them file a grievance or appeal. The Member Rights Specialist will work with the Member throughout the entire grievance and appeal process to try to find a workable solution.

Providers recognize that the Member has the right to file appeals or grievances and assure them that such actions will not adversely affect the way that the Provider treats the Member. If a Provider becomes aware of concerns or dissatisfaction expressed by a member, or on behalf of a member related to the Member's care or needs, the Provider should inform the Member's Care Manager of such concerns. The Care Manager's name, phone number, and email address is printed on every Provider Service Authorization. Care Managers are available Monday through Friday from 8:00 am to 4:30 pm. Providers are permitted to assist Members in the filing of a grievance or appeal.

My Choice Wisconsin members have the right to appeal MCO adverse benefit determinations and to grieve any action or inaction that the member perceives as having a negative impact on them. Members, their legal representative, or, with member's written permission, anyone, (including

provider involved in the member's care) has the right to assist the member or file a grievance or appeal for the member. An "Adverse Benefit Determination" is any of the following:

- The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of the MCO's administration of the long-term care functional screen, including a change from nursing home level of care to non-nursing home level of care.
- The denial or limited authorization of a requested service that falls within the benefit package specified in Addendum VII, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of time or duration and that amount or duration has been completed.
- The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VII.
- The denial of a member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
- The denial of a member's request to obtain services outside the MCO's network when the member is a resident of a rural area with only one managed care entity.
- The failure to provide services and support items included in the member's MCP in a timely manner, as defined by the Department.
- 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.
- The involuntary disenrollment of the member from the MCO at the MCO's request.
- The failure of the MCO to act within the timeframes for resolution of grievances or appeals.

An "action" is not:

- A change of provider.
- A change in the rate the health plan/managed care organization pays a provider.
- The termination of a service that was authorized for a limited number of units of service or duration of a service.
- 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 regarding whether he/she is a member of the group impacted by the change.
- The denial of authorization or payment for a service or item that is not inside the benefit package.

What are Appeals and Grievances?

An **appeal** is a request for My Choice Wisconsin to review an "adverse benefit determination." If a

member is dissatisfied with the My Choice Wisconsin appeal decision, he/she may request a State Fair Hearing.

An appeal of an adverse benefit determination must be filed within sixty-five (65) calendar days of receipt of the NOA. If the member wants a service to continue during the appeal process, the appeal must be filed on or before the effective date on the NOA. However, if My Choice Wisconsin's proposed action is upheld in the appeal process, the member may be liable for the cost of any continued benefits.

A **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination. (i.e., poor quality of service, does not feel respected by staff, etc.). If a member wants to file a grievance it can be either oral or written and should begin by contacting their Care Team Staff or the My Choice Wisconsin Member Rights Specialist. A grievance can be submitted at any time with no time limits.

How Members Can File an Appeal or Grievance
If a member is not satisfied with a decision regarding a service or support, the member is encouraged to contact the Care Team Staff and/or the My Choice Wisconsin Member Rights Specialist to discuss the situation and review the member's options. In addition, a Member Rights Specialist can be available to provide the member assistance in the process of filing for an appeal or grievance including completion of paperwork when assistance is requested.

Members, or their representatives, can contact the My Choice Wisconsin Member Rights Specialist toll-free at (800) 963-0035 (TTY: WI Relay 711).
Members can also send a grievance or appeal letter to:

My Choice Wisconsin
Member Rights Specialist
10201 West Innovation Drive
Suite 100
Wauwatosa WI 53226-4822

Additional information on appeals and grievances can be found on the My Choice Wisconsin website for all programs: www.mychoicewi.org/contact/grievances-appeals/.

Interdisciplinary Care Team Responsibilities

The Interdisciplinary Care Team of My Choice Wisconsin's Family Care Partnership ("Partnership") program has many roles, including playing an integral role with the My Choice Wisconsin provider network. The Interdisciplinary Care Team will:

- Work closely with all care providers, including physicians, to develop and maintain appropriate care plans for our members.
- Communicate any significant changes in a member's health situation to the primary care provider in a timely fashion.
- The My Choice Wisconsin Nurse Practitioner collaborates closely with the primary care provider

in medical management of the member, providing in-home primary care as appropriate, carefully monitoring medication management, and implementing the medical care plan across care settings.

- Provide continuity of care for our members over time and across different care settings.
- Coordinate or provide all the services that are covered in our benefit package in an integrated and cost-effective way.
- Communicate with providers and members in a respectful way.

For information on Medicaid BadgerCare+ or Supplemental Security Income (SSI) programs, reference the Molina Healthcare of Wisconsin, Inc. Provider Manual: molinahealthcare.com/providers/wi/medicaid/manual/provman.aspx.

SECTION 4: PRACTICE GUIDELINES, UTILIZATION MANAGEMENT & PRIOR AUTHORIZATION

Utilization Management Criteria

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

MCW has partnered with MCG Health to implement Cite for Guideline Transparency. With MCG Cite for Guideline Transparency, MCW can share clinical indications with Providers. The tool operates as a secure extension of MCW's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does not affect the process for notifying MCW of admissions or for seeking PA approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

MCW has also partnered with MCG Health, to extend our Cite AutoAuth self-service method, for all lines of business to submit advanced imaging prior authorization (PA) requests.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each prior Authorization request and sending it directly to MCW, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares MCW's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, PET scans. To see the full list of imaging codes that require PA, refer to the PA code LookUp Tool at MolinaHealthcare.com.

Medical Necessity Review

MCW only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, MCW uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, state guidelines, MCW clinical policies, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The MCW review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity adverse determination are reviewed by a health care professional at MCW (medical director, pharmacy director, or appropriately licensed health care professional).

MCW's Provider training includes information on the UM processes and authorization requirements.

Clinical Information

MCW requires copies of clinical information be submitted for documentation. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. MCW does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless state or federal regulations allows such documentation to be acceptable.

Prior Authorization

MCW requires PA for specified services as long as the requirement complies with federal or state regulations and the Provider Agreement with MCW. The list of services that require PA is available in narrative form, along with a more detailed list by CPT and HCPCS codes. MCW PA documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the MCW website at www.mychoicewi.org.

CPT® is a registered trademark of the American Medical Association.

Providers are encouraged to use the MCW Prior Authorization form provided on the MCW website. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, MCW ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Member diagnosis and International Classification of Diseases (ICD)10th Revision (ICD-10) codes
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).
    - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the PA requirements. Obtaining authorization does not guarantee payment. MCW retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. MCW does not retroactively authorize services that require PA.

MCW makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

MCW will make an organizational determination as promptly as the Member's health requires and no later than contractual and regulatory requirements. Expedited timeframes are followed when the provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health.

Providers who request PA for services and/or procedures may request to review the criteria used to make the final decision. A MCW Medical Director is available to discuss medical necessity decisions with the requesting Provider at (855) 326-5059 during business hours.

Upon approval, the requester will receive an authorization number. The number may be provided by telephone, or fax. If a request is denied, the requester and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process.

Physicians and nurses at My Choice Wisconsin use clinical criteria, based on medical necessity, to make coverage decisions. It is the policy of My Choice Wisconsin to use clinical practice guidelines that are evidence-based and/or expert consensus-driven. All clinical practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost consideration. My Choice Wisconsin's clinical decision-making process may include the use of MCG® criteria.

The recommendations for care are suggested as guides for making Medical Necessity clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

My Choice Wisconsin makes available practice guideline references through the My Choice Wisconsin website where they are available to providers, members, and potential members. Go to the MCW Authorizations' screen: Authorizations - My Choice Wisconsin Scroll down where you will find a section titled "Clinical Policies & Third Party Guidelines.".

Resource Allocation Decision (RAD) Method

My Choice Wisconsin staff help members achieve their personal goals or outcomes and take into consideration cost when planning member care and choosing providers to meet member needs. To do this, Family Care and Partnership members and their care teams use a utilization management process called the Resource Allocation Decision (RAD) method. The RAD method identifies the most efficient and appropriate ways to meet member needs and help support member outcomes. Together, the member and the care team develop a Member Centered Plan (MCP) that summarizes the member's needs and outcomes and the services to address them.

If you have questions regarding any of the criteria or decision methods used by My Choice Wisconsin, you may call My Choice Wisconsin to request information regarding the criteria at (800) 963-0035.

Emergency Services

Emergency Services means: a medical assistance service that is:

Required to prevent, identify, or treat a recipient's illness, injury, or disability; and meets the following standards:

Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

1. 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; Is appropriate with regard to generally accepted standards of medical practice; Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
2. Is of proven medical value or usefulness and, consistent with DHS 107.035, is not experimental in nature;
3. Is not duplicative with respect to other services being provided to the recipient; Is not solely for the convenience of the recipient, the recipient's family or a provider; With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and, Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

a. Emergency Medical Condition or Emergency means.

b. 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:

1) 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;

2) Serious impairment of bodily functions; or

3) Serious dysfunction of any bodily organ or part.

c. With respect to a pregnant woman who is in active labor:

1) Where there is inadequate time to effect a safe transfer to another hospital before delivery; or

2) Where transfer may pose a threat to the health or safety of the woman or the unborn

child.
d. A psychiatric emergency involving a significant risk or serious harm to oneself or others.
e. A substance abuse emergency exists if there is significant risk of serious harm to a member or others, or there is likelihood of return to substance abuse without immediate treatment.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Services rendered to the Member do not require prior authorization from My Choice Wisconsin.

Emergency services are covered on a 24-hour basis without the need for PA for all Members experiencing an emergency medical condition.

Post-stabilization care services are covered services that are:

1. Related to an emergency medical condition
2. Provided after the Member is stabilized
3. Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the Member's condition.

