



XXX Amendment to the 2018 Family Care/Partnership/PACE Contract

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

Article I, Definitions, Definition 73 is amended to read:

73. **Legal Decision Maker:** a member's or potential member's legal decision maker is a person who has the legal authority to make certain decisions on behalf of a member or potential member. A legal decision maker may be a guardian of the person or estate (or both) registered under Chapter 53 of the Wisconsin Statutes, a guardian of the person or estate (or both) appointed under Chapter 54 of the Wisconsin Statutes, a conservator appointed under Chapter 54 of the Wisconsin Statutes, a person designated power of attorney for health care under Chapter 155 of the Wisconsin Statutes or a person designated durable power of attorney under Chapter 244 of the Wisconsin Statutes. A legal decision maker may have legal authority to make certain kinds of decisions, but not other kinds of decisions. A member may have more than one legal decision maker authorized to make different kinds of decisions. In any provision of this Contract in which the term "legal decision maker" is used, it applies only to a person who possesses the legal authority relevant to that provision. A person designated by the member or potential member as an "authorized representative" under 42 C.F.R. § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker.

Article I, Definitions, Definitions 86 and 87 are added and subsequent Definitions are renumbered accordingly:

86. **Medical Equipment or Appliances:** are items that are primarily or customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.
87. **Medical Supplies:** are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury.

Article III, Eligibility, Section E.2.b is amended to read:

- b. The income maintenance agency is responsible for determining the member's cost share or patient liability. Cost share is imposed on members in accordance with 42 C.F.R. § 435.726. Patient liability is imposed in accordance with 42 C.F.R. § 435.725. The Department will ensure that a member who has a cost share is not required to pay any amount in cost share which is in excess of the average capitation payment attributable to waiver services, as determined by the Department.

Article III, Eligibility, Section E.2.c.iii is amended to read:

- iii. The MCO will not collect a patient liability for the current month from a member who enrolls in Family Care after the 1st of the month if the member is residing in a nursing



home and receiving nursing home Medicaid benefits. The member will pay his or her patient liability to the nursing home for the current month and his or her patient liability to the MCO beginning the next month.

The MCO will attempt to collect the patient liability amount from the nursing home when the 820 Report (see Article XV.E) indicates that the capitation payment was offset by the patient liability amount but the member already paid the patient liability to the nursing home.

The MCO will pay the patient liability amount to the nursing home when the 820 Report indicates that the capitation payment was not offset by the patient liability amount but the member already paid the patient liability amount to the MCO.

Article IV, Enrollment and Disenrollment, Section A.4 is amended to read:

4. *Enrollment of Persons Wanting to Relocate from a Nursing Home When There is a Waiting List During the Transition to Entitlement*

a. Applicability

This subsection applies when all the following criteria are met:

- i. The person is receiving Medicaid funded nursing home care (excluding situations where the facility is closing) in a county where there is a waiting list while the county is in transition to entitlement status;
- ii. The person is eligible for Family Care (or Family Care-Partnership or PACE if available in the county) and wants to enroll in the MCO for the program of her or his choice;
- iii. The person wants to relocate to a non-institutional setting but cannot do so without Medicaid-funded long-term services and supports available through MCO enrollment; and
- iv. The person may or may not be on the waiting list.

b. Policy

The MCO shall accept enrollment of persons meeting the above criteria, whether or not they are on the waiting list and regardless of position on the waiting list, after the enrollment counseling session with the ADRC and the enrollment form have been completed and according to the normal enrollment timeframe, unless the applicant prefers a later date.

Article V, Care Management, Section K.1.c is amended to read:

c. Authorization of Medicare Services in the Partnership and PACE Benefit Packages for Dual Eligibles

Notwithstanding any other provision of this section, pursuant to their status as Medicare Advantage-Prescription Drug (MA-PD) or PACE plans and their Medicare agreement or



contract with CMS, MCOs in making authorization decisions about Medicare coverable services for dual eligible members in Partnership or PACE shall first use and follow Medicare coverage and authorization policies, procedures and requirements rather than the RAD or other Department-approved service authorization policies and procedures used for the authorization of Medicaid services under this contract. If the MCO determines that Medicare will not cover the service, the MCO must then use and follow the Medicaid coverage rules, including the RAD, to determine if Medicaid will cover the service.

