CONTRACT FOR SERVICES
between
State of Wisconsin Department of Health Services (DHS)
and
PACE ORGANIZATION
for
PACE

This Contract is between the State of Wisconsin Department of Health Services (DHS), at 1 West Wilson Street, Madison, Wisconsin 53703, and Community Care, Inc. at 205 Bishops Way, Brookfield, WI 53005. 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: 435400-W20-PACE-00
Contract Amount: See per member per month capitation rates in this amendment
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: John Kivisaari

Contractor Contract Administrator:
Contractor Telephone:
Contractor Email:

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

Effective January 1, 2021

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 Community Care, Inc., PACE organization, whose principal business address is 205 Bishops Way, Brookfield, WI 53005.

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Article II. PACE Organization Governance and Consumer and Member Involvement

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C. Tribal Liaison

The PO shall designate one member of their staff to act as the Tribal Liaison. The Tribal Liaison will serve as the main point of contact between the PO and the Department and the PO and each tribe for all tribal issues. The PO must provide contact information for the Tribal Liaison to the Department and to each tribe in Wisconsin.

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Article III. Eligibility

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C. Medicaid Deductibles or Cost Share

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2. *Cost Share or Patient Liability*

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c. The PO is responsible for collecting the members' monthly cost share or patient liability, subject to the following Department policies and procedures:

i. The PO will send a bill to any member who has a cost share or patient liability in advance of or as early as possible during the month in which the cost share or patient liability is due.

Members who were enrolled in IRIS as of the first day of the month in which they transition to PACE, generally pay the cost share amount for that month to their IRIS fiscal employer agent. If the PO capitation payment was offset by the cost share amount for that month, the PO will attempt to verify whether the member paid his or her cost share to an IRIS fiscal employer agent. If the PO has documentation to verify the member paid the cost share to the fiscal employer agent, the PO may request a capitation payment adjustment on an enrollment discrepancy report.

ii. Cost share and patient liability are not prorated for partial months.

iii. The system logic that determines a member's patient liability amount can offset either a capitation payment or a Nursing Home Fee-for-Service (NH FFS) claim, but not both. ForwardHealth automatically deducts the appropriate monthly patient liability amount from the first NH FFS claim or capitation payment received for the member. (See ForwardHealth Online Handbook topic #3188: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx).

Generally, when members residing in a NH are enrolled into a PO and the enrollment includes past months, the NH FFS claim will be offset by the patient liability amount for the past month(s), and the subsequent capitation payment(s) for the past month(s) will not be offset by the patient liability amount. However, this depends on when the NH FFS claim is submitted and processed in the system, so the PO should monitor the 820 transaction to determine whether or not the patient liability amount was used to offset the capitation payment.

If the patient liability amount was used to offset the capitation payment, the PO should collect the liability amount.

The PO 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 PO will attempt to collect the patient liability amount from the member when the 820 Report indicates the capitation payment was offset by the patient liability amount, the paid FFS NH claim was not offset by the patient liability amount, and the member did not pay the patient liability to the nursing home.

The PO will transfer 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 PO.

iv. If a member fails to pay the cost share or patient liability as billed by the due date, the PO will:

a) Contact the member to determine the reason for non-payment.

b) Remind the member that non-payment may result in loss of Medicaid eligibility and disenrollment unless the member becomes a private pay PACE member.

c) Attempt to convince the member to make payment or negotiate a payment plan.

d) Offer the member assistance with financial management services or refer the member for establishment of a representative payee or legal decision maker if needed.

e) If all efforts to assist the member to meet the financial obligation are unsuccessful, refer the situation to the income maintenance agency for ongoing eligibility determination and the ADRC for options counseling.

f) For a member with a cost share, inform the member that if he or she is having a financial hardship, he or she may file an Application for Reduction of Cost Share with the Department, requesting that it be reduced or waived (see Addendum VII.10.). The PO shall also offer to assist the member in completing and submitting the Application.

d. The PO shall reimburse members for cost share or patient liability amounts that were collected by the PO that need to be returned to the member.

i. The income maintenance agency or the Department will retroactively adjust the member's cost share amount in CARES. Once the PO is informed of retroactive adjustment of the member's cost share or patient liability, the PO must reimburse the member for the incorrectly collected cost share or patient liability amount within 30 calendar days.

ii. If the cost share retroactive adjustment is within the past 365 days, FHiC will adjust the PO's capitation payment. If the retroactive adjustment is more than 365 days, the PO may need to contact the Department via the enrollment discrepancy mailbox for an adjustment in capitation payment.