Providers requesting an in-patient admission as a Post Stabilization service must request this type of service by contacting My Choice Wisconsin at (608) 210-4050.

Inpatient admission requests (not including post stabilization requests) received via fax will be processed within standard inpatient regulatory and contractual time frames.

My Choice Wisconsin also provides Members with a 24-hour Nurse Advise Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area, My Choice Wisconsin contracts with vendors that provide 24- hour emergency services for ambulance and hospitals. An out-of-network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to an available participating facility. Services provided after stabilization in a non-participating facility may not be covered and the Member may be responsible for payment.

MCW Care Managers will contact Members over-utilizing the emergency department to provide assistance whenever possible and determine the reason for using Emergency Services.

Care managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Inpatient Management

Planned Admissions

My Choice Wisconsin requires PA for all elective inpatient admissions and procedures to any facility. Facilities are required to also notify My Choice Wisconsin within 24 hours or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without PA may not be eligible for payment.

Emergent Inpatient Admissions

My Choice Wisconsin requires notification of all emergent inpatient admissions within 24 hours of admission or by the Following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. My Choice Wisconsin requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission may result in a denial of authorization for the inpatient stay.

Inpatient at time of Termination of Coverage

When a Member's coverage with Medicaid terminates during a hospital stay, My Choice Wisconsin 42 will continue to cover services through discharge unless law or program requirements mandate otherwise.

Inpatient/Concurrent Review

My Choice Wisconsin performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. My Choice Wisconsin will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. My Choice Wisconsin requires that requested clinical information updates be received by My Choice Wisconsin from the inpatient facility within 24 hours of the request.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

My Choice Wisconsin will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide My Choice Wisconsin with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

My Choice Wisconsin's UM staff follow federal and state guidelines along with evidence-based criteria to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and medical necessity requirements (refer to the Medical Necessity Review subsection of this Provider Manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for My Choice Wisconsin Members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of My Choice Wisconsin's Quality Improvement (QI) Program to ensure that My Choice Wisconsin Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

My Choice Wisconsin will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
    - o Premature or inadequate discharge from the same hospital.
    - o Issues with transition or coordination of care from the initial admission.
    - o For an acute medical complication plausibly related to care that occurred during the initial admission.

- Readmissions that are excluded from consideration as preventable readmissions include:
    - o Planned readmissions associated with major or metastatic malignancies, multiple traumas, and burns.
    - o Neonatal and obstetrical Readmissions.
    - o Initial admissions with a discharge status of "left against medical advice" because the

intended care was not completed.
o Behavioral Health readmissions.
o Transplant related readmissions.

Home Health Agency Responsibilities:

- Pre-certify all services.

Pre-certification of Hospital Admissions

Based on medical diagnoses, information, or proposed surgery, My Choice Wisconsin will:

- Authorize coverage for a length of stay based on clinical protocols.
- Notify the member of the number of days authorized for elective admissions by letter.
- Notify the Physician of concurrent review for those admissions with no specific length of stay.
- Follow the admission with the hospital's utilization review department if the member is not discharged within the pre-certified period. The admission will be reviewed for medical necessity and intensity of service.
- If not available through the hospital utilization review department, contact the provider for additional information to determine if additional days should be covered or denied. The decision will be based on the medical necessity for an acute care setting. Alternate settings and/or appropriate home health services will be explored for members who do not meet criteria for continued coverage of acute care.

The **provider**, not the member, is responsible for pre-certifying an admission to the hospital for medical and/or surgical treatment.

Second Opinions

My Choice Wisconsin members are covered for a second opinion within the Provider Network.

Prior Approval Coverage for My Choice Wisconsin members is provided in accordance with Medicaid and Medicare criteria and guidelines, including the use of Utilization Management Criteria. Procedures that do not meet applicable coverage criteria and guidelines are not covered by My Choice Wisconsin. To ensure coverage, services must be:

- Obtained from a Network Provider, unless prior approval is obtained through My Choice Wisconsin to utilize an Out-of-Network Provider, as outlined below.
- Approved in advance by the member's My Choice Wisconsin Interdisciplinary Team or other care management staff, except in a medical emergency. For additional information on My Choice Wisconsin's prior authorization requirements, go to www.mychoicewi.org/providers/authorizations/.

Prior Authorization for Out-of-Network Providers

My Choice Wisconsin's Medical Advisor will consider approval of prior authorization requests for Out-of-Network Providers only if all of the following requirements are met:

- The services are medically necessary.
- The services are a covered benefit.
- The services are not available from a Network Provider.

- The services will be provided by a My Choice Wisconsin approved Out-of-Network Provider.

Contact My Choice Wisconsin before a member is referred to an Out-of-Network Provider.

New Technology

My Choice Wisconsin will follow Medicare's coverage determinations for new technology.

Remote Waiver Services and Interactive Telehealth
Remote waiver services mean waiver services delivered using audiovisual communication technology that permits 2-way, real-time, interactive communications between a provider and a member. Remote waiver services do not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail.

To authorize a waiver service for remote delivery the following, but not limited to, requirements must be met:
- The service can be delivered remotely with functional equivalence to face to face. Functional equivalence exists when there is no reduction in quality, safety, or effectiveness of the face-to-face service because it is delivered by using audiovisual telecommunication technology.
- Member consent to receive the service remotely.
- The member has the proper equipment and connectivity to participate in the service remotely. The MCO is not required to provide the proper equipment and connectivity to enable the member to access the service remotely.
- The provider must have the service in their contract with the 95 modifier prior to services being rendered and providers must bill using the 95 modifier if Remote Services is approved and authorized.
    - The following services may not be authorized for remote delivery:
        - Adult Day Care Services
        - Home-delivered meals
        - Residential Care
        - Transportation – Community and Other
        - Relocation Services
        - Self – Directed Personal Care
        - Skilled Nursing Services RN/LPN
        - Specialized Medical Equipment and Supplies
        - 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 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.

Guide to Pre-certification, Notification, and Concurrent Review Hospital Responsibilities:

- Pre-certify all elective admissions/surgeries.
- Notify My Choice Wisconsin on date of admission or within 24 hours of the first business day of emergency admission.

- Cooperate with concurrent review activities, by telephone, fax or on-site requests.

Skilled Nursing Facility Responsibilities:

- Pre-certify all admissions.
- Cooperate with concurrent review activities, by telephone, fax or on-site requests.
- Agency providers must be certified by Medicare per Wis. Admin Code DHS 105.16

Home Health Agency Responsibilities:

- Pre-certify all services.

Pre-certification and Concurrent Review of Hospital Admissions

Based on medical diagnoses, information, or proposed surgery, My Choice Wisconsin will:

- Authorize coverage for a length of stay based on clinical protocols.
- Notify the member of the number of days authorized for elective admissions by letter.
- Notify the Physician of concurrent review for those admissions with no specific length of stay.
- Follow the admission with the hospital's utilization review department if the member is not discharged within the pre-certified period. The admission will be reviewed for medical necessity and intensity of service.
- If not available through the hospital utilization review department, contact the provider for additional information to determine if additional days should be covered or denied. The decision will be based on the medical necessity for an acute care setting. Alternate settings and/or appropriate home health services will be explored for members who do not meet criteria for continued coverage of acute care.

The **provider,** not the member, is responsible for pre-certifying an admission to the hospital for medical and/or surgical treatment.

Prior Approval

Coverage for My Choice Wisconsin members is provided in accordance with Medicaid and Medicare criteria and guidelines, including the use of Utilization Management Criteria. Procedures that do not meet applicable coverage criteria and guidelines are not covered by My Choice Wisconsin. To ensure coverage, services must be:

- Obtained from a Network Provider, unless prior approval is obtained through My Choice Wisconsin to utilize an Out-of-Network Provider, as outlined below.
- Approved in advance by the member's My Choice Wisconsin Interdisciplinary Team or other care management staff, except in a medical emergency. For additional information on My Choice Wisconsin's prior authorization requirements, go to www.mychoicewi.org/providers/authorizations/.

SECTION 5: RESIDENTIAL PROVIDERS

Introduction

Residential services include Adult Family Homes (AFHs), Community Based Residential Facilities (CBRFs), and Certified Residential Care Apartment Complexes (RCACs). My Choice Wisconsin utilizes a tiered facility contracted rate methodology for setting residential rates for each facility.

Residential Placement Process

Member needs are assessed by their Interdisciplinary Team. Once an assessment has been completed and the determination made for the appropriate residential setting, the team submits a request to the Residential Team. The Residential Team Specialist assigned to a member's county works closely with the Interdisciplinary Team and identifies providers who have availability and ability to safely and effectively provide service in a cost-effective manner to aid the member in achieving successful outcomes based upon that member's care plan. Those options are presented to the Interdisciplinary Team who shares the information with the member, schedules assessments and facility tours, communicates with the member to identify the chosen provider (if more than one option is available) and schedules a move date.

Member placement occurs at the provider's contracted rate. The Interdisciplinary Team will enter a Service Authorization at the appropriate contracted tier rate and a move can be completed.

Excessive Damage to a Residential Facility Caused by a Member

Residential Facility shall develop written policies that apply to all the facility's residents whose neglect or failure to adhere to the rules of the facility results in excessive damage to the facility. The residential facility shall require eligible residents to read and sign an agreement of compliance with the facility's policies and rules, clearly communicating a resident's rights, privileges and obligations with respect to functioning safely and in consideration of other residents, employees, and visitors to the facility.

Residential Facility shall monitor My Choice Wisconsin member's use of mobility aids including, but not limited to motorized wheelchairs and scooters and shall promptly inform Member's Interdisciplinary Team in the event a Member's ability to safely and competently use such equipment appears to be impaired.

Residential Facility shall make reasonable physical adaptations (wide-angle mirrors for sharp corners, door/wall guards, etc.) to the facility to minimize the opportunity for collisions and physical damage.

