



[NUMBER] Amendment to the 2016 [PROGRAM TITLE] Contract

The following changes are made to the contract through this amendment:

Article XVII, Fiscal Components/Provisions, Section E.3.i. is amended to include:

- i. A completed supplemental audit report summarizing the number of claims sampled from the auditors' work papers and the number of claims that did and did not satisfy each of the required elements in the report.
(<https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm>)

Article XVIII, Payment to the Managed Care Organization, Section L, is amended to include:

L. PPACA Primary Care Rate Increase – Partnership Program Only

1. *Definitions*

As used in this Agreement, the following terms have the indicated meanings:

- a. PPACA (aka ACA) Primary Care Rate Increase Fee Schedule
A separate fee schedule from the Fee-For-Service Maximum Fee Schedule. It outlines the codes and amount the MCO must pay to qualifying providers for the PPACA Primary Care Rate Increase and is based on the Medicare Fee Schedule for the corresponding dates of service. The fee schedule is updated annually (effective each calendar year of the increase) and can be found at:
<https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx>
- b. Encounter Paid Amount
The amount paid by the MCO for the specified service.
- c. PPACA Paid Amount
ACA Primary Care Rate Increase Fee Schedule rate for specified dates of services.
- d. Net PPACA Supplement
The difference between the Encounter Paid Amount and PPACA Paid Amount.
- e. Amount Distributed to Provider
The total payment the MCO made to the provider related to each specific detail in the encounter.
- f. MCO Paid Amount
The total amount of money the MCO paid to the provider after cost sharing and prior to the PPACA Primary Care Rate Increase being applied to the encounter.



2. *Background*

Federal law requires that physicians who attest to the Department as primary care providers be eligible to receive a rate increase for evaluation and management services and vaccine administration provided to Medicaid members, including those who are dual eligible Medicare and Medicaid members. Eligible providers include any physician who attests to practicing in the community as a primary care provider and is either certified by a board identified in the rule or provides sixty percent (60%) or more of services from the targeted code set. Advanced practice providers who are supervised by an eligible provider may also attest to receive the increase. The increase will apply to services rendered from January 1, 2013 through December 31, 2014.

The Department will maintain attestation records for all eligible physicians and advanced practice providers. The MCO shall ensure that eligible providers receive the primary care rate increase in the manner described below.

a. Encounter Data

The MCO shall submit accurate encounter records reflecting amounts paid for services purchased for members.

b. Method of Payment to Providers

i. The Department shall calculate the payments due to eligible providers to ensure that each provider has received at least the amount identified on the ACA Primary Care Rate Increase Fee Schedule. The Department will document the amount due to eligible providers in a Partnership PPACA Primary Care Report and will send the report and a payment to the MCO in the amount to be distributed to the providers.

ii. Payments must be sent within 45 calendar days after the Department sends the Partnership PPACA Primary Care Report to the MCO.

iii. An example of the payment methodology follows:

Encounter & TPL Paid Amount (A)	PPACA Paid Amount (B)	Net PPACA Supplement (B - A)
\$100.00	\$150.00	\$50.00

The MCO must ensure that the provider receives the full \$50.00 Net PPACA Supplement from the Department.

iv. If the MCO has a sub-capitated payment arrangement with providers for the qualifying service or it is unable to determine the MCO Paid Amount, the MCO shall pay to the provider the full Net PPACA Supplement from the Department.



3. *MCO Reporting requirements*

a. PPACA Report

- i. Within 45 calendar days of receipt of payment from the Department, the MCO shall return the entire Partnership PPACA Primary Care Report to the Department with the following fields completed by the MCO:
 - a) Distributed to Provider by MCO (Y/N)
 - b) Amount Distributed to Provider
- ii. The MCO should mark the Distributed to Provider by MCO field with a "Y" if the ACA Primary Care Rate Increase Fee Schedule amount was paid out to the listed provider.
- iii. The MCO should mark the Distributed to Provider by MCO field with an "N" if the amount was not paid out to the listed provider. The MCO shall return all payments not distributed to listed providers to the Department within 45 days of receipt of the payments from the Department.