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D. 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 PO 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. Any PO contribution to a member's room and board obligation from capitation revenue shall not be considered a countable expense in developing PACE capitation rates.

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Article IV. Enrollment and Disenrollment

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B. Disenrollment

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3. *Processing Disenrollments*

a. The enrollment plan, developed in collaboration with the resource center and income maintenance agency, shall be the agreement between entities for the accurate processing of disenrollments.

b. The PO shall fully cooperate with other agencies and personnel with responsibilities for eligibility determination, eligibility re-determination, and enrollment in the PO. This includes but is not limited to the resource center, income maintenance and the enrollment consultant if any.

c. The PO shall participate in the Department's annual review and revision of the enrollment/disenrollment resource guide, which describes how the agencies will work together to assure accurate, efficient, and timely eligibility determination, eligibility re-determination, enrollment and disenrollment in the PO. The enrollment/disenrollment resource guide shall describe the PO's responsibility to timely report known changes in members' level of care, finances, or other circumstances that may affect eligibility, and the manner in which to report those changes.

4. *Discriminatory Activities*

Enrollment continues as long as desired by the eligible member regardless of changes in life situation or condition, until the member voluntarily disenrolls, loses eligibility, or is involuntarily disenrolled according to terms of this contract.

The PO may not discriminate in enrollment and disenrollment activities between individuals on the basis of age, disability, association with a person with a disability, national origin, race, ancestry or ethnic background, color, record of arrest or conviction which is not job related, religious belief or affiliation, sex or sexual orientation, marital status, military participation, political belief or affiliation, use of legal substance outside of work hours, life situation, condition or need for long-term care or health care services. The PO shall not discriminate against a member based on income, pay status, or any other factor not applied equally to all members, and shall not base requests for disenrollment on such grounds.

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Article V. Care Management

A. Member Participation

The PO is expected to ensure that the member, the member's legal decision maker and any other persons identified by the member will be included in the care management processes of assessment, member outcomes identification, member-centered plan development, and reassessment. This process must reflect cultural considerations of the individual and must be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities through the provision of auxiliary aids and services at no cost to the individual and for persons who are limited English proficient through the provision of language services at no cost to the member. The PO shall provide information, education and other reasonable support as requested and needed by members, other persons identified by the member or legal decision makers in order to make informed long-term care and health care service decisions. If the member's enrollment form indicates the member is an American Indian/Alaskan Native, the PO must ask the member if he/she would like to invite a representative from his/her tribe to participate in the care management process.

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C. Assessment and Member-Centered Planning Process

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1. *Comprehensive Assessment*

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b. Procedures

i. The PO shall use an assessment protocol that includes an in person interview in the member's current residence by the IDT social worker, PCP, and registered nurse every twelve (12) months (or every six (6) months for a vulnerable/high risk member) with the member and other people identified by the member as important in the member's life.

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3. *Member-Centered Planning*

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c. Documentation

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iv. The MCP shall document at least the following:

a) The member's personal experience and long term care outcomes;
b) The member's strengths and preferences;
c) The frequency of in person and other contacts, consistent with the minimums required by Article V.H, and an explanation of the rationale for that frequency. These figures and the supporting rationale shall be based upon the assessment of the complexity of the member's needs, preferences, risk factors including potential vulnerability/high risk, and any other factors relevant to setting the frequency of in person visits;

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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.

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D. Timeframes

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1. *Initial Assessment and MCP Timeframes*

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b. Initial Contact

The PO shall contact the member (in person or via telephone) within three (3) calendar days of enrollment to:

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v. Schedule an in person contact with the IDT and member.

c. Initial Assessment

Within ten (10) calendar days from enrollment, the IDT shall meet in person with the member to:

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E. Providing, Arranging, Coordinating and Monitoring Services

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4. *Monitoring Services*

IDT staff shall, using methods that include in person and other contacts with the member, monitor the services a member receives. This monitoring shall ensure that:

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G. Reassessment and MCP Update

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3. *MCP Update*

The IDT shall review and update the MCP and 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. The IDT shall obtain the member's signature or the signature of the member's legal decision maker.