Residential Facility and Interdisciplinary Team shall document efforts to ensure member safety and safety of others in a member's vicinity.

The Residential Facility agrees not to hold My Choice Wisconsin members responsible for the cost of Reasonable Wear and Tear. However, if a member is responsible for excessive damage to the residential facility due to member's failure to adhere to the rules of the facility, the residential facility may hold the My Choice Wisconsin member responsible for the cost of the excessive damage after

documented efforts have failed to resolve member's failure to adhere to the rules of the facility. The facility agrees not to hold My Choice Wisconsin responsible for the cost of excessive damage.

Room and Board

My Choice Wisconsin collects the Room and Board payment from the member. The residential provider submits a claim for one rate that is inclusive of both Support Services and Room and Board and My Choice Wisconsin pays the provider.

- **HUD Fair Market Rent (FMR) Rate Updates**
  - Room and board rates for home and community-based residential services shall be determined based on HUD Fair Market Rent (FMR) rates, which are updated annually by February 1st. The most current HUD FMR rates are publicly available at: huduser.gov/portal/datasets/fmr.html and mychoicewi.org.
  - Providers are responsible for reviewing the most current HUD FMR rates to ensure compliance with applicable room and board obligations.
- **Application of HUD Rates and Member Contribution Adjustments**
  - Reimbursement for Room and Board shall be adjusted in accordance with the member's financial obligation, as required by Wisconsin DHS and Federal Medicaid.
  - Room and Board reimbursement shall be applied as follows:
    - If a member has no financial obligation zero dollars ($0) towards room and board, reimbursement will be fifty percent (50%) of the HUD Fair Market Rent rate.
    - If a member has a partial obligation of less than fifty percent (50%) towards room and board, reimbursement will be fifty percent (50%) of the HUD Fair Market Rent rate.
    - If a member has a financial obligation of fifty percent (50%) or greater, reimbursement will be at one hundred percent (100%) of the HUD Fair Market Rent rate.

Respite for Residents of an AFH

Owner-Occupied (respite provided in the owner's AFH) – Paid to Owner at 100% of usual Care & Supervision rate for the member. The owner pays respite provider at whatever rate owner has negotiated with respite provider. The residential provider submits a claim for one rate that is inclusive of both Support Services and Room and Board and My Choice Wisconsin pays the provider.

Owner-Occupied (respite provided outside the owner's AFH) – Paid to external respite provider at 100% of external provider's contracted rate with My Choice Wisconsin.

SECTION 6: BILLING AND CLAIMS

Contracted providers are responsible for submitting clean claims within the timely filing requirements outlined in their contract. If you have any questions related to billing, claims, reimbursement, denials, adjustments, or refunds, please contact:

My Choice Wisconsin Dual Advantage & Partnership Provider Help Desk:
Toll-Free at (855) 878-6699

My Choice Wisconsin WPS Family Care Customer Service
Toll-Free at (800) 223-6016

Family Care Claim and Authorization Information

MCW requires prior authorization for all Family Care Services. Failure to obtain an authorization prior to the delivery of services could result in denial of claim payment. MCW requires contracted providers to utilize our provider portal. Our provider portal, MIDAS (Member Information Documentation Authorization System), allows you to view your service authorizations, submit claims, and view claims status for our Members you serve.

MIDAS System Requirements

Your computer will require the following specifications:

- Microsoft Windows 95 or later
- Internet Explorer 7.0 or above

MIDAS will **not** work with the following:

- Apple computers or applications
- Google Chrome or Firefox

MIDAS Access

Your Provider Relations and Network Representative will provide you with a MIDAS provider portal login and initial password. Keep this login information in a safe place as the records contained in the MIDAS database contain protected Member health information.

On the MIDAS home page at www.mcfc-midas.com select “Provider Portal” from the system drop down menu and enter your login and password information.

My Choice Wisconsin Claims Web Portal

Long-Term Care providers who currently bill on the My Choice Wisconsin General or Residential claim forms have access to My Choice Wisconsin’s Claims Web Portal (Partnership members only).

If you are one of these providers, you have the option to bill electronically using the Claims Web Portal. You can view electronic remittance, verify eligibility, and check claim status through the Claims Web Portal.

Providers may sign up and obtain instructions for the Claims Web Portal at: www.mychoicewi.org/providers/claims/.

Providers serving Family Care Partnership members:

- Please do not submit claims for covered services to Medicare or Medicaid. Doing so will delay your payment.

Providers serving Family Care members:

- When providing services to Family Care members who have both Medicare and Medicaid, claims for Medicare-covered services must first be submitted to the member's Medicare plan,including My Choice Wisconsin's Medicare Dual Advantage Plan.

General Claims Information

Physicians/providers are required to use the standard CMS codes for ICD-10, CPT and HCPCS services, regardless of the type of submission. Claims processing is subject to change based upon newly promulgated guidelines and rules from the Department of Health Services Wisconsin Medicaid Program (WMP) or Centers of Medicare and Medicaid Services (CMS). See Long-Term Care Claims Information for more information on submitting Long-Term Care claims.

General Payment Guidelines

For payment of claims, My Choice Wisconsin has adopted all guidelines and rules established by Medicaid and Medicare. This includes Mandatory Payment Reductions in the Medicare Program – "Sequestration." In general, Medicare claims with dates-of-service or dates-of-discharge on or after April 1, 2013, incur a 2 percent reduction in Medicare payment.

Claims should be submitted in one of three formats:

- Electronic claims submission;
- CMS 1500 form; or
- UB04 form

Claims by Mail

This correct mailing address can be found on the Service Authorization

Mail Claims to the appropriate address.

Medicare Dual Advantage & Family Care Partnership Claims:

My Choice Wisconsin
PO Box 7000
Columbia, MD 21045-7000

Family Care Claims:

My Choice Wisconsin
C/O WPS Insurance Corporation
PO Box 211595
Eagan, MN 55121

WPS ONLY – New and Corrected Claims Submitted by Fax:

Providers can now submit paper claims and the Corrected Claim Form to WPS via fax to (608) 327-6332 instead of mailing.

- For new and corrected claims, please **do NOT include a FAX coversheet**. You may fax just the claim form or just the Corrected Claim Form and normal supporting documents (PRA).

Electronic Claims Submission

My Choice Wisconsin accepts standard electronic billing for Professional and Institutional claims (837P or 837I as appropriate) using Payer ID 27004 for Dual Advantage and Family Care Partnership claims or Payer ID SC022 for Family Care Claims.

Pharmacy Claims Submission

All My Choice Wisconsin pharmacy claims should be submitted to CVS electronically.

Non-Covered Services

My Choice Wisconsin administers Wisconsin Medicaid healthcare benefits through our Family Care and Partnership programs and complies with Wisconsin Administrative code outlined in DHS 107.03. My Choice Wisconsin provides Medicare benefits to members in our Dual Advantage program, as well as dual eligible members in our Partnership program. Please see Items and Services Not Covered Under Medicare for more information. The Family Care and Partnership programs include Home and Community-based Waiver benefits in addition to traditional Medicaid coverage.

Coordination of Benefits General Information

If a member carries other insurance through more than one insurer, My Choice WI will coordinate the benefits to ensure maximum coverage without duplication of payments.

Provider must submit claims to the primary insurance before submitting to My Choice WI. Following the primary insurance determination, a copy of the original claim form and a copy of the primary insurance Remittance Advice (RA) must be submitted to My Choice WI for secondary benefit determination (regardless of balance due). Providers must submit the documents within one hundred and twenty (120) days from the date on the primary RA.

If the Provider fails to comply, or is unaware of the primary insurance, claims for which My Choice Wisconsin is secondary will be denied. This denial reason will print on the Provider's RA.

If primary insurance is discovered after charges have been processed and both My Choice Wisconsin and the primary insurance make payment, the Provider may have an overpayment and will be required to return the balance to My Choice Wisconsin.

If My Choice Wisconsin discovers a primary insurance after charges have been processed, My Choice Wisconsin will reverse its original payment. The adjustment will be reflected on the Provider's RA.

If the primary insurance denies a claim because of lack of information, My Choice Wisconsin will also deny. In the event the denial was due to the member's lack of compliance in responding to the primary insurance request for additional information, My Choice Wisconsin may reconsider the denial based on the following process: the provider must make, and document, three attempts (verbal or written) to the member indicating they must become compliant in providing the missing information in order for the primary insurance to process. There must be at least one (1) week between contacts attempts. The provider must submit documentation of these outreach efforts and if the member is not following through, documentation of the outreach attempts can be resubmitted with the claim, documenting in box 19 of the CMS-1500 "non-compliant". In the case where the claim is submitted on a UB, notation of "non-compliant" can be documented anywhere on the claim form.

- If a member has Medicare and/or other insurance, complete information must be on the CMS1500 claim or UB-04 claim for the claim to be processed efficiently.
- On the CMS-1500 claim, box 11d should be checked "Yes" if there is any other insurance information. If box 11d is checked "Yes", boxes 9a – 9d on the CMS-1500 claim must be completed with the other insurance information.
- On the UB-04 claim, box 50 is completed if there is any other insurance information.
- Other insurance remittance advice needs to accompany each CMS-1500 claim and UB-04 claim where other insurance is indicated on the claim.