Article V, Care Management, Section K.2.b is amended to read:

c. Amount, Duration and Scope of Medicaid Services

Members shall have access to services in the benefit package that are identified as necessary to support the long term care outcomes in an amount, duration and scope that will support member outcomes and are no less effective than would be achieved through the amount, duration and scope of services that would otherwise be furnished to fee-for-service Medicaid recipients, as set forth in 42 CFR § 440.230 and, for members under the age of 21, as additionally set forth in 42 CFR §§ 441.50 – 441.62 (EPSDT).

Article VII, Services, Section C.2.e is amended to read:

e. Outpatient Prescription Drugs

i. Drug Rebates

Outpatient prescription drugs covered for members are subject to the same rebate requirements as the fee-for-service drug benefit is subject to under §1927 of the Social Security Act. The MCO shall take such actions as the Department may determine necessary to permit the Department to collect such rebates from manufacturers for outpatient prescription drugs the MCO covers as a Medicaid benefit for members.

ii. Formulary or Preferred Drug List (PDL)

- a) The MCO may use its own formulary or preferred drug list or the preferred drug list used by the State plan outpatient drug benefit. It may also apply its own utilization management practices consistent with the requirements of §1927 of the Social Security Act.
- b) The MCO must make its formulary or PDL available to members in paper or electronic form. The formulary must indicate which generic and brand name medications are covered and what formulary tier each medication is on, and must be on the MCO's website in a machine readable format specified by the Department.

iii. Prior Authorization



- a) The MCO shall conduct prior authorization for coverable outpatient drugs in accordance with §1927(d)(5) of the Social Security Act.
- b) The MCO shall provide a response to a prior authorization request for a coverable outpatient drug by telephone or other telecommunication device within 24 hours of the request and shall provide for the dispensing of at least a 72 hour supply of a covered drug in an emergency situation.
- c) If the MCO's formulary or preferred drug list does not include a coverable outpatient drug that is covered by the State plan drug benefit, the MCO must use its prior authorization process to consider requests for coverage of such off-formulary drugs and shall cover them where appropriate and medically necessary.

Article VIII, Provider Network, Section D.14 is amended to read:

14. *Notices*

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

Article VIII, Provider Network, Section D.31 is added:

31. *Direct Care Workforce Provider Payment Permitted Uses and Reporting Requirements*

a. Definition of Direct Care Worker

Under this section, a “direct care worker” is defined as an employee who contracts with or is an employee of an entity that contracts with an MCO to provide adult day care services, daily living skills training, habilitation services, residential care (adult family homes of 1-2 beds, adult family homes of 3-4 beds, community-based residential facilities, residential care apartment complexes), respite care services provided outside of a nursing home, and supportive home care, and who provides one or more of the following services through direct interaction with members: assisting with activities of daily living or instrumental activities of daily living, administering a member's medications, providing personal care or treatments for a member, conducting activity programming for a member, or providing services such as food service, housekeeping or transportation to the member. Staff who would be excluded from the definition of “direct care worker” include but are not limited to: licensed practical nurses, registered nurses, nurse practitioners, nursing home staff, personal care agency staff, staff in marketing, sales, reception, finance, maintenance/plant operations and those staff who work exclusively in food service, transportation, and housekeeping and do not have direct contact with members.



b. Provider Use of Direct Care Workforce Funds

The provider agreement shall include the following provisions regarding the use of any funds received pursuant to Article VIII.L.9.:

- i. That the funds shall only be used for the following purposes or to pay for employer payroll tax increases that result from using the funds for one of the following purposes:
 1. Wage increases;
 2. Retention/longevity bonuses;
 3. Performance bonuses;
 4. Employee paid time off;
 5. Staff referral bonus;
 6. Sign on bonus.
- ii. That providers must complete making payments to direct care workers by the deadlines established in Addendum IX.
- iii. That providers may claim expenditures they made on or after January 1, 2018 as appropriate uses of the direct care workforce funding.
- iv. That providers must distribute the direct care workforce funding to direct care workers providing services to Family Care, Family Care Partnership, or PACE members in Wisconsin.
- v. The MCO shall recoup direct care workforce payments the MCO paid to a provider for a particular quarter:
 1. If the provider does not complete the Department-developed survey and attestation required in Article VIII.D.31.c. for that particular quarter by September 13, 2019; and
 2. When the amount of the quarterly direct care workforce payment the MCO paid to the provider for that particular quarter was equal or greater than \$1,000.
- vi. Providers must submit the signed provider agreement to the MCO within 45 days from when the MCO sent the agreement to the provider to be eligible for the initial direct care workforce payment; and
- vii. Providers that submit the signed provider agreement to the MCO after 45 days will only be eligible for direct care workforce funding distributed after the signed provider agreement was received by the MCO.

c. Provider Documentation and Reporting

- i. The provider agreement shall require the provider, upon acceptance of the above-referenced funds, to respond to Department-developed surveys regarding the funds' use and effectiveness, to attest to the manner in which



- the funds were used, and to retain documentation proving the funds were paid to individual workers.
- ii. For all quarters except the final payment to be distributed by the Department by December 20, 2019, Providers must complete the Department-developed survey and provide the necessary attestation by the deadlines established in Addendum IX to be eligible to receive future Direct Care Workforce funding.
- d. **Provider Ineligibility for Direct Care Workforce Funding**
- i. The provider agreement shall specify that when a direct care workforce provider discontinues operations or enters bankruptcy, the provider will not be eligible for direct care workforce payments.
 - ii. The provider is only eligible for direct care workforce funding if they have a contract with the MCO to provide Family Care, Family Care Partnership, or PACE services at the time the MCO distributes the direct care workforce funding. Providers that do not have an active service contract with the MCO are not eligible to receive direct care workforce funding.
 - iii. Providers that do not complete the Department-developed survey and provide the necessary attestation by the deadlines established in Addendum IX will not be eligible to receive subsequent Direct Care Workforce funding.
- e. **Changes in Provider Identification**
- i. The Department will specify information unique to each provider to calculate the amount of direct care workforce funding for each provider. Providers that change or discontinue their unique identifying information will only receive funding after the Department gives the MCO approval to distribute the funding. Providers that change their unique identifying information are required to submit documentation to the MCO that the old and new information belong to the same provider.

Article VIII, Provider Network, Section L.9 is added:

9. *Direct Care Workforce Payment*

To comply with Wis. Stat. § 49.45(47m), the Department may make payments to the MCO, which the MCO shall distribute to direct care workforce providers, under the following terms and conditions:

- a. For purposes of this section, “direct care workforce provider” means providers of adult day care services, daily living skills training, habilitation services, residential care (adult family homes of 1-2 beds, adult family homes of 3-4 beds, community-based residential facilities, residential care apartment complexes), respite care services provided outside of a nursing home, and supportive home care. Providers of self-directed services are not eligible for direct care workforce



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payments for self-directed services. Nursing homes, personal care agencies, and MCOs are not direct care workforce providers under this section.

- b. The Department will divide the total funds allocated under Wis. Stat. §49.45(47m) into four quarterly amounts. The amounts will be weighted by the projected statewide enrollment for each claims period.
- c. The dates by which the Department will make Direct Care Workforce payments to each MCO and the dates of service of the encounters used to calculate each payment are shown in the following schedule:

Quarterly Payment	Payment to MCO Made By:	Dates of Service
Quarter 1	June 29, 2018	January 1 – March 31, 2018
Quarter 2	September 28, 2018	April 1 – June 30, 2018
Quarter 3	December 21, 2018	July 1 – September 30, 2018
Quarter 4	June 28, 2019	October 1 – December 31, 2018