H. Interdisciplinary Team and Member Contacts

1. *Minimum Required In Person Contacts*

IDT staff shall establish a schedule of in person contacts based upon the complexity of the member's needs and the risk in the member's life including an assessment of the member's potential vulnerability/high risk per Article V.J.1. At minimum, IDT staff is required to conduct an in person visit with a member every three months. The IDT social worker, registered nurse, and PCP are required to conduct an in person visit in the member's residence at minimum:

a. Every twelve (12) months as part of the reassessment; and

b. Every six (6) months for vulnerable/high risk members as part of the reassessment. The

scheduled reassessment visits count for two of the in person contacts required by this subsection. The PO shall notify the DHS assigned oversight team of members

who meet the vulnerable/high risk criteria but refuse in person visit(s) in their primary residence.

2. Minimum Required Telephone or Live Video Messaging Contacts

For any month in which there is not an in person meeting with the member, IDT staff is required to make telephonic or live video contact with the member, the member's legal decision maker, or an appropriate person associated with the member (for example, a provider, friend, neighbor, or family member) who has been authorized by the member or the member's legal decision maker to speak with IDT staff. IDT staff shall document that each telephone or live video contact covered all aspects of service monitoring as required under section V.E.4., including assuring the member is receiving the services and supports authorized, arranged for and coordinated by the IDT staff and the services and supports identified in the MCP as being provided by natural and community supports are being provided, and that the quality of the services and supports received is adequate and still necessary to continue to meet the needs and preferences of the member and support the member's outcomes identified in the MCP. For live video messaging to be used it must occur in real time and be interactive. The PO may not record the live video conference with the member without prior consent from the member; if consent is given orally, the PO shall follow-up with the member or the member's legal decision maker to confirm the consent in writing. The plan for member's contacts should be discussed with the member, follow PO policy and be documented in the member's record.

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K. Service Authorization

1. *Service Authorization Policies and Procedures*

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e. Remote Waiver Services and Interactive Telehealth

i. Remote Waiver Services

Remote waiver services means waiver services delivered using audiovisual communication technology that permits 2-way, real-time, interactive communications between a provider and a member. Other than telephonic care management contacts discussed in Article V., remote waiver services does not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail. The IDT cannot require the use of remote services to authorize the service

For services in Addendum VI.A, the IDT must first determine the service is necessary to support an outcome by using the RAD or other Department approved alternative and then determine whether it can be authorized remotely.

To authorize a waiver service for remote delivery, the IDT must:

a) Determine that the service can be delivered remotely with functional equivalence to face to face as the in-person service. Functional equivalence exists when there is no reduction in quality, safety, or effectiveness of the in person service because it is delivered by using audiovisual telecommunication technology.

b) Obtain informed consent from the member to receive the service remotely.

c) Determine that the member has the proper equipment and connectivity to participate in the service remotely. The PO is not required to provide the proper equipment and connectivity to enable the member to access the service remotely.

If the IDT determines that the service cannot be authorized remotely based on the above, the IDT must authorize the service in person. A member may grieve the IDT decision.

POs must include the modifier 95 when the PO submits claims that are delivered remotely.

The following services in Addendum VI.A may not be authorized for remote delivery:

1. Adult Day Care Services
2. Home-delivered meals
3. Residential Care
4. Transportation – Community and Other
5. Relocation Services
6. Self – Directed Personal Care
7. Skilled Nursing Services RN/LPN
8. Specialized Medical Equipment and Supplies

ii. 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 authorizing State Plan services in Addendum VI.B via interactive telehealth, the IDT must provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to the member under fee for service Medicaid.

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Article VI. Self-Directed Supports

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B. PACE Organization Requirements

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9. Develop and implement a Department-approved policy and procedure describing conditions under which the PO may restrict the level of self-direction exercised by a member where the team finds any of the following:

   a. The health and safety of the member or another person is threatened.

   b. The member's expenditures are inconsistent with the established plan and budget.

   c. The conflicting interests of another person are taking precedence over the outcomes and preferences of the member.

   d. Funds have been used for illegal purposes.

e. The member has been identified as a Vulnerable/High Risk member and insufficient measures have been taken to mitigate risk.

f. The member refuses to provide access to the home or otherwise refuses to provide information necessary for the IDT to adequately monitor member health and safety.

g. Additional criteria for restricting the level of self-direction exercised by a member may be approved by the Department in relation to other situations that the PO has identified as having negative consequences.

