CONTRACT FOR SERVICES
between
State of Wisconsin Department of Health Services (DHS)
and
Managed Care Organization
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 My Choice Wisconsin Health Plan, Inc. at 10201 West Innovation Drive, Suite 100, Wauwatosa, WI 53226-4822. 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 listed on the website.
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, 2021

Article I. Definitions

3. **Acute and Primary Care Benefit Package:** services covered in Addendum VII.C. that are not also included in Addendum VII.B.

22. **Competitive Integrated Employment (CIE):** Work performed on a full-time or part-time basis; compensated not less than the applicable state or local minimum wage law (or the customary wage), or if self-employment, yields income comparable to persons without disabilities doing similar tasks; the worker should be eligible for the level of benefits provided to other employees; the work should be at a location typically found in the community; where the employee with a

disability interacts with other person who do not have disabilities and are not in a supervisory role, and; the job presents opportunities for advancement.

The minimum criteria that must be met for employment to qualify as CIE for purposes of the Quarterly Employment Data Report described in Article XIV.C.5. and the CIE Pay for Performance initiative described in Article XVIII.E.3. include all of the following:

a) Compensation

i. Wage Employment: Paid at state minimum wage (or local minimum wage if a local ordinance sets the minimum wage higher than the state minimum wage) or higher; or

ii. Self-Employment: Yields income comparable to persons without disabilities doing similar tasks, and for those self-employed at least one (1) year, the income, when calculated on a per hour worked basis, is at least state minimum wage or the customary wage for that type of employment.

b) Location

The work location must be a location typically found in the community:

Excludes locations leased, owned and/or operated by contracted service providers or other entities for the primary purpose of employing and/or providing prevocational or vocational training/rehabilitation to people with disabilities.

c) Interactions

When at the work location, the employee with a disability routinely interacts with co-workers and customers/patrons who do not have disabilities to the same extent as a worker without disabilities filling the same or similar position would interact with co-workers and customers/patrons who do not have disabilities.

Co-workers and customers/patrons do not include supervisors or provider agency staff providing supported employment or personal care supports to the employee with a disability.

d) Individualized Position

The person is employed or self-employed in a distinct position. This means:

i. The person is not sharing a job with another person(s) with disabilities that the business would consider to be one job, unless those sharing a position are working at different times/days.

ii. The person is not working in a team (side by side; same work schedule; identical or virtually identical tasks and duties).

iii. People working in teams of 2 to 8 are considered to be in Group Community Employment, not CIE. This exclusion applies regardless of the service title and billing code used for waiver-funded supports needed to work.

e) Employer of Record

CIE assumes that in the vast majority of cases the employer of record will be the business or organization that:

i. Operates the location(s), typically found in the community (as defined above), where the individual engages in paid work; and

ii. Benefits directly from the work done by the person with a disability.

The only exceptions to this expectation are when:

iii. The business or organization does not typically act as employer of record for other employees without disabilities; or

iv. The business or organization is a government entity, including tribal government, and/or a unionized workplace.

In these two documented situations, the employer of record may be a provider of services.

Article II. MCO Governance and Consumer and Member Involvement

D. Tribal Liaison

The MCO 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 MCO and the Department and the MCO and each tribe for all tribal issues. The MCO must provide contact information for the Tribal Liaison to the Department and to each tribe in Wisconsin.

Article III. Eligibility

D. Medicaid Deductible or Cost Share

2. *Cost Share or Patient Liability*

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

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

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

b) Remind the member that non-payment may result in loss of eligibility and disenrollment.

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 VIII.10.). The MCO shall also offer to assist the member in completing and submitting the Application.

d. The MCO shall reimburse members for cost share or patient liability amounts that were collected by the MCO 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 MCO is informed of

retroactive adjustment of the member's cost share or patient liability, the MCO 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 MCO's capitation payment. If the retroactive adjustment is more than 365 days, the MCO may need to contact the Department via the enrollment discrepancy mailbox for an adjustment in capitation payment.