Coordination of Benefit Rules for My Choice Wisconsin Partnership and Medicare Dual Advantage Members

- If the member is 65-years or older and has coverage under an employer group health plan through either the member's current employment, or the employment of a spouse or partner, that coverage pays first. This rule applies to health plans of employers with 20 or more employees.
- If the member is under age 65 and entitled to Medicare due to disability (other than end-stage renal disease), is a My Choice Wisconsin member, and has group health coverage through an employer with 2 to 99 employees, either through the member's own employment or the employment of a family member, My Choice Wisconsin pays first. The group health plan will pay first if the employer has 100 or more employees.
- If the member is eligible for Medicare solely based on end-stage renal disease (ESRD) and is covered under an employer group health plan, the employer plan is primary for the first thirty (30) months.
- My Choice Wisconsin is the secondary payer for work-related illnesses or injuries, or veteran's benefits for treatment of service-connected disabilities.
- My Choice Wisconsin follows the same guidelines as Medicare.

Corrected Claims

Corrected claims for Medicare Dual Advantage or Family Care Partnership members can be submitted on the appropriate claim form with "Corrected Claim" written or stamped on the UB-04 or the CMS-1500. Claims that are corrected and/or resubmitted to My Choice Wisconsin are subject to the claim appeal time frame identified in the Claim Appeal Process section of this Provider Manual and the provider's contract. Corrected claims should be sent to the normal claims address at:

My Choice Wisconsin
PO Box 7000
Columbia, MD 21045-7000

Corrected claims for Family Care members must be submitted on the WPS Corrected Claim form. Submission of the Corrected Claim Forms to WPS are subject to the timely filing time frame identified in the provider's contract. Corrected Claim forms should be sent to the normal WPS claims address at:

My Choice Wisconsin
C/O WPS Insurance Corporation PO
Box 211595
Eagan, MN 55121

Subrogation

My Choice Wisconsin does not pay for services to the extent that there is a third party that is required to be the primary payer.

For services for Partnership and Medicare Dual Advantage enrolled members, My Choice Wisconsin follows Medicare's guidelines for reimbursement any time there is a third-party entity involved. Providers may reference the following:

Medicare Managed Care Manual for Medicare Secondary Payer (MSP) procedures, go to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

Medicare Claims Processing Manual for Medicare claims processing procedures, go to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals.

For services for Family Care enrolled members, My Choice Wisconsin follows Medicaid's guidelines for reimbursement any time there is a third-party entity involved. Providers may reference the online, searchable Provider handbooks, go to https://www.forwardhealth.wi.gov/WIPortal/Default.aspx.

General Subrogation Information

- All liability insurer medical or dental coverage benefits are considered primary to My Choice Wisconsin payment of Medicaid claims as per Wisconsin Statutes, Medicaid is payer of last resort. My Choice Wisconsin reserves the legal right to process claims accordingly.

- Wisconsin Statutes Chapter 49 and Administrative Code DHS §106 govern how providers should submit liability claims and how My Choice Wisconsin reviews these claims for processing. Wisconsin law also protects My Choice Wisconsin's right of subrogation.
- My Choice Wisconsin reserves all legal, statutory, and contractual subrogation and recoupment rights related to paid claims and will enforce its right in all cases, unless waived in writing by My Choice Wisconsin.

Reimbursement Policy

My Choice Wisconsin reimburses providers based on the terms outlined in their contracts and in compliance with all applicable federal and state laws, including specific program requirements for Medicaid, Medicare, Family Care, and Family Care Partnership.

Under no circumstances will payment for any covered service exceed the provider's billed charges, except where required by law or regulatory guidelines.

Balance Billing Information

Providers may not bill, charge, collect a deposit from, seek remuneration from, or have any recourse against a My Choice Wisconsin member for covered benefits.

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions, termination of Medicaid certification, and/or be fined, imprisoned or both.

However, a member may request a non-covered service, a covered service for which authorization was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for these services may be collected from the member if the following conditions are met **prior to** the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers must obtain a written statement in advance, documenting that the member has accepted responsibility for the payment of the service. Furthermore, the service must be separate or distinct from a related, covered service.

Payer of Last Resort

Following Wisconsin Fee-For-Service Medicaid guidelines, My Choice Wisconsin's programs are the payor of last resort for any Medicaid covered services. Therefore, the provider is required to make a reasonable effort to exhaust all of the member's other health insurance sources before submitting claims to My Choice Wisconsin.

When providing services to Family Care members who have both Medicare and Medicaid, claims for Medicare-covered services must first be submitted to the member's Medicare plan, including My Choice Wisconsin's Medicare Dual Advantage Plan.

For information on Medicaid BadgerCare+ or Supplemental Security Income (SSI) programs, reference the Molina Healthcare of Wisconsin, Inc. Provider Manual: molinahealthcare.com/providers/wi/medicaid/manual/provman.aspx.

SECTION 7: PROVIDER APPEALS

This process is to be used to appeal My Choice Wisconsin determinations relative to claim denials, payments, medical necessity, and prior authorization for Covered Services. My Choice Wisconsin providers must appeal within sixty-five (65) days after receiving an initial denial or partial payment of a claim.

The provider may call the My Choice Wisconsin Provider Help Desk at (855) 878-6699. The Provider Help Desk will help answer provider questions, and/or will route the call to the appropriate department.

All appeals related to denials based on medical necessity will be reviewed by My Choice Wisconsin's health care professionals possessing the appropriate clinical expertise.
All appeals must be put in writing and mailed or sent via fax to:

My Choice Wisconsin
ATTN: Claims Appeals
5117 W. Terrace Drive
Suite 100
Madison, WI 53718

Fax Number 608-245-3340

If you wish to file an appeal, the following documentation must be included:

- Provider's Name and ID Number
- Member Name and Member ID number
- Date of Service
- Procedure Code
- Units billed
- Copy of your Claim
- Copy of your My Choice Wisconsin Remittance Advice
- Copy of your Primary Insurer EOB or Medicare (EOMB), if applicable
- Reason your Claim Merits Reconsideration
- Any other documentation to support your appeal

My Choice Wisconsin will respond to provider appeals within forty-five (45) calendar days of receipt of the request for review. The response will be in writing.

Family Care and/or Family Care Partnership Providers Only

All Family Care and Family Care Partnership providers must appeal first to My Choice Wisconsin and then to the Department if they disagree with My Choice Wisconsin's payment or nonpayment of a claim. Appeals must be submitted to DHS within sixty-five (65) days of the date of written notification of My Choice Wisconsin's final decision resulting from a request for reconsideration, or, if My Choice Wisconsin fails to respond, within sixty-five (65) days from the forty-five (45) day timeline allotted to

My Choice Wisconsin to respond. DHS appeals may be emailed, faxed, or mailed.

Email: DHSLTCProviderAppeals@dhs.wisconsin.gov

Fax: (608) 266-5629

Mail: Provider Appeals Investigator
Division of Medicaid Services
1 West Wilson Street, Room 518
P.O. Box 309
Madison, WI 53701-0309

For information on Medicaid BadgerCare+ or Supplemental Security Income (SSI) programs, reference the Molina Healthcare of Wisconsin, Inc. Provider Manual: molinahealthcare.com/providers/wi/medicaid/manual/provman.aspx.

SECTION 8: COMPLIANCE

My Choice Wisconsin is dedicated to the detection, prevention, investigation and reporting of potential health care fraud, waste and abuse. As such, MCW's Compliance department maintains a comprehensive plan, which addresses how MCW will uphold and follow state and federal statutes and regulations pertaining to fraud, waste and abuse. The plan also addresses fraud, waste and abuse prevention, detection and correction along with and the education of appropriate employees, vendors, Providers and associates doing business with MCW.

MCW's Special Investigation Unit (SIU) supports Compliance in its efforts to prevent, detect, and correct fraud, waste and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Fraud, Waste and Abuse Program

Under the direction of the Centers for Medicare and Medicaid Services (CMS) and the Wisconsin Department of Health Services, My Choice Wisconsin is required to have an effective fraud, waste, and abuse (FWA) program in place.

Provider Requirements

- All providers and their employees must complete training within ninety (90) calendar days of new hire and annually thereafter.
- Please maintain records of all training—this is to include dates, methods of training, materials used for training, identification of trained employees via sign-in sheets or other method, etc.
    - My Choice Wisconsin may request such records to verify that training occurred.
- If the organization has contracted with other entities to provide health and/or administrative services on behalf of My Choice Wisconsin members, you must provide this training material to your subcontractor for training and ensure the subcontractor and any other entity they may have contracted with to provide the service, also maintain records of training.
- All contracted entities should have policies and procedures to address fraud, waste, and abuse—including effective training, reporting mechanism and methods to respond to detected offenses.

Definitions

First Tier Entity – Any party that enters into a written agreement with the health plan to provide administrative or healthcare services for the health plan's enrollees**.**

- Examples include, but are not limited to, pharmacy benefit manager (PBM), contracted hospitals, or providers.

Downstream Entity – Any entity that enters into a written agreement below the level of the arrangement between a sponsor and a first-tier entity for the provision of administrative or healthcare services for the provision of administrative or healthcare services for a Medicare eligible individual under Medicare Advantage or Part D programs.

- Examples include, but are not limited to, pharmacies, claims processing firms, billing agencies.

Related Entity – Any entity that is related to the health plan by common ownership or control and,

1. Performs some of the sponsor's management of functions under contract of delegation;
2. Furnishes to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the sponsor at a cost of more than $2,500 during a contract period.

Fraud – Means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to her or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

- Examples include Billing for services not furnished;
- Soliciting, offering, or receiving a kickback, bribe or rebate; or
- Violations of the physician self-referral ("Stark") prohibition.

Waste – Generally, means over-use of services, or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources.

Abuse – Means provider practices that are inconsistent with generally accepted business or medical practices, and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary, or that fail to meet professionally recognized standards for health care.

Some examples of abuse:

- Charging in excess for services or supplies;
- Providing medically unnecessary services; or
- Providing services that do not meet professionally recognized standards.

