CONTRACT FOR SERVICES
between
State of Wisconsin Department of Health Services
and
Contractor Name
for
Family Care/Partnership Program

This Contract is between the State of Wisconsin Department of Health Services (DHS), at 1 West Wilson Street, Madison, Wisconsin 53703, and Contractor Name at Contractor Address. With the exception of the terms being modified by this Contract modification, all other terms and conditions of the existing contract, including funding, remain in full force and effect. This Modification, including any and all attachments herein and the existing contract, collectively, are the complete contract of the parties and supersede any prior contracts or representations. DHS and the Contractor acknowledge that they have read the Modification and understand and agree to be bound by the terms and conditions of the existing contract as modified by this action. This Modification becomes null and void if the time between the earlier dated signature and the later dated signature exceeds sixty (60) days, unless waived by DHS.

Contract ID Number:
Contract Amount: See per member per month capitation rates in contract issue January 1, 2020
Contract Term: January 1, 2020 to December 31, 2021
Optional Renewal Terms: N/A

DHS Division: Division of Medicaid Services
DHS Contract Administrator: Dana Raue
DHS Contract Manager: Dana Raue

Contractor Contract Administrator:
Contractor Telephone:
Contractor Email:

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

Effective January 1, 2020

Preamble

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This contract is entered into between the State of Wisconsin represented by its Division of Medicaid Services, of the Department of Health Services, whose principal business address is One West Wilson Street, P.O. Box 309, Madison, Wisconsin, 53701-0309, and <<Generic>> Managed Care Organization, hereafter MCO, whose principal business address is <<Address>>.

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Article III, Eligibility

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E. Room and Board

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4. Implementing Contingencies if the Member Lacks Funds for Room and Board

If the member lacks sufficient income available to pay room and board in the facility, the MCO either:

a. Develops an alternative plan of care to support the member's needs and outcomes; or

b. May contribute to the member's payment to the facility. The MCO may use its discretion to determine an amount to contribute to the member's room and board obligation. Any MCO contribution to a member's room and board obligation from capitation revenue shall not be considered a countable expense in developing MCO capitation rates.

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Article V, Care Management

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C. Assessment and Member-Centered Planning Process

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3. Member-Centered Planning

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g. Member-Centered Plan Signatures

i. Member or Legal Decision Maker Signature

IDT staff shall review the MCP with the member and legal decision maker, if applicable, and obtain the signature of the member or the member's legal decision maker to indicate his/her agreement with the MCP.

If a member declines to sign the MCP, the IDT staff shall:

a) Document in the member record the request to the member to sign the MCP and the reason(s) for refusal; and
b) If the refusal to sign the MCP reflects the member's disagreement with the MCP, the IDT staff shall discuss the issues with the member and provide the member with information on how to file a grievance or appeal.

If the member's record contains documented evidence, including case notes or, when available, documentation from a mental health professional, that obtaining the member's signature on the MCP is detrimental to the member's clinical or functional well-being, the IDT staff shall:

a) Document in the member record the specific reason(s) why the IDT staff and/or mental health professional believe that the member's signature should not be obtained; and
b) At each subsequent MCP review, reevaluate the decision to not obtain the member's signature on the MCP or provide the member with a copy of the MCP.

ii. Provider Signatures

a) Essential Providers

The IDT shall obtain the signatures of all essential waiver service providers. Providers of the following waiver services are essential service providers:

i. Adult Day Care Services;

ii. Day Habilitation Services;

iii. Daily Living Skills Training;

iv. Prevocational Services;

v. Adult residential care (adult family homes, community-based residential facilities, residential care apartment complexes);

vi. Respite;

vii. Skilled nursing services RN/LPN;

viii. Supported employment (individual and small group employment support); and

ix. Supportive home care (excluding routine chore services).

b) Non-Essential Providers

For non-essential providers, the MCO must attach a copy of the provider's current signed provider agreement or service authorization to the MCP.

iii. Methods and Frequency for Obtaining Essential Provider Signatures

Acceptable methods to obtain essential provider signatures are: electronic, telephonic, secure email, mail, fax, electronic access through a case management system, and face-to-face.

Signatures shall be obtained at the initial MCP development and annually. A signature must be obtained from a new essential provider when that provider is added to the MCP.

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G. Reassessment and MCP Update

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2. MCP Update

The IDT shall review, update, and obtain the member's signature or the signature of the member's legal decision maker on the MCP and review and update the service authorization document periodically as the member's outcomes, preferences, situation and condition changes, but not less than the end of the sixth month after the month in which the previous MCP review and update occurred.

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Article VIII, Provider Network

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D. Provider Agreement Language

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), individual and group supported employment, prevocational employment, vocational futures planning, 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, assisting with employment activities and skills, 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:

a) Wage increases;

b) Retention/longevity bonuses;

c) Performance bonuses;

d) Employee paid time off;

e) Staff referral bonus;

f) Sign on bonus;

g) Supplemental payments to workers during the declared state of emergency in response to the COVID-19 pandemic that are above and beyond a worker's normal reimbursement for hours worked.

ii. That providers must complete making payments to direct care workers within 6 months of receiving the payment from the MCOs they contract with.

iii. That providers may claim expenditures they made in the 12 months prior to receiving the direct care workforce payment 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 and Family Care Partnership members in Wisconsin.

v. 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

vi. 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

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.

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. Subject to iii. below, the provider is only eligible for direct care workforce funding if they have a contract with the MCO to provide Family Care or Family Care Partnership 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. If an MCO discontinues operations in a geographic service region in which the provider is located, providers remain eligible for direct care workforce funding from that MCO if they had a contract with that MCO to provide the specified Family Care or Family Care Partnership services 30 days prior to that MCO discontinuing operations in the geographic service region.

e. Changes in Provider Identification

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.

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L. Payment

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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 a provider 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),individual and group supported employment, prevocational employment, vocational futures planning, 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 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 amounts per 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 will be communicated by the Department.

d. Encounters submitted after the Department's data pull for the payment calculation in one claims period will be included in the data pull for the payment calculation in a subsequent claims period, as appropriate.

e. As requested by the Department, the MCO shall 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 for each claims period, the Department will:

i. Calculate the direct care workforce percentage increase by dividing the Direct Care Workforce funding allocated to the claims period in Article VIII.L.9.b. by the sum of the cost of all direct care workforce encounters within the dates of service for the claims period and, as appropriate, any encounters not included in prior payment calculations. As necessary, the costs from encounters that span more than one claims period will be allocated between periods based on the number of days of service which occurred in each period.

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 deadlines established by the Department. The Direct Care Workforce payment will be in addition to the provider's negotiated payment rate. The MCO shall return any direct care workforce payments for providers who have not returned a signed provider agreement according to deadlines established by the Department.

i. The MCO shall only distribute direct care workforce payments to those providers from whom the MCO has received a signed provider agreement and whom:

i. The MCO still contracts for provision of services to Family Care or Family Care Partnership members in Wisconsin; or

ii. If an MCO discontinues operations in a geographic service region, the MCO had a contract with the provider to provide the specified Family Care or Family Care Partnership services 30 days prior to the MCO discontinuing operations in the geographic service region in which the provider is located. This provision applies to any successor organization that assumed the financial or legal obligations of the MCO that discontinued operations in the geographic service region.

j. 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.

k. 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 Department will include funds returned to the Department in subsequent direct care workforce payment calculations.

l. The Department will use funds returned to the Department under Article VIII.L.9.k. for future direct care workforce payments.

m. 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

n. The MCO shall provide to the Department the following items by deadlines established by the Department:

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.

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M. Appeals to the MCO and Department for Payment/Denial of Providers Claims

2. Provider Appeals to the Department

c. Appeals to the Department are submitted by:

Fax: (608) 266 - 5629

Or

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

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Article XVII, Fiscal Components/Provisions

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E. Financial Audit

5. *Submission of the Audit Reports*

The audit report should be submitted electronically in PDF format to DHSLTCFiscalOversight@dhs.wisconsin.gov.

If the MCO is unable to submit the report electronically, then two complete paper copies must be mailed to:

Director
Department of Health Services
Bureau of Rate Setting
1 West Wilson Street, Room 472
P.O. Box 309
Madison, WI 53701-0309

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Article XVIII, Payment to the Managed Care Organization

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E. Pay for Performance

The Department will implement a pay for performance mechanism in 2020. This incentive applies only to CY 2020 and will not be renewed automatically. The pay for performance withhold payments, as described in Article XVIII.E.1.c will be based on results from the member satisfaction survey. MCOs may additionally be eligible for an incentive payment based on results from the member satisfaction survey and assisted living quality improvement incentive. The following programs and any payments thereunder are expressly contingent upon receiving federal approval for the programs.

