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| DEPARTMENT OF HEALTH SERVICES Division of Medicaid Services F-00152 (01/2020) | | | | |  | | | | | STATE OF WISCONSIN | |
| MCO NOTIFICATION TO PAY OVER THE MEDICAID FEE-FOR-SERVICE REIMBURSEMENT RATE | | | | | | | | | | | |
| Completion of this form meets the contract requirement to notify DHS that the MCO will provide a reimbursement rate over the Medicaid fee-for-service established rate, including paying more than Medicaid fee-for-service would pay when coordinating benefits with other payers. The Division of Medicaid Services will review only requests that are submitted using this form. No Personally identifiable information (PII) is required on this form. A separate form should be submitted for each provider receiving a reimbursement rate over the Medicaid fee-for-service established rate. | | | | | | | | | | | |
| Section 1: Managed Care Organization (MCO) Information | | | | | | | | | | |
| Name - MCO | | | | | Name - Contact Person | | | | | |
| Program  Family Care  Family Care Partnership  PACE | | | | | Telephone Number  (     ) | | | | | |
| Email Address | | | | | | | | | | |
| Section 2: Notification Information (Completed F-00152A must accompany this form) | | | | | | | | | | |
| New Notification  Renewal Notification | | Date of Previous Notification | | | | | | | | |
| If Renewal, Provide Details on Other Options Pursued Since Last Notification | | | | | | | | | | |
| Description of Service | | | | | | | | | | |
| What is the Proposed Rate Based On? | | | | | | | Projected Total Annual Cost (attach [F-00152A](https://www.dhs.wisconsin.gov/forms/f0/f00152a.xls))  $ | | | |
| Rationale for Rate (include if this proposed rate will increase the likelihood for the member achieving outcomes and if the increase is necessary to increase access to services) | | | | | | | | | | |
| Date of Request | Length of Waiver  One-time  Annual | | | | | | | | | |
| Section 3: Provider Information | | | | | | | | | | |
| Type of Provider | | | Is the Provider Medicaid certified?  Yes  No | | | | | Is the Provider Medicare certified?  Yes  No | | |
| Provider ID Type (NPI or EIN) | | | Provider ID (NPI, EIN) | | | | | | | |
| Name - Provider | | | Provider Address (street address, city, state, zip code) | | | | | | | |
| Section 4: Member Information | | | | | | | | | | |
| Request for  Individual or  Multiple member(s) | | | County(ies) of Residence | | | | | | | |
| Explain How this Service will Add Quality or Value to Increase the Likelihood of Achieving the Member’s Outcome | | | | | | | | | | |
| Section 5: Additional Information | | | | | | | | | | |
| List Other Options that have been Explored | | | | | | List Other Providers that have been Contacted | | | | |
| Does this rate increase pose any conflicts of interest? (Is the intended provider a related party or a party the MCO is associated with?)  No  Yes—Explain: | | | | | | | | | | |
| Court Ordered Service  Yes  No | | Language in Court Order (if applicable) | | | | | | | | |
| **Submit completed form either as a part of annual three-year business plan submission or to Department of Health Services, Division of Medicaid Services, Bureau of Rate Setting at the following:**  [**DHSLTCFiscalOversight@dhs.wisconsin.gov**](mailto:DHSLTCFiscalOversight@dhs.wisconsin.gov) **or**  **Director**  **Bureau of Rate Setting**  **Department of Health Services**  **1 West Wilson Street, Room 550**  **PO Box 7851**  **Madison, WI 53707-7851** | | | | | | | | | | |