- d. The MCO shall adhere to the encounter reporting due dates identified in Addendum II.A.1. Encounters submitted after the Department's data pull for the payment calculation in one quarter will be included in the data pull for the payment calculation in a subsequent quarter.
- e. The MCO shall also submit to the Department a list of the providers and encounters it believes should be included in the Direct Care Workforce funding calculations.
- f. The MCO shall provide the Department a final list of all the direct care workforce providers the MCO contracts with and the providers' encounters. The MCO shall attest that the information they provide is complete and accurate.
- g. To calculate the amount that each MCO needs to pay each provider each quarter, the Department will:
 - i. Calculate the Direct Care Workforce percentage increase by dividing the Direct Care Workforce funding allocated to the quarter in Article VIII.L.9.b. by the sum of the cost of all direct care workforce encounters within the dates of service specified in Article VIII.L.9.c. for the quarter and any encounters not included in prior quarterly payment calculations. The costs from encounters that span more than one quarter will be allocated between quarters based on the number of days of service which occurred in each quarter.
 - ii. Multiply the Direct Care Workforce percentage increase calculated in Article VIII.L.9.g.i. by the sum of all payments the MCO made to the provider.



- iii. If any provider would receive a Direct Care Workforce payment of less than \$25, the Department shall exclude expenditures from those providers and recalculate the amounts in Article VIII.L.9.g.i. and ii.
- h. The MCO shall distribute to each direct care workforce provider the amount determined by the Department by the deadlines established in Addendum IX. The Direct Care Workforce payment will be in addition to the provider's negotiated payment rate. The MCO shall only distribute direct care workforce payments to those providers from whom the MCO has received a signed provider agreement and with which the MCO still contracts for provision of services to Family Care, Family Care Partnership, or PACE members in Wisconsin. The MCO shall return any direct care workforce payments for providers who have not returned a signed provider agreement according to the deadlines established in Addendum IX.
- i. The Department will specify information unique to each provider to calculate the amount of direct care workforce funding for each provider. The MCO shall not distribute direct care workforce funding to providers that change or discontinue their unique identifying information until the MCO receives the Department's written approval. Providers that change their unique identifying information are required to submit documentation to the MCO that the old and new information belong to the same provider. The MCO is required to submit this documentation to the Department.
- j. The MCO shall return to the Department any payments to providers that are not accepted by or recouped from providers and notify the Department of the amounts and reason the payments were not accepted or recouped. The MCO shall return recouped payments by the deadlines established in Addendum IX. The Department will include funds returned to the Department in subsequent direct care workforce payment calculations.
- k. The Department will make a final payment by December 20, 2019, for any funds returned after the Quarter 4 payments. The final payment will follow the calculations in Article VIII.L.9.g. using encounters for Quarter 4.
- l. The MCO shall assist the Department in obtaining the survey responses and attestation required in Article VIII.D.31., from direct care workforce providers who receive payments under this subsection. If directed by the Department, the MCO shall distribute and collect from providers the survey and attestations developed by the Department.
- m. The MCO shall recoup direct care workforce payments the MCO paid to a provider for a particular quarter if the provider:
 - i. Does not complete the Department-developed survey and attestation required in Article VIII.D.31. for that particular quarter by September 13, 2019; and
 - ii. The amount of the quarterly direct care workforce payment the MCO paid to the provider for that particular quarter was equal or greater than \$1,000.



- iii. Recoupment is not required as long as the provider meets the final deadline of September 13, 2019.
- n. The MCO shall provide to the Department the following items by the deadlines established in Addendum IX:
 - i. A print out from the MCO accounting system demonstrating the provider payments were made within the required distribution timeline and that the total payments equal the direct care workforce funding the MCO received from the Department. The MCO will include provider-specific explanations for any direct care workforce funding the MCO did not distribute to a provider.
 - ii. A signed attestation that all direct care workforce providers received the funding paid to the MCO by the Department for this purpose.
- o. The MCO shall send all documents they are required to submit to the Department under this section to DHSLTCFiscalOversight@dhs.wisconsin.gov with “Attention: Direct Care Workforce MCO Submission” in the subject line.

Article VIII, Provider Network, Section L.10 is added:

10. *Health Professional Shortage Area (HPSA) Payments for Family Care Partnership/PACE*

The MCO must pay the HPSA enhanced rates outlined under Medicaid FFS policy or the equivalent for MCO covered primary care and emergency care services provided to a member living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA. Specified MCO-covered obstetric or gynecological services (see Wisconsin Health Care Programs Online Handbooks) provided to a member living in a HPSA or by a provider practicing in a HPSA must also be paid at the HPSA enhanced rates as outlined under Medicaid FFS policy or the equivalent. However, this does not require the MCO to pay more than the enhanced FFS rate or the actual amount billed for these services.