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C. IDT Staff Responsibilities

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It is the responsibility of the IDT staff to provide:

1. Information regarding the philosophy of SDS and the choices available to members within SDS. The information provided to members must include:

a. A clear explanation that participation in SDS is voluntary, and the extent a.to which members would like to self-direct is the members' choice;

b. A clear explanation of the choices available within SDS;

c. An overview of the supports and resources available to assist members to participate to the extent desired in SDS;

d. An explanation of the member's right to request a grievance, as specified in Article XI.F.4., if the IDT denies the member's request to self-direct a service; and

e. An overview of the conditions in which the PO may limit a member's existing level of self-direction, the actions that would result in the removal of the limitation, and the member's right to request a grievance, as specified in Article XI.F.4. if he or she disagrees with the PO's decision to limit the member's existing level of self-direction.

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Article VII. Services

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J. Prevention and Wellness

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2. *Prevention and Wellness Programs*

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b. Practice Guidelines

Practice guidelines are guidelines that are developed in consultation with network providers to assist them to apply the current best evidence in making decisions about the care of individual members. The PO will review and update practice guidelines periodically, as appropriate.

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Article VIII. Provider Network

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D. Provider Agreement Language

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15. *Authorization for Providing Services*

The provider agreement directs the provider on how to obtain information that delineates the process the provider follows to receive authorization for providing services to members. The PO agrees to clearly specify authorization requirements to its providers and in any provider agreements with its providers.

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25. *Telehealth or Remote Waiver Services*

The provider may not require the member to receive a service via interactive telehealth or remotely if in person service is available.

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J. Change in Providers

1. *Required Notifications*

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b. Notice to members and Resource Centers

i. The PO must make a good faith effort to give written notice of termination of a contracted provider, by the later of 30 calendar days prior to the effective date of the termination or fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who received his/her primary care from, or was seen on a regular basis by, the terminated provider.

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

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2. *Provider Appeals to the Department*

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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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N. Standards for PACE Organization Staff

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2. *Relatives and Legal Guardians*

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f. There is a properly executed provider agreement;

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Article IX. Marketing and Member Materials

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E. Accessible Formats and Languages and Cultural Sensitivity

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1. *Accessible Language*

a. All written materials for potential members must include taglines in the prevalent non-English languages in the State, as well as conspicuously visible font explaining the availability of written translations or oral translation to understand the information, the toll free number of the resource center providing choice

counseling, and the toll free and TTY/TDY telephone number of the PO's member/customer service unit. DHS shall determine the prevalent non-English languages in each service area.

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2. *Materials Easily Understood and Accessible*

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d. Include conspicuously visible taglines and information on how to request auxiliary aids and services, including the provision of materials in alternative formats and the toll free and TTY/TDY telephone number of the PO's member/customer service unit.

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Article XI. Grievances and Appeals

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B. Definitions

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1. *Adverse benefit determination*

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b. An "adverse benefit determination" is not:

i. A change in provider;

ii. A change in the rate the PO pays a provider;

iii. A termination of a service that was authorized for a limited number of units of service or duration of a service as defined in Article V.K.3.a. and b.; or

iv. 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 in regard to whether he/she is a member of the group impacted by the change.

v. The denial of authorization for remote delivery of a waiver service or a state plan service delivered via interactive telehealth.

vi. The denial of a member's request to self-direct a service or the limitation of a member's existing level of self-direction.

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C. Overall Policies and Procedures for Grievances and Appeals

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4. *Provision of Case File*

The PO must ensure that the member is aware that he or she has the right to access his or her case file, free of charge, and to be provided with a free copy of his or her case file. "Case file" in this context means all documents, records, and other information relevant to the PO's adverse benefit determination and the member's appeal of that adverse benefit determination. This includes, but is not limited to, medical necessity criteria, third party records the PO relied upon to make a service authorization decision, functional screen results, any processes, strategies, or evidentiary standards used by the PO in setting coverage limits and any new or additional evidence considered, relied upon, or generated by the PO (or at the direction of the PO) in connection with the appeal of the adverse benefit determination. This information must be provided to the member sufficiently in advance of the appeal resolution timeframes described in Article XI.F.5.e. and f.

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E. Notification of Appeal Rights in Other Situations

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3. Requirement to Provide Notification of Appeal Rights

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c. Other Adverse Benefit Determinations

A member has the right to appeal the other adverse benefit determinations identified in Article XI.B.1.a.v.-viii. On the date it becomes aware of any such adverse benefit determination, the PO shall mail or hand deliver to the member a written notification of the right to appeal these adverse benefit determinations."

