# CONTRACT FOR SERVICES MODIFICATION
**between**
**State of Wisconsin Department of Health Services (DHS)**
**and**
**Vendor**
**for**
**Program**

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, 2024 – December 31, 2024
Optional Renewal Terms: n/a

DHS Division: Division of Medicaid Services
DHS Contract Administrator: Dana Raue, Dana.Raue@dhs.wisconsin.gov
DHS Contract Manager: Kelly VanSicklen, Kelly.VanSicklen@dhs.wisconsin.gov

Contractor Contract Administrator: (contract signatory)
Contractor Telephone:
Contractor Email:

Modification Description: Adding requirements that MCOs pay residential providers and supportive home workers a minimum rate established by the State. 2024 MCO capitation rates are also being updated.

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**Article III. Eligibility**

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**E. Room and Board**

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4. *Collecting and Giving the Member's Room and Board Obligation to the Residential Facility*
    a. The MCO shall collect the member's room and board obligation and give it to the residential facility on behalf of the member.
    b. Upon request, the MCO shall disclose the monthly amount attributable to services and supervision to the residential provider.

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**Article VIII. Provider Network**

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**D. Provider Agreement Language**

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5. *Term and Termination*

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i. Residential rates

Residential rates shall be for a period of not less than one year, unless there is mutual agreement upon a shorter term. Residential services provider agreements or amendments shall specify a contracted rate, include a fee schedule or reference an acuity-based rate setting model. Rates may be changed:

i. Anytime, through mutual agreement of the MCO and provider.

ii. When a member's change in condition warrants a change in the acuity-based rate setting model.

iii. An adjustment in payment rate made pursuant to VIII.L.6.c-e, whether resulting in a State directed rate increase or rate decrease, shall not be considered a rate change for purposes of this twelve (12) month period.

iv. When a rate has been in effect for at least twelve (12) months, and a change is proposed for an individual member or facility:

a) The MCO must provide a sixty-day written notice to the provider prior to implementation of the new rate.

b) The rate change may apply to the entire contract or to specific rates within the contract, but only on a prospective basis.

c) Rates which are reduced using sub iii are protected from additional decreases during the subsequent twelve (12) month period.

d) A State directed rate increase shall not be considered a rate change for purposes of this twelve (12) month period.

Nothing herein shall impair the right of either party to terminate a residential services contract as otherwise specified therein.

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**L. Payment**

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6. *Home and Community-Based Waiver Services Rates*

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c. Residential Providers: The MCO must pay residential providers at least the minimum rates as established below.

i. Residential Providers are defined as follows:

a) Certified, corporate-owned 1-2 bed Adult Family Homes ("1-2 bed AFH") as defined in Add. VI.

b) Certified 3-4 bed Adult Family Homes ("3-4 bed AFH") as defined by Wis. Stat. §50.01(1)(b).

c) Certified Community-Based Residential Facility ("CBRF") as defined by Wis. Stat. §50.01(1g).

d) Certified Residential Care Apartment Complex ("RCAC") as defined by Wis. Stat. §50.01 (6d).

ii. The minimum payment rates by benefit and by member acuity tier are:

| TABLE 1: HCBS RESIDENTIAL PROVIDER BENEFIT AND MINIMUM FEE SCHEDULE RATE | | | | |
|---|---|---|---|---|
| Benefit | Revenue Code | Procedure Code | Modifier Code(s) | Per Diem Rates |
| AFH 1-2 bed corporate owned | 0240 | T2031 | U1, U6, U7 | Tier 1 - $373.80 |
| | | | U2, U6, U7 | Tier 2 – $406.36 |
| | | | U3, U6, U7 | Tier 3 - $423.65 |
| AFH 3-4 bed | 0241 | T2031 | U1, U8 | Tier 1 - $203.50 |
| | | | U2, U8 | Tier 2 – $220.79 |
| | | | U3, U8 | Tier 3 - $238.08 |
| CBRF 5-8 members | 0242 | T2033 | U1, U7 | Tier 1 - $141.35 |
| | | | U2, U7 | Tier 2 – $158.65 |
| | | | U3, U7 | Tier 3 - $168.31 |
| CBRF 9+ members | 0243 | T2033 | U1, U8 | Tier 1 - $100.75 |
| | | | U2, U8 | Tier 2 – $115.07 |
| | | | U3, U8 | Tier 3 - $133.38 |
| RCAC | 0670 | T2033 | U9 | $67.41 |

iii. "Member Acuity Tiers" are defined in Table 2, "Member Acuity Tiers: Criteria", with members being assigned to the highest tier for which they have any single need listed in the acuity tier criteria. Members qualify for Acuity Tier 1 if they do not meet any of the needs listed in the higher acuity tiers.

| TABLE 2: MEMBER ACUITY TIERS: CRITERIA | | |
|---|---|---|
| Tier 1 | Tier 2 | Tier 3 |
| Wandering = 0<br>• Does not wander | Wandering = 1<br>• Daytime wandering but sleeps nights | Wandering = 2<br>• Wanders at night or day and night |
| Self-Injurious Behaviors = 0<br>• No injurious behaviors demonstrated | Self-Injurious Behaviors = 2<br>• Self-injurious behaviors require interventions 2-6 times per week or 1-2 times per day | Self-Injurious Behaviors = 3<br>• Self-injurious behaviors require intensive one-on-one interventions more than twice each day |