Article VIII, Provider Network, Section N.5.c is amended to read:

- c. If the MCO requires providers to perform background checks on caregivers, the MCO shall ensure that the providers perform the background checks in compliance with Wis. Stat. § 50.065 and Wis. Admin. Code § Chapter DHS 12;



Article VIII, Provider Network, Section P is added and subsequent sections adjusted forward:

P. Non-risk Provisions for Members Receiving Care Management from an Indian Health Care Provider (IHCP)

1. *Interim Payments*

- a. The Department shall pay the MCO a monthly interim payment for each Indian member receiving care management from an IHCP as part of a three party agreement between the Department, the IHCP, and the MCO.
- b. The amount of the interim payments the MCO receives under this section will equal the MCO's capitation rate for the level of care and geographic service region of the member. No additional capitation payment will be made to the MCO for that member.
- c. The interim payments the Department makes to the MCO under this section are not actuarially sound.
- d. All other provisions in this contract concerning the capitation payments the Department pays to the MCO apply to the interim payment the Department pays to the MCO under this section.

2. *MCO Cost Settlement*

- a. The Department will complete an annual cost settlement of the MCO's costs of providing services to Indian members for whom the MCO received an interim payment under (1).
- b. The Department may complete one interim cost settlement if requested by the MCO.
- c. The cost settlement amount that the Department will pay or recoup from the MCO will be determined as follows:
 - i. The Department will calculate the total amount the MCO paid for all services provided to Indian Family Care members based on the MCO's submitted encounter records. Indian Family Care members will be identified using a list of members the IHCP will provide to the Department.
 - ii. The Department will subtract from the amounts in i. the total non-administrative portion of the interim payments the Department paid the MCO before the member's cost share was deducted as well as any other revenues the MCO received towards the cost of the member's care.
- d. The Department will complete the annual cost settlement within eighteen months of the calendar year in which the member received services.

3. *Encounter Data Reporting*



- a. The MCO shall submit encounter data for services provided to members receiving care management from an IHCP in accordance with all provisions of this contract.
- b. Encounter data for members for whom the MCO received an interim payment under (1) will be removed from the data used for development of actuarially sound capitation rates.

Article XI, MCO Grievances and Appeals, Section D.1.a is amended to read:

- a. Denial in Whole or in Part of a Request for Service

The MCO must mail or hand deliver written notice of action

<https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm> to an affected member when the MCO intends to deny in whole or in part a request for a service included in the benefit package.

Although the MCO may cover a service that is outside of the benefit package under the circumstances set forth in Article VII, Section A.7., an MCO is not required to provide a notice of action when it denies a member's request for such a service. The MCO is however required to inform members in writing when a request for a service outside the benefit package is denied. The MCO must utilize DHS' Notification of Non Covered Benefit template and must maintain a copy of the completed form in the member's file.

Denial of a request for an item meeting the definition of medical equipment or appliances (Article I.86) or medical supplies (Article I.87) shall be treated by the MCO as a denial of a benefit package service regardless of whether the item is on the Forward Health Durable Medical Equipment Index or the Wisconsin Medicaid Index of Disposable Medical Supplies or other indices of coverable medical equipment and supplies used by the MCO.

Article XI, MCO Grievances and Appeals, Section D.1.c is amended to read:

- c. Denial of Payment for a Service

The MCO must mail or hand deliver written notice of action

<https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm> to an affected member when the MCO intends to deny a member's request for payment of a service included in the benefit package. Although the MCO may pay for a service that is outside of the benefit package under the circumstances set forth in Article VII, Section A.7., an MCO is not required to provide a notice of action when it denies a member's request for payment of such a service. The MCO is however required to inform members in writing when a request for payment of a service outside of the benefit package is denied. The MCO must utilize DHS' Notification of Non Covered Benefit template

(<https://www.dhs.wisconsin.gov/forms/f0/f01283.doc>) and must maintain a copy of this completed form in the member's file.



Denial of payment for an item meeting the definition of medical equipment or appliances (Article I.86) or medical supplies (Article I.87) shall be treated by the MCO as a denial of a benefit package service regardless of whether the item is on the Forward Health Durable Medical Equipment Index or the Wisconsin Medicaid Index of Disposable Medical Supplies or other indices of coverable medical equipment and supplies used by the MCO.

Article XII, Quality Management, Section C.7.b is amended to read:

- b. Annually, each MCO shall make active progress on at least one clinical or non-clinical PIP relevant to long-term care.
 - i. A dual Family Care and Family Care Partnership MCO may fulfill this PIP requirement by one of the following options:
 - 1. One PIP inclusive of both Family Care and Family Care Partnership members; or
 - 2. One PIP for Family Care and one PIP for Family Care Partnership.
 - ii. A Partnership MCO may use a CMS required Quality Improvement Project (QIP) or Chronic Care Improvement Project (CCIP) to meet Department requirements. The MCO must receive Department approval prior to utilizing this option and may submit the request to the Department using the CMS improvement project template.
 - iii. A PACE MCO is not required to submit a PACE PIP to the Department. A PACE MCO may include its PACE members in its Family Care and/or Partnership PIP.

Article XIII, MCO Management, Section G.1.d is amended to read:

- d. Reporting Information on Disclosure

The MCO shall submit ownership and control information on the DHS designated form as required in sub. 1.

The Department must provide this information to CMS upon CMS's request. Failure to provide this required disclosure information puts the federal financial participation (FFP) portion of the capitation payments at risk, and the MCO shall be liable for any penalty or disallowance imposed by CMS resulting from the MCO's failure to report this information as required.

Addendum I, Actuarial Basis, Section B.1.a.i is amended to read:

- i. Criteria

For the purposes of this reimbursement, a ventilator-assisted patient must have died while on total respiratory support (or within 48 hours of removing total respiratory support) or must meet all of the criteria below.



Addendum II, State Reporting Requirements for 2018, Section A.1 is amended to read:

A. Materials with specific due dates – all programs

The following tables are provided for information only. Due dates indicated in the table are based upon reporting requirements as set forth in the contract.

Report	Reporting Period	Due Date	Submit To	Contract Reference
1. Encounter Reporting Submission and Data Certification Forms, as applicable	12/01/17-12/31/17	01/30/18	DHS LTCare IES Encounter Reporting website: https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html	Article XIV.B.
	01/01/18-01/31/18	03/02/18		
	02/01/18-02/28/18	03/30/18		
	03/01/18-03/31/18	04/30/18		
	04/01/18-04/30/18	05/30/18		
	05/01/18-05/31/18	07/02/18		
	06/01/18-06/30/18	07/30/18		
	07/01/18-07/31/18	08/30/18		
	08/01/18-08/31/18	10/01/18		
	09/01/18-09/30/18	10/30/18		
	10/01/18-10/31/18	11/30/18		
	11/01/18-11/30/18	12/31/18		
	12/01/18-12/31/18	01/30/19		

Addendum II, State Reporting Requirements for 2018, Section A.17 is amended to read:

A. Materials with specific due dates – all programs

The following tables are provided for information only. Due dates indicated in the table are based upon reporting requirements as set forth in the contract.

Report	Reporting Period	Due Date	Submit To	Contract Reference
17. IMD Capitation Report	01/01/17-12/31/17	04/06/18	DHS-DMS-BALTCS DHSBMC@wisconsin.gov	Article XIV.C.1; Article XIV.D and Article XVIII.M

Addendum II, State Reporting Requirements for 2018, Section B.3 is amended to read:

B. Materials with specific due dates – Partnership and PACE

The following tables are provided for information only. Due dates indicated in the table are based upon reporting requirements as set forth in the contract.



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Report	Reporting Period	Due Date	Submit To	Contract Reference
3. IMD In Lieu Of Service Report	01/01/16-12/31/17	06/08/18	DHS-DMS-BALTCS DHSBMC@wisconsin.gov	Article XIV.C.1; Article XIV.D and Article XVIII.M

Addendum VIII, Benefit Package Service Definitions, Section B.9 is amended to read:

9. **Medicare deductible and coinsurance amounts** for a dual eligible Family Care member, the MCO shall pay any deductible, coinsurance or copayment amount for a Medicare service that Medicaid would pay for fee-for-service recipients, if the service is also a Medicaid State Plan service in the Family Care benefit package. For non-network providers, the MCO must remit Medicare deductible and coinsurance amounts to providers if the claim is submitted within 365 days from the date of service or 90 days from Medicare disposition, whichever is later, in accordance with Wis. Admin. Code § DHS 106.03.

Addendum IX, Direct Care Workforce Funding Dates, is added:

IX. Direct Care Workforce Funding Dates

Materials with specific due dates – all programs

The following table contains the deadlines required of the MCO, providers, and Department for the Direct Care Workforce Funding.

Deliverable	Payment	Due Date	Submit To	Contract Reference
1. Deadline for MCOs to send DHS initial list of providers and encounters to be used in DCW calculations.	Quarter 1	05/31/18	DHSLTCFiscalOversight@dhs.wisconsin.gov	Article VIII.L.9.e
	Quarter 2	08/31/18		
	Quarter 3	11/30/18		
	Quarter 4	05/31/19		
2. Target date for DHS to issue DCW payments to MCOs.	Quarter 1	06/29/18	Not applicable	Article VIII.L.9.c
	Quarter 2	09/28/18		
	Quarter 3	12/21/18		
	Quarter 4	06/28/19		
	Final	12/20/19		



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Deliverable	Payment	Due Date	Submit To	Contract Reference
3. Deadline for MCOs to distribute DCW funding to providers.	Quarter 1	08/15/18	Not applicable	Article VIII.L.9.h
	Quarter 2	10/31/18		
	Quarter 3	01/31/19		
	Quarter 4	07/31/19		
	Final	01/31/20		
4. Deadline for MCOs to send provider attestation and survey to providers.	Quarter 1	08/15/18	As indicated in MCO subcontract with provider.	Article VIII.L.9.l
	Quarter 2	10/31/18		
	Quarter 3	01/31/19		
	Quarter 4	07/31/19		
5. Deadline for MCOs to return to the Department Quarter 1 funds for providers that did not sign the provider agreement.	Quarter 1	08/31/18	DHSLTCFiscalOversight@dhs.wisconsin.gov	Article VIII.L.9.h
6. Deadline for MCOs to return to the Department the MCO accounting records and attestations	Quarter 1	9/1/18	DHSLTCFiscalOversight@dhs.wisconsin.gov	Article VIII.L.9.n
	Quarter 2	12/1/18		
	Quarter 3	3/1/19		
	Quarter 4	9/1/19		
	Final	2/1/20		
7. Deadline for providers to distribute DCW funding to direct care workers.	Quarter 1	09/14/18	Not applicable	Article VIII.D.31.b.ii
	Quarter 2	12/15/18		
	Quarter 3	03/18/19		
	Quarter 4	09/13/19		
	Final	03/16/20		
8. Deadline for providers to respond to attestation and survey and still be eligible for the next DCW payment.	Quarter 1	09/14/18	Providers to respond to online survey created by the Department.	Article VIII.D.31.c.ii
	Quarter 2	12/15/18		
	Quarter 3	03/18/19		
	Quarter 4	09/13/19*		
	*This is the final attestation and survey providers must respond to.			



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Wisconsin Department of Health Services, Division of Medicaid Services
And **<< MCO >>**

Deliverable	Payment	Due Date	Submit To	Contract Reference
9. Deadline for providers to complete attestation and survey to avoid having DCW funds recouped.	All Quarters	09/13/19	Providers to respond to online survey created by the Department.	Article VIII.D.31.b.v .1
10. Deadline for MCOs to return to DHS the funds recouped from providers.	All Quarters	12/01/19	DHSLTCFiscalOversight@dhs.wisconsin.gov	Article VIII.L.9.j

THIS CONTRACT AMENDMENT SHALL BECOME EFFECTIVE UPON SIGNING.

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

Executed on behalf of
<< MCO >>

Executed on behalf of
Department of Health Services

<<CEO / Director>>
Chief Executive Officer

Heather K. Smith, Medicaid Director
Division of Medicaid Services

Date

Date