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F. PACE Organization Grievance and Appeal Process

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5. *PACE Organization Process for Appeals*

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c. Acknowledgement of Appeal Receipt

The PO must provide written acknowledgement of receipt for each appeal. The PO must use the Department issued template language in its written acknowledgment, which includes the date the PO will make a decision on the member's appeal and that the member can request a State Fair Hearing if the PO does not provide the member with its decision by that date. Additionally, for oral appeals, the MCO must include a written summary of the member's appeal request.

The acknowledgement must be provided to the member, person acting on the member's behalf, or the member's legal decision maker, if applicable;~~,~~ and it must be mailed or hand delivered within five (5) business days of the date of receipt of the appeal. See Article XI.F.5.a.i. for a description of individuals who may be authorized to submit an appeal.

d. Procedures

i. A member can request an appeal orally or in writing. The PO must document all appeals – oral or written – to establish the earliest possible filing date for the member.

ii. When processing expedited appeal requests, the PO is not required to seek written follow-up from the member. Upon receipt, the expedited appeal should be adjudicated within its limited timeframe.

iii. Unless contrary to the expressed desire of the member, the PO must attempt to resolve all appeals through internal review, negotiation, or mediation.

iv. An appeal that cannot be resolved through internal review, negotiation, or mediation, must be reviewed by the PO grievance and appeal committee.

v. A member who files an appeal must be given the right to appear in person before the grievance and appeal committee.

vi. The PO grievance and appeal committee will make its determinations related to authorization of services based on whether services are necessary to support outcomes as defined in Article I, Definitions.

vii. The PO grievance and appeal committee must make a decision on an appeal as expeditiously as the member's situation and health condition requires. The PO must mail or hand deliver notification of the decision with an effective date of implementation of the decision not less than fifteen (15) calendar days from the date of the decision.

Article XIII. PACE Organization Administration

A. Member Records

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9. *Contents of Member Records*

a. Face sheet of demographic information;
b. Consent forms;
c. Comprehensive health assessment;
d. Comprehensive social assessment;
e. Documentation of re-assessment(s);
f. Member-centered plan;
g. Copy of advance directive document (if applicable);
h. Copy of signed guardianship order (if applicable);
i. Copy of activated power of attorney document (if applicable);
j. Case notes by PACE interdisciplinary team members;
k. Cost share forms/documentation (if applicable);
l. Notice of change forms (if applicable);
m. Signed enrollment request;
n. Reports of consultations;
o. Third party records relied upon to make a service authorization decision;
p. Notification of the results or outcomes of an investigation described by Article V.J.5.b.xiii; and
q. Copy or documentation of member's most up to date DVR coordination plan (if applicable).

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D. Management of Subcontractors and Providers

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2. *Quality Monitoring of Providers Regulated by the Division of Quality Assurance (DQA)*

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b. Identify provider deficiencies or areas for improvement (inclusive of monitoring statements of deficiency (SOD) issued by the Department of Health Services, Division of Quality Assurance).

i. The PO shall have specific SOD review processes in place to address SODs with significant enforcement action, such as: provider visit verification, no new admission orders, impending revocations, repeat citations, immediate jeopardy with unresolved deficiencies, or situations of actual serious harm or risk for serious harm to members not already identified via the PO's internal critical incident reporting system.

Q. Supplier Diversity and Reporting Requirements

Minority-Owned Business Enterprises (MBE) and Disabled Veteran-Owned Businesses (DVB) are certified by the Wisconsin Department of Administration (DOA). This program can be found at: https://doa.wi.gov/Pages/DoingBusiness/SupplierDiversity.aspx

The State of Wisconsin is committed to the promotion of MBEs and DVBs in the State's purchasing program. The PO is strongly urged to use due diligence to further this policy by awarding Subcontracts to MBEs and DVBs or by using such enterprises to provide goods and services incidental to this Agreement.

The PO-shall furnish appropriate monthly information about its efforts to subcontract with MBEs and DVBs, including the identities of such businesses certified by the Wisconsin Supplier Diversity Program, their contract amount, and spend for each period to DHS. A listing of certified MBEs and DVBs, as well as the services and goods they provide, is available at: https://wisdp.wi.gov/Search.aspx

In accordance with WI Stats. Ch. 16.75 (3m), after completion of this contract, the PO shall report to DHS any amount of this contract that was subcontracted to DOA certified MBEs and DVBs.