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|---|---|---|
| Self-Injurious Behaviors = 1<br>• Some self-injurious behaviors require interventions weekly or less | | |
| Offensive or Violent Behavior to Others=0<br>• No offensive or violent behaviors demonstrated | Offensive or Violent Behavior to Others = 2<br>• Offensive or violent behaviors that require interventions 2-6 times per week or 1-2 times per day | Offensive or Violent Behavior to Others = 3 Offensive or violent behaviors that require intensive one-on-one interventions more than twice each day |
| Offensive or Violent Behavior to Others = 1<br>• Some offensive or violent behaviors that require interventions weekly or less | | |
| | Dressing = 2<br>Help (supervision, cueing, hands-on assistance) needed-helper MUST be present | Uses Mechanical Lift (not a lift chair) selected for Transferring ADL. |
| | Toileting = 2<br>Help (supervision, cueing, hands-on assistance) needed-helper MUST be present | Tracheostomy Care selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day |
| | Transferring = 2<br>Help (supervision, cueing, hands-on assistance) needed-helper MUST be present | Tube Feedings selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day |
| | Ostomy – Related Skilled Services selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day | Positioning in Bed or Wheel Chair every 2-3 hours selection is any of the following: 3-4/Day, or 5+/Day |

iv. Member acuity tiers are to be calculated or re-calculated according to the timelines found in Articles III.F.4-5.

v. Minimum payment rates for owner-occupied 1-2 bed AFHs:

a) Owner-occupied 1-2 bed Adult Family Homes (AFHs) are not subject to the minimum rate tiers found in VIII.L.6.c.ii.

b) The minimum payment rates for owner-occupied 1-2 bed AFHs are to be no less than the equivalent of the 15-minute MCO-directed supportive home care (SHC) minimum payment rate, as contained in Article VIII.L.6.d.i, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision.

For the purposes of enforcement DHS will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

c) Encounters for owner-occupied 1-2 bed Adult Family Homes (AFHs) are identified with Revenue Code "0240", procedure code "T2031" and modifier "U5" to indicate owner-occupied.

vi. MCO-Residential Provider contracts shall include the following:

a) One or more of the following according to the services being contracted for:

1) Tier structure listed in Article VIII.L.c.iii.,

2) The minimum payment rates for owner-occupied 1-2 bed AFHs under Article VIII.L.c.v.

b) The Rate per tier listed in Article VIII.L.c.ii. for the applicable provider type.

c) Provisions stating that the contracted rate will be no less than that listed in Article VIII.L.c.ii. for a member meeting the tier requirements.

vii. MCO-Supportive home care provider contracts shall include the following:

a) One or more of the following according to the services being contracted for:

1) The requirement in Article VIII.L.d., or

2) The requirements in Article VIII.L.e.

viii. MCO-Residential Provider authorization requirements: MCO-Residential Provider authorizations shall include the following for each member:

a) The acuity tier that is applicable to the member;

b) The date the acuity tier was determined.

c) Whether the member's plan of care requires 1 or more staff dedicated solely to the individual member for 24-hours a day on a daily basis.

d) Changes to member's acuity tier:

1) In the event of a change in the member's acuity tier, the MCO shall have 60 (sixty) days to implement an updated authorization that reflects the member's updated acuity tier and associated minimum payment rate. The member's updated acuity tier and associated minimum payment rate shall be calculated as of the date of the functional screen result that caused a change to the member's acuity tier.

2) The effective date of the updated rate in the authorization under 1) shall be 30 days following the date of the functional screen result that caused a change to the member's acuity tier.

d. Payment Rates for MCO-Directed Supportive Home Care (SHC) services

i. MCOs must pay at least the 15-minute unit SHC minimum rate of $6.38 when the services are MCO-directed. MCOs must pay SHC daily or hourly rates that are greater than or equal to what the MCO would pay if it was paying the 15-minute unit SHC minimum rate, as contained in Article VIII.L.6.d.i, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision.

ii. For the purposes of enforcement DHS will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

iii. SHC minimum rates apply to the following medical codes when used for SHC services.

a) 15-Minute Codes: S5120, S5125, S5130, S5135

b) Per Diem Codes: S5121, S5126, S5131, S5136

e. Payment Rates for Self-Directed Supportive Home Care (SHC) services

i. The MCO shall increase self-directed services budgets of members so that all members have sufficient budget authority to pay the 15-minute unit self-directed SHC minimum fee rate of $4.08 and an additional $0.48 of state and federal payroll taxes and workers compensation for all units of supportive home care they receive through self-direction.

ii. The MCO shall pay at least $4.56 per 15-minutes for self-directed supportive home care for the sum of supportive home care worker wages, state and federal required payroll taxes, and workers compensation.

a) Members who are self-directing supportive home care services must pay their supportive home care workers at least the $4.08 per 15-minute minimum rate unless a worker voluntarily opts out of the minimum rate. Members must pay SHC daily or hourly rates that are greater than or equal to what the member would pay if they were paying the 15-minute unit self-directed SHC minimum rate, as contained in Article VIII.L.6.e.i, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision.

For the purposes of enforcement DHS will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

iii. SDS supportive home care workers may voluntarily opt out of the minimum rate payment requirement.

a) If an SDS supportive home care worker voluntarily opts out of the MCO minimum rate payment requirement, they must sign a form designated by the Department confirming their decision to do so and the self-directing member and MCO must retain the signed form.

f. Encounter data requirements

i. MCOs must include in their adult family home encounters the following DHS-assigned modifiers:

a) “U1” to indicate Acuity Tier 1, “U2” to indicate Acuity Tier 2, or “U3” to indicate Acuity Tier 3 as the first modifier.

b) “U5” to indicate owner-occupied or “U6” to indicate corporate owned as the second modifier.

c) “U7” to indicate 1-2 bed adult family home or “U8” to indicate 3-4 bed adult family home as the third modifier.

d) “U4” to indicate the member received 24-hour 1-on-1 (or greater) care, when applicable, as the fourth modifier.

ii. MCOs must include in their community based residential facility encounters the following DHS-assigned modifiers:

a) “U1” to indicate Acuity Tier 1, “U2” to indicate Acuity Tier 2, or “U3” to indicate Acuity Tier 3 as the first modifier.

b) “U7” for community based residential facilities with 5-8 beds or “U8” for community based residential facilities with 9 or more beds as the second modifier.

c) “U4” to indicate the member received 24-hour 1-on-1 (or greater) care, when applicable, as the third modifier.

iii. MCOs must include in their residential care apartment complex encounters the following DHS-assigned modifiers:

a) “U9” to indicate residential care apartment complex as the first modifier.

b) “U4” to indicate the member received 24-hour 1-on-1 (or greater) care, when applicable, as the second modifier.

iv. MCOs must include the DHS-defined self-direction indicator for all self-directed supportive home care encounters.

g. After a member’s functional screen is calculated or re-calculated according to the timelines found in Articles III.F.4-5. and the Functional Screen Information Access (FSIA) generates an acuity tier report, the MCO must provide to the provider upon request the first page of the acuity tier assignment report from FSIA which contains:

i. Applicant’s name;

ii. Agency that calculated residential acuity tier;

iii. Date residential acuity tier was determined;

iv. Residential Acuity tier, if applicable.

h. The HCBS minimum fee schedule state-directed payment will be submitted annually to CMS for review and approval.

i. The MCO must update all provider agreements to comply with Article VIII.L.6.c-g. by December 31, 2024. The MCO shall pay all claims for dates of service October 1, 2024 through November 30, 2024 that the MCO receives by November 30, 2024 in compliance with Article VIII.L.6.c. through e. by December 31, 2024. If the MCO is unable to meet these requirements by the dates listed herein, the MCO may submit an extension request to the Department to be approved at the Department’s sole discretion. The MCO will be subject to all requirements and reporting set forth by the Department.

j. Failure to Meet Minimum Fee Schedule Requirements

i. The MCO may be subject to financial penalty of up to $10,000 for each payment to a provider that fails to meet the provisions in Article VIII.L.6.c-i.

ii. If the MCO is found to have failed to meet the provisions in Article VIII.L.6.c-g. for payments made to a provider, the MCO will reprocess payments to that provider such that the reprocessed payments meet the provisions in Article VIII.L.6.c-g.

iii. The MCO may be placed on a corrective action plan (CAP) as a result of the Department finding the MCO out of compliance with Article VIII.L.6.c-i.

iv. For the purposes of enforcing the requirements under Article VIII.L.6.c-i, the Department shall compare the MCO’s reimbursement to the provider

to the sum of the member's minimum payment rate and the member's room and board obligation.

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**Article XIX. MCO Specific Contract Terms**

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**G. Capitation Rates**

**Effective January through September**

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

**Effective October through December**

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

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**State of Wisconsin**
**Department of Health Services**

Authorized Representative

Name: ______________________

Title: ______________________

Signature: ______________________

Date: ______________________

**Contractor**
Contractor Name: ______________________

Authorized Representative

Name: ______________________

Title: ______________________

Signature: ______________________

Date: ______________________

## SUPPLIER DIVERSITY AMENDMENT

**The Wisconsin Department of Health Services (DHS) and Contractor agree to the below change to the Agreement. The below Agreement amendment is hereby incorporated by reference into the Agreement and is enforceable as if restated therein in its entirety.**

**The Agreement is hereby amended by incorporating and adding the following Section:**

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

The Contractor 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 Contractor 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

## HIGH-RISK IT REVIEW

Pursuant to Wis. Stat. 16.973(13), Contractor is required to submit, via the contracting agency, to the Department of Administration for approval any order or amendment that would change the scope of the contract and have the effect of increasing the contract price. The Department of Administration shall be authorized to review the original contract and the order or amendment to determine whether the work proposed in the order or amendment is within the scope of the original contract and whether the work proposed in the order or amendment is necessary. The Department of Administration may assist the contracting agency in negotiations regarding any change to the original contract price.