The withhold and incentive percentages will be applied to the MCO's capitation rate before reductions for the high cost risk pool and member cost share. The payment amounts will be calculated based on the Long Term Care Functional Screen and enrollment data used to develop capitation rates for the next contract year. The payment amounts will reflect the Target Group Mix and Long-Term Care Functional Status retrospective adjustments.

1. Member Satisfaction Survey

   a. Criteria

      The Department will conduct a member satisfaction survey that will be sent to a sample of each MCO's members in the 3rd quarter of 2020. The pay for performance criteria will be based on four questions that are part of the complete survey. The four questions will assess:

      i. Member access to services

      ii. Member participation in the care planning process

      iii. Member satisfaction with care plan/team

      iv. Member satisfaction with services

      The Department will establish benchmarks and minimum performance standards for each of the four questions based on previous member satisfaction surveys. The MCOs will be notified of what the benchmarks are prior to survey distribution. If the responses and results of the survey show an MCO has met the minimum performance standard for a survey question, the portion of the capitated rate withheld for that question will be returned to the MCO. If an MCO meets the minimum performance standards for all four questions and meets or exceeds the targeted performance benchmark for one or more questions, the MCO will receive the entire amount withheld from the capitation rate and will receive an incentive payment to their capitated rate.

   b. Notification of Survey Results

      The Department shall notify each MCO of their survey results upon compilation.

   c. Methodology

      All MCOs will have 0.25% of their calendar year 2020 capitation rate withheld to be returned based on the MCO's performance on the member satisfaction survey. The MCO will receive one fourth of the 0.25% withheld from the capitation rate for each survey question in which they meet the minimum performance standard set by the Department. MCOs that meet the minimum performance standards for all four questions will earn back all of the 0.25% withheld from the rate. MCOs will earn a 0.05% performance enhancement to their rate for each targeted performance benchmark they meet. The survey results used to make payments will be based on a statistically significant sample at the MCO level. Payments under this section will be made by December 31, 2021.

Survey Question	Meets Minimum Performance Standard	Meets Targeted Performance Benchmark
	MCO will earn 0.0625% withhold for each survey question for which it meets the minimum performance	The MCO must meet the minimum performance standards for all 4 survey questions to qualify for an

	standard up to a total of 0.25%.	enhanced performance payment for meeting any one of the target performance benchmarks for the 4 survey questions. The MCO will earn 0.05% incentive payment for each survey question for which it meets the targeted performance benchmark up to a total of 0.20%.
1. Member access to services	0.0625% withhold returned	0.05% incentive payment
2. Member participation in the care planning process	0.0625% withhold returned	0.05% incentive payment
3. Member satisfaction with care plan/team	0.0625% withhold returned	0.05% incentive payment
4. Member satisfaction with services	0.0625% withhold returned	0.05% incentive payment

2. Assisted Living Quality Improvement Incentive

a. Criteria

MCOs may receive an incentive payment for each member residing in an assisted living facility if the assisted living facility satisfies one of two qualifying incentive criteria:

i. Incentive Criteria 1: Qualifies for the abbreviated Division of Quality Assurance survey and is compliant with Home and Community-Based Services settings rule; or

ii. Incentive Criteria 2: Qualifies for the abbreviated Division of Quality Assurance survey, is compliant with the Home and Community-Based Services settings rule, is a member in good standing with Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL), and has a rate of less than 3 falls with injury per 1000 occupied bed days from January 1, 2020, through December 31, 2020, as documented by WCCEAL. A fall with injury means a fall that results in an injury requiring medical treatment.

b. Reporting Requirement

The MCO must submit the completed template to the Department by January 31, 2021.

c. Amount of Incentive Payment

The amount of the per member incentive payment will be determined by the Department on a per-member basis. The total amount to be distributed for the assisted living quality improvement incentive is $2 million. One million dollars will be allocated to each incentive criteria (3.a.i. and 3.a.ii.). MCOs will only receive one payment per member living in an eligible assisted living facility; for

members that reside in an assisted living facility that meets the criteria under 3.a.ii., the MCO will receive a payment only from the funding allocated to 3.a.ii.

MCOs receiving the assisted living quality improvement incentive payment must report to DHS how they spent, or intend to spend, the incentive funds by June 30, 2021.

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State of Wisconsin **Department of Health Services**		**Contractor** Contractor Name:	
Authorized Representative		Authorized Representative	
Name:	James D. Jones	Name:	
Title:	Medicaid Director	Title:	
Signature:		Signature:	
Date:		Date:	