Potential FWA committed by: Skilled Nursing Facility ("SNF")

- SNFs improperly up-coding resident HIPPS assignments to gain higher reimbursement;
- SNF improperly utilizing therapy services to inflate the severity of the HIPPS classification to obtain additional reimbursement; and
- DME or supplies offered by DME provider that are covered by the Medicare Part A benefit in the SNP's payment.

Potential FWA committed by: Hospital

- Failure to follow the same day rule;
- Abuse of partial hospitalization payments;
- Same day discharges and readmissions;
- Improper billing for observation services;
- Improper reporting of pass-through costs;
- Billing on an outpatient basis for "inpatient only" procedures;

- Submitting claims for medically unnecessary services by failing to follow local policies; and
- Improper claims for cardiac rehabilitation services.

Potential FWA committed by: Physician and Others

- Chiropractor intentionally billing Medicare for physical therapy and chiropractic treatments that were never actually rendered for the purpose of fraudulently obtaining Medicare payments;
- A psychiatrist billing Medicare, Medicaid, the health plan and private insurance for psychiatric services that were provided by the practices' nurses rather than by them;
- Physician certifies on a claim form that they performed laser surgery on a Medicare beneficiary when they knew that the surgery was not actually performed on the patient;
- Physician instructs their employees to tell the OIG investigators that the physician personally performs all treatments when, in fact, medical technicians do the majority of the treatment, and the physician is rarely present in the office;
- Physician, who is under investigation by the FBI and the health plan, alters records to cover up improprieties;
- Neurologist knowingly submits electronic claims to Medicare carrier for tests that were not reasonable and necessary and intentionally up-coded office visits and electromyograms to Medicare;
- Podiatrist knowingly submits claims to the Medicare and Medicaid programs for non-routine surgical procedures when they performed routine, non-covered services such as the cutting and trimming of toenails and the removal of corns and calluses; and
- Performing tests on a beneficiary to establish medical necessity.

Potential FWA committed by: Pharmaceutical Manufacturer

- **Illegal Off-label Promotion** – Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotion campaigns;
- **Illegal Usage of Free Samples** – Providing free samples to physicians knowing and expecting those physicians to bill the federal health care programs for the sample;
- Billing for items or services not rendered or not provided as claimed;
- Submitting claims for equipment or supplies and services that are not reasonable and necessary;
- Double billing resulting in duplicate payment;
- Billing for non-covered services as if covered;
- Knowing misuse of provider identification numbers, which results in improper billing;
- Unbundling (billing for each component of the service instead of billing or using all-inclusive code);
- Failure to properly code using coding modifiers;
- Improper telemarketing practices;
- Compensation programs that offer incentives for items or services ordered and revenue generated;

- Inappropriate use of place of service codes;
- Routine waivers of deductibles/coinsurance;
- Clustering; and
- Up coding the level of service provided.

Potential FWA committed by: Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS)

- DME provider billed for items or services not provided to the beneficiary;
- Continued billing for rental items after they are no longer medically necessary;
- Resubmission of denied claims with different information in an attempt to be improperly reimbursed;
- Providing and/or billing for substantially excessive amounts of DME items or supplies;
- Up coding a DME item by selecting a code that is not the most appropriate;
- Providing a wheelchair and billing for the individual parts (unbundling);
- Delivering or billing for certain items or supplies prior to receiving a physician's order and/or appropriate certificate of necessity;
- Completing portions of the certificate of necessity that is reserved for completion by the treating physician only;
- Cover letters to encourage physicians to order medically unnecessary items or services;
- Improper use of KX modifier;
- Providing false information on the DMEPOS supplier enrollment form;
- Knowing misuse of a supplier number, this results in improper billing;
- Furnishing more visits than as medically necessary;
- Duplicate billing for the same service;
- Submission of claims for home health aide services to beneficiaries that did not require any skilled qualifying service;
- Provision of personal care services by aides in assisted living facilities when such is required by the assisted living's state licensure;
- Providing services at no charge to an assisted living center.

Examples of Fraud, Waste and Abuse by a Member

The types of questionable Member schemes investigated by MCW include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits
- Conspiracy to defraud state and federal health care programs
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services
- Falsifying documentation in order to get services approved
- Forgery related to health care

- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else

Reporting Obligation

If you identify, or are made aware of, potential misconduct or a suspected fraud, waste, or abuse situation, it is your right and responsibility to report it. Providers, vendors, and delegates can report compliance concerns to any of the following:

- The compliance officer/hotline of the applicable Medicaid or Medicare plan with whom you contract
- My Choice Wisconsin's Compliance Hotline at (608) 245-3576
- 1-800-Medicare if Medicare funds are involved
- Your county public assistance fraud agency

All Providers shall immediately investigate and contact MCW in writing within five (5) business days of: any payment, claim, action, inaction, error, and/or omission by Provider's staff, contractors, and/or subcontractors which may constitute Medicare and/or Wisconsin Medicaid fraud, waste, and/or abuse. In accordance with applicable Law, Providers shall assist MCW with any reporting, investigation, and/or actions necessary for both parties' continued compliance with Medicare and/or Wisconsin Medicaid regulations, including, but not limited to, providing MCW, CMS and/or DHS with access to all records and personnel necessary to fully investigate the alleged or actual fraud, waste, and/or abuse. Providers understand and agree that in conjunction with the requirements of the Accountable Care Act, 42 C.F.R.
§ 455.2 and .23, MCW may suspend claims payment pending investigation of a credible allegation of fraud.

If the provider or MCW demonstrates based on the criteria under 42 C.F.R. § 455.23 (e) or (f) that there is good cause for not suspending 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 provider's request for a good cause exception. If the Department's Office of Inspector General disapproves the request, MCW suspend payments to the provider.

Retaliation is prohibited when a report is made in good faith.

Fraud, Waste and Abuse Training

- My Choice Wisconsin's providers, including first-tier, downstream and related entities, must complete fraud, waste, and abuse training within ninety (90) calendar days of new hire and annually thereafter.
- Providers are required to maintain records of all training, to include dates of training, methods of training, training curriculum, identification of trained employees via sign in sheets or other method. My Choice Wisconsin may request such records to ensure training has occurred.

Providers should have policies and procedures to address fraud, waste, and abuse, including effective training, reporting mechanisms and methods to respond to detected offenses.

- My Choice Wisconsin offers fraud, waste, and abuse training curriculum to its providers. Training is available on the My Choice Wisconsin website at: www.mychoicewi.org/providers/providercompliance-privacy/.
- Medicare participating providers may complete the CMS training available through the CMS Medicare Learning Network (MLN) at: The Medicare Learning Network® | CMS.

Fraud, Waste, and Abuse Resources

- CMS Prescription Drug Benefit Manual – Chapter 9: https://www.cms.gov/medicare/prescription-drugcoverage/prescriptiondrugcovcontra/partdmanuals.html.
- Code of Federal Register (see 42 CFR 422.503 and 42 CFR 422.504): http:www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms4124fc.pdf.
- Office of Inspector General: https://oig.hhs.gov/fraud/index.asp.
- Medicare Learning Network (MLN) Fraud & Abuse Resources: The Medicare Learning Network®.

Pertinent Statutes, Laws and Regulations

Federal False Claims Act

The Federal False Claims Act 1985 permits a person with knowledge of fraud against the United States Government, referred to as the "qui tam plaintiff," to file a lawsuit on behalf of the government against the person or business that committed the fraud (the defendant). If the action is successful, the qui tam plaintiff is rewarded with a percentage of the recovery.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the Claim
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim
- Acts in reckless disregard of the truth or falsity of the information in a Claim

Violations of Medicare laws and the Medicare Fraud and Abuse Statute also constitute violations of the False Claims Act. Since the Federal Government indirectly funds Medicaid, violations of Medicaid laws will also be covered under the False Claims Act.

The Federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have also enacted false claims laws modeled after the Federal False Claims Act.

A "claim" is broadly defined to include any submissions that results, or could result, in payment. Claims "submitted to the government" includes claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer health care benefits.

Liability can also be created by the improper retention of an overpayment. Examples include:

- A physician who submits a bill for medical services not provided.
- A government contractor who submits records that they know (or should know) are false and that indicates compliance with certain contractual or regulatory requirements.
- An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare health plan sponsor.

Deficit Reduction Act (DRA)
The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with My Choice Wisconsin, Providers and their staff have the same obligation to report any actual or suspected violation or fraud, waste or abuse. Entities must have written policies that inform employees, contractors and agents of the following:

- The federal False Claims Act and state laws pertaining to submitting false Claims
- How Providers will detect and prevent fraud, waste and abuse
- Employee protection rights as whistleblowers
- Administrative remedies for false Claims and statements

These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false Claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two (2) times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. MCW will take steps to monitor MCW contracted Providers to ensure compliance with the law. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which MCW has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to MCW.

Whistleblower and Whistleblower Protections
The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud. Individuals who file such suits are known as "whistleblowers." The Federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

The Anti-Kickback Statute (AKS) law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under federal health care programs.

The Anti-Kickback law is intended to ensure that referrals for health care services are based on medical need and not based on financial or other types of incentives to individuals or groups.

Examples include:

- A frequent flier campaign in which a physician may be given credit toward airline frequent flier mileage for each questionnaire completed for a new patient placed on a drug company's product.
- Free laboratory testing is offered to health care providers, their families, and their employees to induce referrals.

In addition to criminal penalties, violation of the Federal Anti-Kickback Statute could result in civil monetary penalties and exclusion from federal health care programs, including Medicare and Medicaid programs.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission or causing the submission of Claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn).

Sarbanes-Oxley Act of 2002

The Sarbanes-Oxley Act requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Post-payment recovery activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with My Choice Wisconsin and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to MCW under the Provider Agreement with MCW or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement with MCW, the parties agree that MCW shall in its sole discretion exercise the terms that are expressed in the Provider Agreement with MCW, the terms that are expressed here, its rights under law and equity or some combination thereof.

The Provider will provide MCW, governmental agencies and their representatives or agents, access to

examine, audit and copy any and all records deemed by MCW, in MCW's sole discretion, necessary to determine compliance with the terms of the Provider Agreement with MCW, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where the Provider provides services to any MCW Members. Auditable documents and records include but are not limited to medical charts, patient charts, billing records and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by MCW and without charge to MCW. In the event MCW identifies fraud, waste or abuse, the Provider agrees to repay funds or MCW may seek recoupment.

If a MCW auditor is denied access to the Provider's records, all of the Claims for which the Provider received payment from MCW is immediately due and owing. If the Provider fails to provide all requested documentation for any claim, the entire amount of the paid Claim is immediately due and owing. MCW may offset such amounts against any amounts owed by MCW to the Provider. The Provider must comply with all requests for documentation and records timely (as reasonably requested by MCW) and without charge to MCW. Claims for which the Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

The Provider acknowledges that HIPAA specifically permits a covered entity, such as the Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that in order to receive payment from MCW, the Provider is required to allow MCW to conduct audits of its pertinent records to verify the services performed and the payment claimed and that such audits are permitted as a payment activity of the Provider under HIPAA and other applicable privacy laws.

Claim Auditing

My Choice Wisconsin shall use established industry Claim adjudication and/or clinical practices, state and federal guidelines, and/or MCW's policies and data to determine the appropriateness of the billing, coding and payment.

The Provider acknowledges MCW's right to conduct pre and post-payment billing audits. The Provider shall cooperate with MCW's Special Investigation Unit (SIU) and audits of Claims and payments by providing access at reasonable times to requested Claims information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment.

In reviewing medical records for a procedure, MCW reserves the right and where unprohibited by regulation, to select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that MCW paid in error. The estimated proportion or error rate may be extrapolated across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. MCW asks that you provide MCW or MCW's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If MCW's SIU suspects that there is fraudulent or abusive activity, MCW may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, MCW reserves the right to recover the full amount paid or due to you.

Provider Certification Standards

The Department of Health Services is responsible for monitoring and terminating providers from the Wisconsin Medicaid program for reasons listed under Wisconsin Admin. Code § 106.06 as well as the reasons listed below in Art. VIII.D.5.e and h. My Choice Wisconsin must immediately terminate a provider from the MCO's network if the Department provides notice to the MCO of any of the following:

- When a provider applies to enroll in Wisconsin Medicaid but fails to meet the enrollment requirements; and

- When a provider is terminated from the Wisconsin Medicaid program for cause.

MCW shall use only providers that 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, except for Community Transportation providers that meet the definition of mass transit system under Wis. Stat. § 85.20(1). The MCO must also provide assistance and support to the Department for training, outreach, and utilization of the data collection system, as requested. Encounters without a current and valid Medicaid Provider ID for the service provided may be excluded in future rate setting development.

Upon request by the provider, the MCO must act as a third party delegate. The 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 must complete the data entry and upload supporting documentation, signed by the provider authorizing the action, to the ForwardHealth Portal. It is the responsibility of the provider to supply the data to the MCO and to ensure the information entered by the MCO is truthful, correct, and accurate.

Provider Education

When My Choice Wisconsin identifies, through an audit or other means, a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, MCW may determine that a provider education visit is appropriate.

MCW will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a Correction Action Plan (CAP) to MCW addressing the issues identified and how it will cure these issues moving forward.

Artificial Intelligence

The Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as

applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to MCW Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician. In addition, the Provider shall not use AI-generated voice technology, including but not limited to AI voice bots, voice cloning, or synthetic speech systems to initiate or conduct outbound communications to MCW. The prohibition includes, but is not limited to, communications for billing, eligibility verification, prior authorization, or any other administrative function.

Notwithstanding the foregoing, the Provider shall give advance written notice to your MCW Contract Manager (for any AI used by the Provider that may impact the provision of covered services to MCW Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by MCW, the Provider further agrees to (i) allow MCW to audit Providers' AI use, as requested by MCW from time to time, and (ii) to cooperate with MCW with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to MCW Members.

Marketing Prohibitions

Providers shall comply with all Medicare Marketing Guidelines as set forth by the Centers for Medicare and Medicaid Services (CMS). At minimum, participating physicians and providers should observe the following:

1. Providers or provider groups are prohibited from distributing printed information comparing benefits of different health plans, unless the materials have consent from all the health plans listed, and received prior approval from the Centers for Medicare and Medicaid Services (CMS);
2. Providers shall not accept enrollment applications or offer inducement to persuade beneficiaries to join plans;
3. Providers may not offer anything of value to induce plan enrollees to select them as a provider; and
4. Provider offices or other places where health care is delivered shall not accept applications for health plans, except in the case where such activities are conducted in common areas in the healthcare setting.

Provider Compliance & Member Privacy

Federal and state laws require My Choice Wisconsin and all of our providers to protect the privacy of our members. We are committed to only sharing information with others who have the legal right and the need to know. If the federal and state laws do not typically apply to you, My Choice Wisconsin will require you to sign a Business Associate Agreement. This agreement explains how you are allowed to use and disclose our members' information, as well as your responsibilities to protect that information and report any improper use or disclosure to My Choice Wisconsin.

- When you must discuss member information, services, or care, remember to do so in a private place

- *Unless it is an emergency,* avoid discussing members in public areas, like hallways, elevators, cafeterias, or other common areas
- Do not use a member's name or other identifying information, like date of birth or home address, in an email unless the information is encrypted

Personal concern or curiosity about an "interesting case" are not sufficient reasons to access or share member information. Information that you hear, see, and learn regarding our members is confidential and not to be shared with friends or family unless they have the legal right and need to know.

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains provisions and rules related to protecting the privacy and security of protected health information (PHI).

- HIPAA Privacy – The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.
- HIPAA Security – The Security Rule outlines specific protections and safeguards for electronic PHI.

If you become aware of a potential breach of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.

Protected Health Information (PHI)

My Choice Wisconsin is, and requires its providers to be, committed to using and disclosing Protected Health Information (PHI) in compliance with the Privacy Rule (45 C.F.R. Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This commitment includes password protection or encryption of any external email communication to My Choice Wisconsin that contains PHI. Because of the risk of inappropriate disclosure, My Choice Wisconsin requests that providers not email PHI to My Choice Wisconsin unless necessary.

In working with My Choice Wisconsin, providers and their employees and subcontractors may have access to confidential and/or proprietary information. Such information may include, but not be limited to, medical records, staff compensation, and certain proprietary and management information concerning both organizations. Any providers or employees or subcontractors assigned to perform services or who otherwise have access to such information will be made aware of the confidential nature of such information and will receive training and education on protecting confidentiality.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patient Records under 42 USC § 290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2") apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. "SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 CFR Part 2. Providers that are Part 2 Programs must comply with the requirements of 42 CFR Part 2, as amended from time to time.

SUD Records are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, 42 CFR Part 2 is more restrictive than HIPAA and does not allow disclosure without the patient's written consent except as set forth in 42 CFR Part 2. Any disclosure of SUD Records to MCW with the written consent of the patient, by a Provider that is a Part 2 Program, must meet the notice requirements of 42 CFR Part 2, specifically Sections 2.31 and 2.32, and shall include a copy of the patient's consent or a clear explanation of the scope of the consent provided.

Providers that are Part 2 Programs pursuant to 42 CFR Part 2 must promptly inform MCW that they are a Part 2 Program.

Inadvertent Disclosures of PHI

My Choice Wisconsin may, on occasion, inadvertently misdirect or disclose PHI pertaining to MCW Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected MCW Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of MCW.

National Provider Identifier (NPI)

Providers must comply with the NPI rule promulgated under HIPAA. The Provider must obtain an NPI from NPPES for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to MCW and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to MCW within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to MCW as applicable.

Additional Requirements for Delegated Providers and Atypical Providers

Providers that are delegated for Claims and Utilization Management activities ("Delegated Providers") are the "Business Associates" of My Choice Wisconsin for the delegated functions performed on behalf of MCW. Providers that provide services to MCW members but who are not health care providers under HIPAA ("Atypical Providers") are the Business Associates of MCW. Under HIPAA, MCW must obtain contractual assurances from all Business Associates that they will safeguard MCW Member PHI. Delegated Providers and Atypical Providers must agree to various contractual provisions required under HIPAA's privacy and security rules, including entering into a Business Associate Agreement with MCW. Delegated Providers and Atypical Providers agree to comply with the following HIPAA Business Associate Agreement requirements.

HIPAA Required Business Associate Agreement

Applicability: This HIPAA Required Business Associate Agreement ("BAA") sets forth the requirements with which the Business Associate must comply when it receives or has access to Protected Health Information ("PHI") in the performance of Services under the Agreement(s) and with respect to that PHI.

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Covered Entity," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the Provider subject to this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Covered Entity" or "MCW" shall mean Molina Healthcare of Wisconsin.

"Electronic Protected Health Information" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Party or Parties" shall mean Covered Entity and Business Associate who parties to this BAA.

"Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use, maintenance, transmission, or disclosure of PHI, the services provided by the Business Associate to MCW under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 USC §290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2").

"Unsecured PHI" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. GENERAL PROVISIONS

2.1. Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by MCW to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2. Amendment. MCW may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon forty-five (45) business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. MCW may otherwise materially amend this BAA only after forty-five (45) business days prior written notice to the Business Associate and only if mutually agreed to by the Parties as evidenced by the amendment being

executed by each Party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of the Business Associate's receipt of MCW's written notice to amend this BAA, MCW shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of MCW.

3. SCOPE OF USE AND DISCLOSURE

3.1. The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s), if such use or disclosure of PHI would not violate the Privacy Rule.

3.2. The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by MCW, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3; and

b. to provide Data Aggregation services relating to the Health Care Operations of MCW if required under the Agreement.

3.3. The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or

b. the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4. The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, MCW, is as between the Parties, the sole property of MCW.

3.5. The Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of MCW in each instance. Further, the Business Associate or its agents or Subcontractors shall not transmit or store PHI outside of the United States of America without MCW's prior written consent.

3.6. The Business Associate agrees to be fully bound by the requirements of 42 CFR Part 2 upon receipt of any SUD Records disclosed under this Agreement. The Business Associate shall not use or disclose SUD Records except as necessary for the Business Associate to perform Services. The Business Associate shall not redisclose any SUD Records to a third party, except to a contract agent acting on the Business Associate's behalf to provide Services or back to MCW. The contract agent may only redisclose such information to the Business Associate or MCW. The Business Associate and any contract agent shall not disclose SUD Records for use in any civil, criminal, administrative or legislative proceeding against the individual who is the subject of the SUD Record and shall immediately notify MCW of any such request. The Business Associate must ensure that any such contract agent agrees in writing to these same restrictions and obligations set forth in this Section.

4. OBLIGATIONS OF THE BUSINESS ASSOCIATE

The Business Associate shall:

4.1. Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2. Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of MCW. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4. Promptly report to MCW any unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI, Breach of Unsecured PHI or Security Incident. The Business Associate shall take all reasonable steps to mitigate any harmful effects of such unauthorized use or disclosure, Breach of Unsecured PHI, or Security Incident. The Business Associate shall indemnify MCW against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI and the provision of two years of credit monitoring and identity protection services to the affected individuals. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5. The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify MCW of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to MCW shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that MCW is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

   a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;
   b. a description of the types of Unsecured PHI that were involved in the Breach; and
   c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7. Within ten (10) days of receiving a request, make available PHI in a Designated Record Set to MCW as necessary to satisfy MCW's obligations under 45 CFR 164.524.

4.8. Within fifteen (15) days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by MCW pursuant to 45 CFR 164.526.

4.9. Maintain and make available to MCW, within twenty (20) days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy MCW's obligations under 45 CFR 164.528.

4.10. Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of MCW available to MCW or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11. To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of MCW, Business Associate shall comply with the HIPAA Rules, "Administrative

Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12. To the extent the Business Associate is to carry out one or more of MCW's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to MCW in the performance of such obligation(s).

5. MISCELLANEOUS

5.1. Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2. Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3. No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4. Governing Law and Venue. This BAA shall be governed by Wisconsin law notwithstanding any conflicts of law provisions to the contrary. The venue shall be the jurisdiction where the applicable services were received by MCW.

5.5. Compliance with Confidentiality Laws. The Business Associate acknowledges that it must comply with all applicable laws that may protect the confidentiality of PHI or other personally identifiable information received and will comply with all such laws.

5.6. Notices. Any notices to be given hereunder to MCW shall be made via certified U.S. Mail or express courier to MCW's address given below, and/or (other than for the delivery of fees) via email to the email listed below:

Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802
Attn: Privacy Official
Email: PrivacyOfficial@MolinaHealthcare.com

6. TERM AND TERMINATION OF BAA

6.1. Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date MCW terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2. Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), MCW may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if MCW determines, in its sole discretion, that Business Associate has violated a material

term of this BAA.

6.3. Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to MCW or, if agreed to by MCW, destroy all PHI received from MCW, or created, maintained, or received by Business Associate on behalf of MCW, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide MCW with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required by Law. If return or destruction of all PHI, and all copies of PHI, received from MCW, or created, maintained, or received by Business Associate on behalf of MCW, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and
b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4. Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

Reimbursement for Copies of PHI

My Choice Wisconsin does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization management
- Care coordination and/or complex medical care management services
- Claims review
- Resolution of an appeal and/or grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment and/or operation purposes
- Collection of HEDIS® medical records

Information Security and Cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by MCW to perform a health plan function(s) and in connection with such delegated functions.

1. Definitions:

(a) "MCW Information" means any information: (i) provided by MCW to Provider; (ii) accessed by Provider or available to Provider on MCW's Information Systems; or (iii) any information with

respect to MCW or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any MCW Nonpublic Information.

(b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized or unlawful destruction, loss, alteration, use, disclosure of or access to MCW Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition or disclosure of MCW Information or sustained interruption of service obligations to MCW.

(c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

(d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

(e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH
ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1 or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors,

such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:

i. MCW's proprietary and/or confidential information;

ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and

iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement and at all times maintain, appropriate administrative, technical and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon and MCW Information that are accessible to or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical and physical safeguards pursuant to HIPAA, HITECH and other applicable U.S. federal, state and local laws.

(a) Policies, Procedures and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards and standards, including as applicable, a written information security program, which MCW shall be permitted to audit via written request and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and MCW Information accessible to or held by Provider.

ii. Encryption. Use of encryption to protect MCW Information, in transit and at rest, accessible to or held by Provider.

iii. Security. Safeguarding the security of the Information Systems and MCW Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls and personnel training programs that include phishing recognition and proper data management hygiene.

iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. Provider agrees that any and all MCW Information will be stored, processed and maintained solely on designated target servers or cloud resources. No MCW Information at any time will be processed on or transferred to any portable or

laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. Provider agrees to store all MCW Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all MCW Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with MCW and/or any other parties expressly designated by MCW shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. Provider agrees that any and all MCW Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement with MCW and this section. Data shall not be distributed, repurposed or shared across other applications, environments or business units of Provider. Provider further agrees that no MCW Information or data of any kind shall be transmitted, exchanged or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by MCW.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade or disrupt Provider's delivery of services to MCW.

(a) Resilience Questionnaire. Provider shall complete a questionnaire provided by MCW to establish Provider's resilience capabilities.

(b) BC/DR Plan.

i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and MCW. The BC/DR Plan shall include the following:

a) Notification, escalation and declaration procedures.
b) Roles, responsibilities and contact lists.
c) All Information Systems that support services provided to MCW.
d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third parties or any combination thereof providing services to MCW.
e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
f) Detailed list of resources to recover services to MCW including but not limited to: applications, systems, vital records, locations, personnel, vendors and other dependencies.

g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.

h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to MCW. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

ii. To the extent that MCW Information is held by Provider, Provider shall maintain backups of such MCW Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Notification. Provider shall notify MCW's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to MCW or that detrimentally affects Provider's Information Systems or MCW's Information.

ii. Provider's activation of business continuity plans. Provider shall provide MCW with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) BC and DR Testing. For services provided to MCW, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide MCW a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

(a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects MCW's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or MCW Information accessible to or held by Provider, Provider shall notify MCW's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve MCW Information, Provider shall notify MCW's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve MCW Information, Provider shall provide a written description of the reasons for which the

payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to MCW's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@Molinahealthcare.com

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, Provider will, at MCW's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by MCW, (ii) fully cooperate with MCW to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law) and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving MCW Information without the prior written consent of MCW.

(e) Following notification of a Cybersecurity Event, Provider must promptly provide MCW any documentation requested by MCW to complete an investigation, or, upon request by MCW, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;
ii. assess the nature and scope of the Cybersecurity Event;
iii. identify MCW's Information that may have been involved in the Cybersecurity Event; and
iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release or use of MCW Information.

(f) Provider must provide MCW the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to MCW concerning the Cybersecurity Event. The information provided to MCW must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;
ii. a description of how the information was exposed, lost, stolen or breached;
iii. how the Cybersecurity Event was discovered;
iv. whether any lost, stolen or breached information has been recovered and if so, how this was done;
v. the identity of the source of the Cybersecurity Event;
vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;

vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information or types of information allowing identification of the consumer;

viii. the period during which the Information System was compromised by the Cybersecurity Event;

ix. the number of total consumers in each state affected by the Cybersecurity Event;

x. the results of any internal review identifying a lapse in either automated controls or internal procedures or confirming that all automated controls or internal procedures were followed;

xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by MCW, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and

xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

(g) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon MCW's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by MCW and/or any designated representative or vendor of MCW. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If MCW performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement with MCW will be in compliance with generally recognized industry standards and as provided in Provider's response to MCW's due diligence/security risk assessment questionnaire; (ii) agrees to inform MCW promptly of any material variation in operations from what was provided in Provider's response to MCW's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to MCW's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement with MCW.

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between MCW and Provider, but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between MCW and Provider, the stricter of the conflicting provisions will control.

SECTION 9: QUALITY MANAGEMENT PROGRAM

My Choice Wisconsin administration supports a Quality Management Program that includes assessment, monitoring, and improvement of both operational and clinical services. Data are collected from a variety of sources, case management software, claims, the Medicare Health Outcomes Survey (HOS), customer service feedback via Medicare Consumer Assessment of Health Plans Study (CAHPS), and provider surveys. My Choice Wisconsin utilizes Quality Management committees and work groups to develop and implement quality improvement interventions based upon analyzed data findings. Outcome measures of specific quality improvement interventions are monitored and compared to internal and/or external benchmarks. Interventions are developed and changed, when necessary, based on outcomes analysis.

Periodically, the Managed Care Organization (MCO) may invite providers to participate in targeted programs or initiatives aligned with the Quality Management Program. When both the Health Plan and the Eligible Provider agree, the Health Plan may recognize the provider's contribution for extra services requested, thereby advancing quality outcomes and fostering continual improvement.

Outcomes are reported to My Choice Wisconsin Leadership and CMS regional office. Required CMS disclosures include, but are not limited to, the following:

- Quality and performance indicators regarding enrollee satisfaction.

Quality and performance indicators regarding health outcomes.

Our Quality Improvement Steering Committee:

- Provides general oversight of QI-related activities, maintains organization-wide integration of processes related to quality improvement, shares QI information, and distributes summary reports.
- Reviews and approves methods for evaluation and ongoing monitoring of operational and clinical aspects of care.
- Reviews and evaluates findings, approves interventions and corrections, and makes recommendations.
- Ensures follow-up of interventions and corrections.
- Reviews and approves practice guidelines and performance monitoring of practice guidelines and quality indicators.
- Develops, measures, and assesses clinical initiatives.
- Provides recommendations and reviews policies and procedures related to QI activities.
- Reviews information about member appeal and grievance activities and provides recommendations as appropriate.
- Reviews data regarding member incidents and provides recommendations as appropriate.
- Reviews various subcommittee reports and provides recommendations as appropriate.
- Annually reviews and approves QI program description, evaluation, and work plan.

SECTION 10: APPENDIX A - GLOSSARY

Abuse – Provider practices that are inconsistent with generally accepted business or medical practices, and that result in an unnecessary cost to the Medicaid program, or in reimbursement for goods or services that are not medically necessary, or that fail to meet professionally recognized standards for health care.

Advance Directive – A legal document that describes, in writing, a person's choices about the treatments they want, or do not want, or about how healthcare decisions should be made for when they become incapacitated and cannot express their wishes.

Agreement for Services – The contract between My Choice Wisconsin First, Inc. or My Choice Wisconsin Health Plan and a provider to provide health and/or long-term care services to persons enrolled in My Choice Wisconsin's Family Care or Family Care Partnership program.

Ambulatory Surgery Center – Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Care Management – Individualized assessment and care planning, authorizing, arranging, and coordinating service in the Individual Service Plan (ISP, as defined below) and periodic reassessment and updates of the ISP. Care management also includes assistance in filing complaints and grievances and obtaining advocacy services.

Care Team – See "Interdisciplinary Team."

Centers for Medicare and Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs. CMS contracts with My Choice Wisconsin Health Plan, a Medicare Advantage Special Needs Plan.

Chief Medical Officer – A physician who monitors and reviews the utilization of covered services by My Choice Wisconsin Health Plan members, and also responsible for oversight of clinical quality.

Coordination of Benefits – The process used to determine whether My Choice Wisconsin is the primary or secondary payer on claims submitted on behalf of My Choice Wisconsin members.

Member Incident – A circumstance, event, or condition resulting from action or inaction that is either:

a) Associated with suspected abuse, neglect and financial exploitation, other crime, or a violation of member rights, or any unplanned unapproved use of restrictive measures;
b) Or that:
    - Resulted in serious harm to the health, safety, or well-being of a member; or
    - Resulted in serious harm to the health, safety, or well-being of another person as a result of the member's actions; or
    - Resulted in substantial loss in the value of the personal or real property of a member or of another person as a result of the member's actions; or

- Resulted in the unexpected death of a member; or
- Posed an immediate or serious risk to the health, safety, or well-being of a member, but did not cause harm because of chance or preventive intervention.

Culturally Competent Health Care – Care that incorporates the values of honoring member's beliefs; being sensitive to cultural diversity, including members with limited English proficiency and diverse cultural and ethnic backgrounds, and; fostering in staff/providers attitudes and interpersonal communication styles which respect member's cultural backgrounds.

Department of Health Services (DHS) – The state agency responsible for protecting and promoting the health and safety of the people of Wisconsin.

Downstream Entity – Any entity that enters into a written agreement below the level of the arrangement between a sponsor and a first-tier entity for the provision of administrative or health care services for the provision of administrative or healthcare services for a Medicare eligible individual under Medicare Advantage or Part D programs.

Emergency Medical Condition – A medical emergency includes severe pain, an injury, sudden illness, or suddenly worsening illness that would cause a reasonably prudent layperson to expect that delay in treatment may cause danger to the person's health if they do not get immediate medical care.

Evidence of Coverage – A document that My Choice Wisconsin Health Plan issues to Family Care Partnership members which describes the benefits to which members are entitled. It explains a member's coverage.

First Tier Entity – Any party that enters into a written agreement with the health plan to provide administrative or healthcare services for the health plan's enrollees**.**

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to her or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Health Risk Assessment – A health assessment completed with the member upon enrollment. It provides information for care management planning based on the member's current health status. It is used to assist in identifying members with serious and complex health conditions.

Inpatient Status – A hospital stay longer than 24 hours.

Individual Service Plan (ISP) – A document that lists services and supports, paid or unpaid, provided or arranged by the MCO to address all needs identified in the functional screen and comprehensive assessment and all services and supports provided that are consistent with the Member-Centered Plan and the nature and severity of the member's identified needs. The ISP identifies the types of services or support authorized by the interdisciplinary team (IDT), the amount, the frequency and duration of each service (e.g., start and stop date), and the provider(s) that will furnish each service. It is a supplement to the Member-Centered Plan document. (Also see "Member-Centered Plan".)

Interdisciplinary Team (IDT) – The individuals identified by the MCO to provide care management services to members.

Maintenance or Supportive Care – Services provided to a member after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. These services are provided to a member whose recovery has plateaued, slowed, or ceased, when only minimum rehabilitative gains can be demonstrated with continued care. My Choice Wisconsin Health Plan makes the determination of what constitutes maintenance or supportive care after careful review of the member's case history and treatment plan submitted by a health care provider.

Managed Care Organization (MCO) – An entity that the DHS has certified as having capacity for financial solvency and stability and which has agreed to make certain services available to members for payment.

Medically Necessary – As determined by My Choice Wisconsin, a healthcare service that is required to identify or treat a member's illness or injury. The service must be:

- Consistent with the symptom(s) or diagnosis and treatment of the illness or injury.
- Furnished for an appropriate duration and frequency and in accordance with accepted medical practice and My Choice Wisconsin Health Plan protocols to treat that illness or injury.
- Not solely for the member's convenience or the convenience of the physician, hospital, or other health care provider.
- The most appropriate service or location for providing such a service that can be safely provided to the member and accomplishes the desired end result in the most economical manner.
- Supported by information contained in the member's medical record and from other relevant sources.
- Services or supplies that meet the following: (1) they are appropriate and necessary for symptoms, diagnosis, or treatment of the medical condition; (2) they are provided for the diagnosis or direct care and treatment of medical conditions; (3) they meet the standards of good medical practice within the medical community in the service area: (4) they are NOT primarily for the convenience of the patient or provider; (5) they are the most appropriate level or supply of service that can safely be provided.

Member – An individual entitled to receive long-term care (LTC) and/or healthcare services who has voluntarily enrolled in My Choice Wisconsin's Family Care or Family Care Partnership program.

Member-Centered Plan (MCP) – A record that documents a process by which the member and the IDT further identify, define, and prioritize a member's long-term care outcomes initially identified in the Comprehensive Assessment and identify, define and prioritize quality of life outcomes important to the member. The MCP establishes how the member's strengths, skills and resources and informal and community resources identified in the Comprehensive Assessment, and services and supports available through the MCO benefit and identified in the ISP, will be used to achieve the outcomes identified and defined by the member. The MCP identifies the person(s) on the IDT

responsible for tracking of steps/supports related to achieving these outcomes. The ISP is a part of the Member Centered Plan.

Network Hospital – A hospital with which My Choice Wisconsin has an Agreement for Services for the provision of hospital services to members.

Network Physician – A licensed Doctor of Medicine or osteopathy with which My Choice Wisconsin has an Agreement for Services for the provision of medical services to members.

Network Provider – A provider with which My Choice Wisconsin contracts to provide or arrange for health and/or long-term care services for members. May also be referred to as a "subcontractor" or "MCO Provider."

Observation Status – A short-term hospital stay, classified as outpatient, for the purpose of evaluation or minimal treatment, as determined by the admitting physician.

Out-of-Area or Out-of-Network Services – Services provided outside of My Choice Wisconsin's Service Area only for treatment of an Emergency Medical Condition or Urgently Needed Care.
Outpatient – Services a patient receives without staying overnight. May also be referred to as ambulatory, clinic, or ancillary services.

Post-Stabilization Care Services – Services related to an Emergency Medical Condition that are either: (a) provided after a member is stabilized in order to maintain the stabilized condition; or (b) provided to improve or resolve the member's condition.

Primary Care Provider – Any contracted network provider who is designated by the health plan as a primary care provider, whose primary care specialty is family practice, general internal medicine, pediatric medicine, or geriatric medicine, and who has agreed to work within the parameters of My Choice Wisconsin's model of care. The Primary Care Provider, who, in collaboration with a member's IDT, is responsible for knowing the member's complete medical history, performing routine health care duties, and referring the member to a Specialist when necessary.

Provider Network – All health and long-term care providers who have executed contracts with My Choice Wisconsin to provide or arrange specified services for members.

Prior Authorization – The process of obtaining authorization from a member's IDT for specific services, procedures, or items prior to the provision of such services, procedures or items.

Related Entity – Any entity that is related to the health plan by common ownership or control and:

1. Performs some of the sponsor's management of functions under contract of delegation;
2. Furnishes to Medicare enrollees under an oral or written agreement; or

Leases real property or sells materials to the sponsor at a cost of more than $2,500 during a contract period.

Service Area – The geographic area in which My Choice Wisconsin has been authorized by CMS or DHS to offer its programs.

Specialist – A physician who practices in a branch of medical science that is not primary care.

Subcontractor/MCO Provider – A service provider that My Choice Wisconsin has an Agreement for Services with to provide specified services to My Choice Wisconsin's members.

Waste – Generally, the overuse of services, or other practices that result in unnecessary costs. In most cases, waste is not considered to be caused by reckless actions but rather the misuse of resources.

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