



**CONTRACT FOR SERVICES**  
**between**  
**State of Wisconsin Department of Health Services (DHS)**  
**and**  
**Vendor**  
**for**  
**Family Care**

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

Contract ID Number:

Contract Amount: see rates below

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, [Dana.Raue@dhs.wisconsin.gov](mailto:Dana.Raue@dhs.wisconsin.gov)

DHS Contract Manager: John Kivisaari, [John.Kivisaari@dhs.wisconsin.gov](mailto:John.Kivisaari@dhs.wisconsin.gov)

Contractor Contract Administrator:

Contractor Telephone:

Contractor Email:

Modification Description:

Rates updated for June 1 through December 31 of calendar year 2021 and language added related to the 2021 State Directed Rate Increase. The rates and added language are effective June 1, 2021.

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## **VIII. Provider Network**

### **L. Payment**

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#### **11. 2021 State Directed Rate Increase**

The Department will make payments to the MCO for home and community-based services, which the MCO shall distribute to home and community-based services providers, under the following terms and conditions:

- a. For purposes of this section, “home and community-based services provider” means providers of adult day care services, daily living skills training, habilitation services,

residential care (adult family homes of 1-2 beds, adult family homes of 3-4 beds, community-based residential facilities, residential care apartment complexes), individual and group supported employment, prevocational employment, vocational futures planning, respite care services provided outside of a nursing home, and supportive home care. Providers of self-directed services are not eligible for direct care workforce payments for self-directed services. Nursing homes, personal care agencies, and MCOs are not direct care workforce providers under this section.

- b. MCOs are required to provide a unit rate increase to all eligible providers equal to 4.24% of each eligible provider’s rates for Family Care and Family Care Partnership covered services in effect on June 1, 2021. The 4.24% unit rate increase on covered services equates to a unit rate increase of 3.51% when calculated on covered and non-covered services for residential providers. MCOs will need to identify this unit rate increase in their contracts with providers as a separate line item from other components of the MCO’s contracted rate with the provider. This line item will be labeled “2021 State Directed Rate Increase” and contracts with the provider should include a line item for this same per unit amount. MCOs may not modify the amount of the 2021 State Directed Rate Increase line item. MCOs may negotiate other components of the MCO’s reimbursement rates to providers.
- c. The MCO shall provide to the Department the following items by deadlines established by the Department:
  - i. Financial reporting documenting the number of provider rate increases implemented as of the time period covered in the financial reporting, the number of provider rate increases still to be implemented as of the time period covered by the financial reporting, estimate of the funding paid out to providers as the 2021 State Directed Rate Increase, and an estimate of the increased funding received from DHS through the capitation payments for this state directed payment. Amounts must document actual cash paid and not accrued.
  - ii. A signed attestation that all of the funding paid to the MCO by the Department for this purpose was paid to home and community-based services providers in accordance with VIII.10. of this contract.
- d. The MCO shall send all documents they are required to submit to the Department under this section to [DHSLTCFiscalOversight@dhs.wisconsin.gov](mailto:DHSLTCFiscalOversight@dhs.wisconsin.gov) with “Attention: 2021 State Directed Rate Increase MCO Submission” in the subject line.

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**Article XIX. G. MCO Specific Contract Terms**

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**G. 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 & PACE)	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 (Non-Dual Eligible)	Frail Elder	\$x.xx	\$x.xx	\$x.xx
Nursing Home – Monthly (Non-Dual Eligible)	Developmentally Disabled	\$x.xx	\$x.xx	\$x.xx

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**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: \_\_\_\_\_