The only reasons why the funds should not be distributed is that the provider is no longer in business or the provider has a credible allegation of fraud against him/her. In cases of fraud, the MCO will be responsible for tracking the returned payments, by provider, and separately reporting that information to the Department. If the credible allegation of fraud is lifted it is the responsibility of the MCO to contact the Department to receive reimbursement for the returned funds.

- iv. The MCO must report in the Amount Distributed to Provider field the amount actually paid to the provider to comply with PPACA.
- v. At a minimum, the MCO will be required to forward all of the provider and payment information within the PPACA Primary Care Report specific to each provider that is receiving payment.

b. Attestation

Within 45 calendar days of receipt of payment from the Department, the MCO must attest that the provider received the PPACA Primary Care Rate Increase Fee Schedule Amount. The attestation form will be provided by the Department.

4. *Noncompliance*

- a. The Department shall have the right to audit any records of the MCO and to request any information, including MCO Paid Amounts, to determine if the MCO has complied with the requirements in this section. If, at any time, the Department determines that the MCO has not complied with any requirement in this section, the Department will issue an order to comply



to the MCO. The MCO shall comply within 15 calendar days after the Department's determination of noncompliance. If the MCO fails to comply after an order, the Department may pursue action against the MCO as provided under Addendum VII of the 2016 Partnership Contract.

- b. If the MCO fails to send payment to the provider within 45 calendar days of receiving the primary care payment from the Department, the MCO will be subject to an assessment by the Department equal to three percent (3%) of the delayed payment.

5. *Payment Disputes*

If the primary care provider disputes the amount that the MCO is required to pay, the provider and MCO should follow the appeal process outlined in Article VIII, Section O - Provider Appeals of the 2016 Partnership Contract.

6. *Resolution of Reporting Errors*

If the MCO discovers any error in the payment, the Department's Division of Long Term Care Bureau of Long Term Care Financing must be contacted in writing within 15 calendar days of the discovery. It is the responsibility of the MCO to recoup any overpayments or pay out any underpayments as a result of the error. Errors shall be corrected on the Partnership PPACA Primary Care Report and the entire report should be resubmitted detailing the corrected amounts by provider.

Addendum I, Actuarial Basis, Section B.2. is amended to include:

2. *Vent Dependent – Family Care program*

The Department will retroactively adjust the long-term care capitation rate for a change in the number of members dependent on ventilators between the base year and the rate year for an MCO.

The intent of this adjustment is to better reflect within the long-term care capitation rate method a change in the proportion of an MCO's membership who are ventilator dependent between the population in the base data and contract period enrollment. This adjustment pertains only to the current contract period and shall not be interpreted to apply to any other contract periods.

The methodology for calculating an adjustment:

- a. Identify the predicted per member per month long-term care cost for an MCO's base year population from the rate report.
- b. Identify the predicted per member per month long-term care cost for an MCO's base year population when the proportion of members dependent on ventilators is updated to reflect the actual contract period experience.
- c. Calculate the per member per month cost difference between the rate report and actual contract period amounts.
- d. Multiply the cost difference by actual contract period member months.



This amount shall represent the retrospective rate adjustment.

Addendum I, Actuarial Basis, Section B.8. is amended to include:

8. *High Cost Risk Pool*

The Department will use a portion of all MCOs’ capitation rates to fund risk pools for the developmental and physical disability populations. The pools are intended to reimburse MCOs for “eligible costs” defined as 80% of long term care service costs, excluding care management, above \$225,000 that MCOs incur for any one member during the contract period. Each MCO’s eligible costs will be determined based on the encounter data submitted to the Department by April 30th of the following year. For each pool, MCOs will receive a percentage of the pooled funds equal to the MCO’s percentage of statewide eligible costs. If statewide eligible costs exceed the pooled funds, MCOs will not be fully reimbursed for their eligible costs. If statewide eligible costs are less than the pooled funds, MCOs will be reimbursed for their eligible costs and any remaining funds will be distributed as a target group specific PMPM for all member months during the contract period.

THIS CONTRACT AMENDMENT SHALL BECOME EFFECTIVE UPON SIGNING.

In WITNESS WHEREOF, the State of Wisconsin and **Name of MCO** have executed this agreement:

Executed on behalf of
Name of MCO

Executed on behalf of
Department of Health Services

Name
Title

Curtis Cunningham, Administrator
Division of Long Term Care

Date

Date