Article. V. Care Management

A. Member Participation

1. The MCO is required to ensure that each member has a meaningful opportunity to participate in the initial development of, and updating of, his/her member-centered plan (MCP). The MCO is required to encourage members to take an active role in decision-making regarding the long-term care and health care services they need to live as independently as possible.

   The MCO 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. If the member's enrollment form indicates the member is an American Indian/Alaskan Native, the MCO must ask the member if he/she would like to invite a representative from his/her tribe to participate in the care management process. The MCO 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.

C. Assessment and Member-Centered Planning Process

1. *Comprehensive Assessment*

   b. Procedures

      i. The MCO shall use an assessment protocol that includes an in person interview in the member's current residence by the IDT social service coordinator 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.

3. *Member-Centered Planning*

   c. Documentation

      iv. The MCP shall document at least the following:

         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;

D. Timeframes

1. *Initial Assessment and MCP Timeframes*

   b. Initial Contact

      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:

      …

E. Providing, Arranging, Coordinating and Monitoring Services

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:

   …

G. Reassessment and MCP Update

1. *Reassessment*

   d. The entire IDT shall participate in the annual reassessment that is done no later than the end of the twelfth month after the previous comprehensive assessment was completed, including an in person interview with the member by the IDT social services coordinator and registered nurse in the member's current residence.

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 and both the social services coordinator and registered nurse are required to conduct an in person visit in the member's residence at minimum:

   b. Every six (6) months for vulnerable/high risk members as part of the annual comprehensive assessment and subsequent six month reassessment. The annual comprehensive assessment visit and subsequent six month reassessment visit count for two of the in person contacts required by this subsection. MCOs 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 MCO may not record the live video conference with the member without prior consent from the member; if consent is given orally, the MCO 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 MCO policy and be documented in the member's record.

K. Service Authorization

1. *Service Authorization Policies and Procedures*

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 Art. 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 VII.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 a 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 MCO 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.

MCOs must include the modifier 95 when the MCO submits claims that are delivered remotely.

The following services in Addendum VII.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 VII.B and VII.C 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.

9. *Timeframe for Decisions*

f. Standard Service Authorization Decisions

i. Standard service authorization decisions shall be made no later than fourteen (14) calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to fourteen (14) additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request The notification of extension must inform the member that:

a) The member may file a grievance if dissatisfied with the extension, and

N. Requirement to Notify Counties and Tribal Human/Human and Family Services of At-Risk Members:

1. *If an MCO identifies risk factors for a member that indicate a need to coordinate planning efforts or provide information to a county and tribal Human Services agency, the MCO will do the following:*

a. Send the Family Care Member County Notification Form F-02558 https://www.dhs.wisconsin.gov/forms/f02558.docx to:

i. The county of residence/responsibility on record,

ii. To the county where the person lives (if different), and

iii. To the tribal Human/Human and Family Services agency.

b. When appropriate or requested, work with the receiving county, tribal Human/Human and Family Services agency, and any relevant providers in the development of a behavior support plan, a crisis plan, or other community safety plans.

c. Update the information on form F-02558 if the member's address or other essential information changes, and provide that information to the county and tribal Human/Human and Family Services agency.

d. If the member lives in a residential setting, provide a copy of the notification form to the member's residential provider agency.

e. If a member moves voluntarily to a county in which the MCO does not operate, follow the Change Routing Notification process in Article V.M.b.

f. In instances in which the individual's county of legal residency comes into question, or when the individual does not provide written consent for the MCO to provide this notification form to the county or tribal Human/Human and Family Services agency, the MCO will convey only the necessary information to ensure appropriate service coordination, as defined in Wis. Stat. § 46.22(dm), about the individual to the appropriate county, tribal Human/Human and Family Services agency, or state agency involved in residency determinations and/or in the coordination of services.

P. MCO Duty to Immediately Report Certain Member Incidents

2. *In addition to the immediate reporting requirements provided by Article V.O.1., MCOs shall also comply with all other reporting requirements in this contract, including, but not limited to, the reporting requirements provided at https://www.dhs.wisconsin.gov/familycare/mcos/report-reqs.pdf.*

Article. VI. Self-Direction Supports

B. MCO Requirements

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

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 MCO has identified as having negative consequences.

C. IDT Staff Responsibilities

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:

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 MCO 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 MCO's decision to limit the member's existing level of self-direction.

Article. VII. Services

L. Prevention and Wellness

1. *Prevention and Wellness Program*

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 MCO will review and update practice guidelines periodically, as appropriate.

The MCO shall use practice guidelines for prevention and wellness services that include member education, motivation and counseling about long-term care and health care related services. The MCO must disseminate or make available the guidelines to providers for whom the guidelines apply and, upon request, to members.

Practice guidelines that are condition-specific and/or disease related shall include the following elements:

…

Article. VIII. Provider Network

D. Provider Agreement Language

23. *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 in the benefit package to members. The MCO agrees to clearly specify authorization requirements to its providers and in any provider agreements with its providers.

MCOs shall ensure service authorization is given to the provider prior to the start date of designated services by the provider. When prior written authorization is not practicable, verbal authorization should be provided for the service and written authorization issued thereafter. Services provided on an emergency basis should be followed up with written confirmation of the service, when appropriate.

Revised service authorizations shall be issued to providers promptly, with sufficient notice to allow providers to comply with the terms of the revised service authorization (for example, to prevent providers from unknowingly exceeding reduced authorized service units) and to timely submit accurate claims during the appropriate billing period.

34. *Telehealth or Remote Service Delivery*

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

J. Change in Providers

1. *Required Notifications*

b. Notice to members and Resource Centers

i. The MCO 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.

ii. When the Department determines that a change is significant, the MCO shall provide each member and the resource centers in the service area affected by the change, written notice of the change at least thirty (30) calendar days before the effective date of the change. Notices about significant changes in providers that are to be sent to members and shared with the resource center must be submitted to the Department prior to delivery.

L. Payment

7. *Medicaid Rates*

d. MCO Notification of Payment Above the Medicaid Fee-For Service Rate

In the event that an MCO contracts at a rate above the Medicaid fee-for-service rate, the MCO will document and track each situation. The MCO must submit a single comprehensive report to the Department at DHSDMSBRS@dhs.wisconsin.gov in February and August of each year (see https://www.dhs.wisconsin.gov/familycare/mcos/report-reqs.pdf for the specific due dates) as a component of the Quarterly Report required under Article XIV.C.3. The information will be reported to the Department on a form provided by the Department. The MCO will identify expenditures on the services paid for above the Medicaid Fee-For-Service Rate within the LTCare IES.

N. Standards for MCO Staff

2. *Relatives and Legal Guardians*

f. There is a properly executed provider agreement;

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

1. *Interim Payments*

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, target group, and geographic service region of the member. No additional capitation payment will be made to the MCO for that member.

Article. IX. Marketing and Member Materials

E. Accessible Formats and Languages and Cultural Sensitivity

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 MCO's member/customer service unit. DHS shall determine the prevalent non-English languages in each MCO service area.

   …

2. *Materials Easily Understood and Accessible*

   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 MCO's member/customer service unit.

Article. X. Member Rights and Responsibilities

E. Member Rights Specialist and MCO Advocacy Services

2. *MCO Advocacy Services*

   b. The MCO shall assure that, within 90 calendar days after enrollment, members have had an in person contact to make certain they are aware of the advocacy services available to them. This contact may be done by the interdisciplinary team.

Article. XI. Grievances and Appeals

B. Definitions

1. *Adverse benefit determination*

   b. An "adverse benefit determination" is not:

      v. The denial of authorization or payment for a service or item that is not inside of the benefit package specified in Addendum VII.

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

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

C. Overall Policies and Procedures for Grievances and Appeals

4. *Provision of Case File*

   The MCO 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 MCO'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 MCO relied upon to make a service authorization decision, functional screen results, any processes, strategies, or evidentiary standards used by the MCO in setting coverage limits and any new or additional evidence considered, relied upon, or generated

by the MCO (or at the direction of the MCO) 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.

E. Notification of Appeal Rights in Other Situations

1. *Requirement to Provide Notification of Appeal Rights*

a. Change in Level of Care from Nursing Home to Non-Nursing Home

Members whose level of care changes from the nursing home level of care to the non-nursing home level of care must receive a written notice that clearly explains the potential impact of the change, the member's right to request a functional eligibility re-screening, the member's right to appeal with the MCO and the member's right to request a State Fair Hearing following the MCO's appeal decision or the MCO's failure to issue a decision within the timeframes specified in Article XI.F.5.e and f. The MCO shall provide for functional eligibility re-screening by a different screener within ten (10) calendar days of a request by a member or member's legal decision maker. The MCO must mail or hand deliver the Department issued notice of change in level of care form https://www.dhs.wisconsin.gov/library/f-01590.htm when the MCO administers a long-term care functional screen that results in a reduction of the member's level of care from "nursing home" to "non-nursing home," as identified in Article XI.B.1.a.i.

The MCO does not need to provide notification of change in level of care if the member is found to no longer meet any level of care because the ForwardHealth interChange system will automatically issue a Notice of Loss of Functional Eligibility to the member which includes an explanation of the member's appeal rights.

b. Adverse MCO Grievance or Appeal Decision

When the MCO makes a decision in response to a member's grievance or appeal that is entirely or partially adverse to the member it must on the date of the decision mail or hand deliver a written notification to the member of the reason for the decision and any further grievance or appeal rights. For appeal decisions, the MCO shall use the following Department mandated templates:

i. MCO decision is upheld:

https://www.dhs.wisconsin.gov/library/f-00232e.htm

ii. MCO decision is reversed: https://www.dhs.wisconsin.gov/library/f-00232d.htm

iii. MCO notification of extension for decision: https://www.dhs.wisconsin.gov/forms/f02619.docx

iv. Partnership Dual Eligible SNP appeal decision letter https://www.dhs.wisconsin.gov/forms/f02738.docx

v. Partnership Dual Eligible SNP Expedited Grievance Rights https://www.dhs.wisconsin.gov/forms/f02739.docx

3. *Timing of Notification of Appeal Rights*

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 MCO shall mail or hand deliver to the member a written notification of the right to appeal these adverse benefit determinations.

F. MCO Grievance and Appeal Process

5. *MCO Process for Medicaid Appeals*

c. Acknowledgement of Appeal Receipt

The MCO must provide written acknowledgement of receipt for each appeal. The MCO must use the Department issued template language in its written acknowledgement, which includes the date the MCO will make a decision on the member's appeal and that the member can request a State Fair Hearing if the MCO 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 MCO must document all appeals – oral or written – to establish the earliest possible filing date for the member.

ii. When processing expedited appeal requests, the MCO 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 MCO 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 MCO 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 MCO 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 MCO grievance and appeal committee must make a decision on an appeal as expeditiously as the member's situation and health condition requires. The MCO 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. MCO Administration

A. Member Records

10. *Contents of Member Records*

A member record shall contain at least the following items:

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).

Minimum member record documentation per chart entry or encounter must conform to the applicable provisions of Wis. Admin. Code § DHS 106.02(9).

D. Management of Subcontractors and Providers

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

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 MCO 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 MCO's internal critical incident reporting system.

Q. Supplier Diversity and Reporting Requirement

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 MCO 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 MCO 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 MCO 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 MCO shall provide any such information as requested by DHS and within a time period that is specified by DHS.

The MCO 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 MCO 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

Article. XIV. Reports and Data

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.
- Article XIII. G., Required Disclosures.

Article. XVIII. Payment to the Managed Care Organization

B. Medicaid Capitation Rates

In full consideration of services in the Medicaid benefit package rendered by the MCO for each enrolled member, the Department agrees to pay the MCO a monthly capitation rate. The capitation rates shall be based on an actuarially sound methodology as required by federal regulations.

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 MCO 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 dis-enrollments between programs or MCOs, and changes in target group, level of care, or dual eligibility status.

E. Pay for Performance

The Department will implement a pay for performance mechanism in 2021. This incentive applies only to CY 2021 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 rate year.

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 2021. 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 2021 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, 2022.

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 standard up to a total of 0.25%.	The MCO must meet the minimum performance standards for all 4 survey questions to qualify for an 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, 2021, through December 31, 2021, 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, 2022.

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 (2.a.i. and 2.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 2.a.ii., the MCO will receive a payment only from the funding allocated to 2.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, 2022.

3. *Competitive Integrated Employment*

a. Competitive Integrated Employment (CIE) Withhold Criteria

Each MCO will have 0.25% of its calendar year 2021 capitation rate withheld to be returned based on the MCO's performance maintaining its number of members employed in CIE.

Each MCO's 2021 Quarter 1 and Quarter 4 IES Employment Wage Data will be used to evaluate the P4P results. Any member ages 18-45 meeting CIE IES submission criteria is counted in that review period. DHS will round each MCO's percentage result to the first digit after the decimal point.

i. The MCO will receive 0.25% of its capitation if 90.0-100.0% of the number of members aged 18-45 years who were employed in CIE in Quarter 1 of 2021 are employed in CIE in Quarter 4 of 2021.

ii. The MCO will receive 0.125% of its capitation if 80.0 – 89.9% of the number of members aged 18-45 years who were employed in CIE in Quarter 1 of 2021 are employed in CIE in Quarter 4 of 2021.

iii. The MCO will not receive any capitation return if less than 80% of the number of members aged 18-45 years who were employed in CIE in Quarter 1 of 2021 are employed in CIE in Quarter 4 of 2021.

b. CIE Incentive Criteria

Each MCO is eligible to receive up to 0.10% of its capitation rate as an incentive payment only if the MCO received the full or partial withhold payment under 3.a. and increases its number of members employed in CIE in 2021.

i. The MCO will receive 0.10% of its capitation rate if it increases its number of members in CIE by at least 4.0% in 2021.

ii. The MCO will receive 0.05% of its capitation rate if it increases its number of members in CIE by 2.0% to 3.9% in 2021.

The Department will validate the information contained in the IES Employment Wage Data Mart with the Unemployment Insurance Data provided by the Department of Workforce Development.

I. Health Insurance Fee Reimbursement – Partnership Only, For Rate Year 2020 Only

N. Unauthorized Programs or Activities

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work. If the state paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

O. Risk Corridor – Family Care and Partnership Programs

The Department will utilize a risk corridor mechanism to mitigate the significant uncertainty outside of MCO control related to the ongoing COVID-19 pandemic. The risk corridor will address variances in costs for all benefit services other than care management. The risk corridor will not address variances in administrative costs.

1. *Capitation Rate Target Risk Corridor Loss Ration*
    a. The target Risk Corridor Loss Ratio percentage will be developed by dividing the benefit service component of the rate, excluding care coordination, by the entire capitation rate, gross of pay for performance and high cost risk pool withholds.
    b. The care coordination costs to be excluded from the numerator and the capitation rate used as the denominator in a. will be calculated specific to the actual target group mix, level of care mix, GSR, dual eligibility status for Partnership, and pricing assumptions for each MCO.
2. *Settlement Methodology*
    a. The target Risk Corridor Loss Ratio percentage will be developed by dividing the benefit service component of the rate, excluding care coordination, by the entire capitation rate, gross of pay for performance and high cost risk pool withholds.
    b. The care coordination costs to be excluded from the numerator and the capitation rate used as the denominator in a. will be calculated specific to the actual target group mix, level of care mix, GSR, dual eligibility status for Partnership, and pricing assumptions for each MCO.
    c. The numerator from 2.a. will be divided by the denominator in 2.b. to calculate the actual Risk Corridor Loss Ratio.
    d. The actual Risk Corridor Loss Ratio will be subtracted from the Capitation Rate Target Risk Corridor Loss Ratio calculated in 2.c. to determine the Risk Corridor Loss Ratio gain or loss.
    e. The Department will recoup the Department's share of the MCO's gains and pay out the Department's share of the MCO's losses as a percentage of the MCO's capitation revenue, according to the following schedule:

Gain	MCO Share	Department Share
<= 2.0%	100%	0%
>2.0% to 6.0%	50%	50%
> 6.0%	0%	100%

Loss	MCO Share	Department Share
<= 2.0%	100%	0%
>2.0% to 6.0%	50%	50%
> 6.0%	0%	100%

f. The Department will compare the MCO's encountered medical benefit service costs to the MCO financials to determine reasonableness of the encounter data.

g. The Department may adjust the risk corridor numerator calculation if, upon review of encounters, financials, or other information associated with such payments, that the MCO's benefit services reimbursements are not at market-based levels and do not incent efficient and high quality care.

h. An interim risk corridor settlement will be completed no earlier than 4 months after the rate year has ended.

i. The Department may elect to pay or recoup only a portion for the interim risk corridor settlement.

j. The final risk corridor settlement will be completed no earlier than 9 months after the rate year has ended.

Article. XIX. MCO Specific Contract Terms

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B. Geographic Coverage Where Enrollment Is Accepted

The MCO will provide services in the following counties:

County	**RFP Number**	**Contract Term**
Geographic Service Region 1		
1. Chippewa	S-0505 DLTC-17	01/01/21-12/31/22
2. Dunn	S-0505 DLTC-17	01/01/21-12/31/22
3. Eau Claire	S-0505 DLTC-17	01/01/21-12/31/22
4. Pierce	S-0505 DLTC-17	01/01/21-12/31/22
5. St. Croix	S-0505 DLTC-17	01/01/21-12/31/22
6. Taylor	S-0505 DLTC-17	01/01/21-12/31/22
Geographic Service Region 2		
7. Buffalo	S-0647 DMS-17	01/01/20-12/31/21
8. Clark	S-0647 DMS-17	01/01/20-12/31/21
9. Jackson	S-0647 DMS-17	01/01/20-12/31/21
10. La Crosse	S-0647 DMS-17	01/01/20-12/31/21
11. Monroe	S-0647 DMS-17	01/01/20-12/31/21
12. Pepin	S-0647 DMS-17	01/01/20-12/31/21
13. Trempealeau	S-0647 DMS-17	01/01/20-12/31/21
14. Vernon	S-0647 DMS-17	01/01/20-12/31/21
Geographic Service Region 3		
15. Crawford	S-0647 DMS-17	01/01/20-12/31/21

County	RFP Number	Contract Term
16. Grant	S-0647 DMS-17	01/01/20-12/31/21
17. Green	S-0647 DMS-17	01/01/20-12/31/21
18. Iowa	S-0647 DMS-17	01/01/20-12/31/21
19. Juneau	S-0647 DMS-17	01/01/20-12/31/21
20. Lafayette	S-0647 DMS-17	01/01/20-12/31/21
21. Richland	S-0647 DMS-17	01/01/20-12/31/21
22. Sauk – Family Care	S-0647 DMS-17	01/01/20-12/31/21
23. Sauk – Partnership	S-0647 DMS-17	01/01/20-12/31/21
Geographic Service Region 4		
24. Florence	S-0505 DLTC-17	01/01/21-12/31/22
25. Forest	S-0505 DLTC-17	01/01/21-12/31/22
26. Langlade	S-0505 DLTC-17	01/01/21-12/31/22
27. Lincoln	S-0505 DLTC-17	01/01/21-12/31/22
28. Marathon	S-0505 DLTC-17	01/01/21-12/31/22
29. Oneida	S-0505 DLTC-17	01/01/21-12/31/22
30. Portage	S-0505 DLTC-17	01/01/21-12/31/22
31. Vilas	S-0505 DLTC-17	01/01/21-12/31/22
32. Wood	S-0505 DLTC-17	01/01/21-12/31/22
Geographic Service Region 5		
33. Adams	S-0505 DLTC-17	01/01/21-12/31/22
34. Columbia – Family Care	S-0505 DLTC-17	01/01/21-12/31/22
35. Columbia – Partnership	S-0505 DLTC-17	01/01/21-12/31/22
36. Dodge – Family Care	S-0505 DLTC-17	01/01/21-12/31/22
37. Dodge – Partnership	S-0505-DLTC-17	01/01/21-12/31/22
38. Green Lake	S-0505 DLTC-17	01/01/21-12/31/22
39. Jefferson	S-0505 DLTC-17	01/01/21-12/31/22
40. Jefferson – Partnership	S-0505 DLTC-17	01/01/21-12/31/22
41. Marquette	S-0505 DLTC-17	01/01/21-12/31/22
42. Waushara	S-0505 DLTC-17	01/01/21-12/31/22
Geographic Service Region 6		
43. Ozaukee – Family Care	S-0505 DLTC-17	01/01/21-12/31/22
44. Ozaukee – Partnership	S-0505 DLTC-17	01/01/21-12/31/22
45. Sheboygan	S-0505 DLTC-17	01/01/21-12/31/22
46. Walworth	S-0505 DLTC-17	01/01/21-12/31/22
47. Washington – Family Care	S-0505 DLTC-17	01/01/21-12/31/22
48. Washington – Partnership	S-0505 DLTC-17	01/01/21-12/31/22
49. Waukesha – Family Care	S-0505 DLTC-17	01/01/21-12/31/22
50. Waukesha – Partnership	S-0505 DLTC-17	01/01/21-12/31/22
Geographic Service Region 7		
51. Ashland	S-0707 DMS-18	01/01/21-12/31/22
52. Barron	S-0707 DMS-18	01/01/21-12/31/22
53. Bayfield	S-0707 DMS-18	01/01/21-12/31/22
54. Burnett	S-0707 DMS-18	01/01/21-12/31/22
55. Douglas	S-0707 DMS-18	01/01/21-12/31/22
56. Iron	S-0707 DMS-18	01/01/21-12/31/22
57. Polk	S-0707 DMS-18	01/01/21-12/31/22
58. Price	S-0707 DMS-18	01/01/21-12/31/22
59. Rusk	S-0707 DMS-18	01/01/21-12/31/22
60. Sawyer	S-0707 DMS-18	01/01/21-12/31/22

County	RFP Number	Contract Term
61. Washburn	S-0707 DMS-18	01/01/21-12/31/22
Geographic Service Region 8		
62. Milwaukee – Family Care	S-0707 DMS-18	01/01/21-12/31/22
63. Milwaukee – Partnership	S-0706 DMS-18	01/01/21-12/31/22
Geographic Service Region 9		
64. Fond du Lac	DHS RPA FHA0962	01/01/21-12/31/21
65. Manitowoc	DHS RPA FHA0962	01/01/21-12/31/21
66. Winnebago	DHS RPA FHA0962	01/01/21-12/31/21
Geographic Service Region 10		
67. Calumet	DHS RPA FHA0962	01/01/21-12/31/21
68. Outagamie	DHS RPA FHA0962	01/01/21-12/31/21
69. Waupaca	DHS RPA FHA0962	01/01/21-12/31/21
Geographic Service Region 11		
70. Kenosha – Family Care	S-0647 DMS-17	01/01/20-12/31/21
71. Kenosha – Partnership	S-0647 DMS-17	01/01/20-12/31/21
72. Racine – Family Care	S-0647 DMS-17	01/01/20-12/31/21
73. Racine – Partnership	S-0647 DMS-17	01/01/20-12/31/21
Geographic Service Region 12		
74. Dane – Family Care	DHS RPA FHA096	01/01/21-12/31/21
75. Dane - Partnership	S-0706 DMS-18	01/01/21-12/31/22
Geographic Service Region 13		
76. Brown	S-0797 DMS-19	01/01/20-12/31/21
77. Door	S-0797 DMS-19	01/01/20-12/31/21
78. Kewaunee	S-0797 DMS-19	01/01/20-12/31/21
79. Marinette	S-0797 DMS-19	01/01/20-12/31/21
80. Menominee	S-0797 DMS-19	01/01/20-12/31/21
81. Oconto	S-0797 DMS-19	01/01/20-12/31/21
82. Shawano	S-0797 DMS-19	01/01/20-12/31/21
Geographic Service Region 14		
83. Rock	Not applicable	01/01/20-12/31/21

…

F. Capitation Rate

GSR XX – list counties

Level of Care (Family Care)	Target Group	Administrative	Long Term Care	Medical
Nursing Home - Monthly	Developmentally Disabled	$x.xx	$x.xx	$0.00
Nursing Home - Monthly	Physically Disabled	$x.xx	$x.xx	$0.00
Nursing Home - Monthly	Frail Elder	$x.xx	$x.xx	$0.00
Non-Nursing Home - Monthly	n/a	$x.xx	$x.xx	$0.00

GSR XX – list counties

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

Addendum. I. Actuarial Basis

B. Retrospective Adjustments

1. *HIV/AIDS and Vent Dependent Acute and Primary Retrospective Adjustment – Partnership program, for Rate Year 2020, Only Vent Dependent Acute and Primary Retrospective Adjustment for Rate Year 2021*

   For Partnership enrollees who meet the criteria in this section, the MCO is not at financial risk for changes in utilization or for Medicaid state plan acute and primary costs incurred that do not exceed the upper payment limits specified in 42 C.F.R. § 447.362. The Department will reimburse the MCOs annually for incurred cost for Medicaid-covered state plan acute and primary services provided to MCO enrollees who meet the criteria in this section. Acute and primary services are defined as services included in the development of the acute and primary portion of the capitation rate. These payments will be made based on the data submitted by the MCO to the Department via monthly encounter reporting utilizing the LTCare IES. The data submission schedule is included at https://www.dhs.wisconsin.gov/familycare/mcos/report-reqs.pdf. For the purposes of calculating reimbursement for an MCO's enrollees who meet the criteria under this section, the encounter data submitted for acute and primary services will be priced at the Medicaid Fee-For-Service rates by the Department. Reimbursement already provided to the MCO for Medicaid costs in the form of the acute and primary component of capitation payments for qualified enrollees will be deducted from the repriced reimbursement payments for Medicaid costs. No reimbursement will be made for the long term care services provided or to the long term care component of the capitation payments as part of this adjustment.

The criteria for qualified enrollees are:

…

2. *Vent Dependent Long Term Care Retrospective Adjustment – Family Care and Partnership programs, Rate Year 2020 Only*

5. *Dual Eligibility Status – Partnership program, Rate Year 2020 Only*

6. *Target Group Mix – Family Care and Partnership programs, Rate Year 2020 Only*

7. *Long-Term Care Functional Status - Family Care and Partnership programs, Rate Year 2020 Only*

Addendum. VII. Benefit Package Service Def

B. Medicaid State Plan Services – Family Care Benefit Package

11. ***Nursing home stays*** *as defined in Wis. Admin. Code DHS § 107.09 (nursing home, institution for mental disease (IMD) and ICF-I/ID facility). Inpatient services are only covered for IMD nursing home residents under the age of 21 years or age 65 or older, except that services may be provided to a 21 year old resident of an IMD if the person was a resident immediately prior to turning 21 and continues to be a resident after turning 21. This exception only applies until the person's 22nd birthday.*

Nursing home services include coverage of 95% of the MCO's nursing home daily rate for MCO members who are in hospice and reside in nursing homes, excluding those members who are receiving nursing home hospice respite services for less than 5 day stays in a nursing home.

For members at the non-nursing home level of care nursing home services are coverable only if re-screening results in a change to a nursing home level of care or the member's most recent Minimum Data Set (MDS) assessment in the nursing home indicates that the services are Medicaid reimbursable. See Article VII.B.2.b. and c.

Nursing home services may be authorized to provide skilled nursing or rehabilitation services aimed at helping the member regain the ability to live more independently in his or her own home. Long-term care services in a nursing home may be authorized only:

a. When members' long-term care outcomes cannot be cost-effectively supported in the member's home, or when members' health and safety cannot be adequately safe-guarded, in the member's home; or

b. When nursing home services are a cost-effective option for meeting that member's long-term care needs.

Addendum. VIII. Materials Cited in This Contract & Other Related Communications

Title	URL
9. Cost Share Cap	https://www.dhs.wisconsin.gov/familycare/mcos/cost-share-cap.htm

Grievance and Appeals Forms

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

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