DHS shall have the right to request any information regarding the use of subcontractors including, but not limited to, MBEs and DVBs. The PO shall provide any such information as requested by DHS and within a time period that is specified by DHS.

The PO shall submit monthly reports of efforts to subcontract with MBEs, DVBs, and other diverse entities/suppliers to DHS. A link to the Supplier Diversity PowerForm for submitting these reports can be found on the DHS Compliance Documentation page found here:
https://www.dhs.wisconsin.gov/business/compliance.htm

For the duration of this Agreement, the PO shall provide monthly reporting of efforts to subcontract with MBEs and DVBs no later than the 15th of the following month.

For questions about reporting, please contact DHS Contract Compliance at
DHSContractCompliance@dhs.wisconsin.gov

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Article XIV. Reports and Data

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D. Reports: As Needed

The MCO agrees to furnish reports which may be required to administer this contract, to the Department and the Department's authorized agents. Such reports include but are not limited to corporate restructuring or any other change affecting the continuing accuracy of information previously reported by the MCO to the Department. The MCO shall report each such change in information as soon as possible, but not later than thirty (30) calendar days after the effective date of the change. Changes in information covered under this section include all of the following:

- Any change in information relevant to Article XIII.H, Ineligible Organizations, page 235.
- Article XIII. G., Required Disclosures.

Article XVII. Fiscal Components/Provisions

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E. Financial Audit

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5. *Submission of the Audit Reports*

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

If the PO 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 VIII. Payment to the PACE Organization

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B. Medicaid Capitation Rates

In full consideration of Medicaid services rendered by the PO for each enrolled member, the Department agrees to pay the PO a monthly capitation rate. The capitation rates shall be based on actuarial standards of practice.

The capitation rates shall include funding to support relocation of members from institutional settings into the most integrated community setting.

The capitation rate shall not include any amount for recoupment of losses incurred by the PO under previous contracts nor does it include services that are not covered under the State Plan.

When the rate cell used to process a member's capitation payment changes in the middle of a month, the Department will use a daily rate to calculate the capitation payment for the member. This daily rate is based on the annualized monthly capitation rate (i.e. monthly capitation rate times twelve months) divided by the number of days in the contracted calendar year and rounded to the fourth digit to the right of the decimal. Payment of the rate is based on the daily rate multiplied by the number of days the member was enrolled for the month and rounded to the nearest cent. Examples of mid-month changes that would require the use of a daily rate to calculate the capitation rate include enrollment and disenrollments between programs or MCOs or POs, and changes in target group, level of care, or dual eligibility status.

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H. Health Insurance Fee Reimbursement – For Rate Year 2020 Only

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Article XIX PACE Specific Contract Terms

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E. Capitation Rate

Waukesha County, Milwaukee County, Racine County

Level of Care	Target Group	Administrative	Long Term Care	Medical
Nursing Home – Monthly (Dual Eligible)	Developmentally Disabled	$xx.xx	$xx.xx	$xx.xx
Nursing Home – Monthly (Dual Eligible)	Physically Disabled	$xx.xx	$xx.xx	$xx.xx
Nursing Home – Monthly (Dual Eligible)	Frail Elder	$xx.xx	$xx.xx	$xx.xx
Nursing Home – Monthly (Non-Dual Eligible)	Developmentally Disabled	$xx.xx	$xx.xx	$xx.xx
Nursing Home – Monthly (Non-Dual Eligible)	Physically Disabled	$xx.xx	$xx.xx	$xx.xx
Nursing Home – Monthly (Non-Dual Eligible)	Frail Elder	$xx.xx	$xx.xx	$xx.xx

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Addendum VII. Materials Cited in This Contract and Other Related Communications

1. Cost Share Cap Memo	https://www.dhs.wisconsin.gov/familycare/mcos/cost-share-cap.htm

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63. Enrollment and Disenrollment Plan for Publicly Funded Long-Term Care Programs, F-00366	https://www.dhs.wisconsin.gov/publications/p02320.pdf

State of Wisconsin

Department of Health Services

Authorized Representative

Name: James D. Jones

Title: Medicaid Director

Signature:

Date:

Contractor

Contractor Name:

Authorized Representative

Name:

Title:

Signature:

Date: