



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 201 E. Washington Ave., 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: N/A

Contract Term: 1/1/2025-12/31-2025

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 Van Sicklen, Kelly.VanSicklen@dhs.wisconsin.gov

Contractor Contract Administrator:

Contractor Telephone:

Contractor Email:

Modification Description: Updated language regarding Hospital Access, UW State Directed Payments, and CY2025 Rates.

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Article XVI. Payments to the HMO

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I. Hospital Access Payment

The Department will pay the HMO monthly hospital inpatient BadgerCare Plus and SSI access payments and monthly hospital outpatient BadgerCare Plus and SSI access payments within the limits of the budgeted allocation from the hospital assessment fund.

The Department's monthly hospital access payments to the HMOs are made as prospective per member per month payments, unadjusted for risk.

Each month's payment is based on that month's enrollment and is paid out in the following month.

1. Definitions

- a. An “eligible hospital” means a Medicaid-enrolled Wisconsin hospital that is not
 - i. An institution for mental disease
 - ii. A general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital, nor
 - iii. A long-term care acute hospital.

A list of qualifying hospitals is available from the Department upon request by emailing DHSDMSBRS@dhs.wisconsin.gov.

- b. “Qualifying claims” are all inpatient discharges and outpatient claims for which the HMO made partial or full payments to eligible hospitals for services provided to the HMO’s Medicaid, BadgerCare Plus, and SSI members.
 - i. If the HMO pays any part of the claim, even if there is a third party payer other than Medicare, the claim is a qualifying claim. Qualifying claims include claims for childless adults. Qualifying claims do not include claims for members who are enrolled in Medicare, nor claims that a third party paid in full.

2. HMO Payments to Eligible Hospitals

- a. The HMO must pay hospital access payment rates to eligible hospitals for qualifying claims with dates of service January 1, 2025, through December 31, 2025.
- b. The Department sets hospital access payment rates for critical access and non-critical access hospitals and for inpatient and outpatient services.
- c. The HMO must pay the Department-specified rates for each qualifying claim, regardless of the amount of the base claims payment for those inpatient discharges and outpatient claims.
 - i. The HMO must pay this rate even if the total amount that the HMO must pay differs from the amount that the HMO received from the Department’s per member per month access payment.
 - ii. If the HMO has no qualifying claims for a specific category, the HMO will hold the funding received for that category until the recalculation of the hospital access payment rates after the end of the rating period.
- d. The Department will calculate the payments that the HMO must make to each hospital for qualifying claims with dates of service January 1, 2025, to December 31, 2025.
- e. The payments calculated by the Department will equal the qualifying claims multiplied by the access payment rate determined by the Department minus access payments that the HMO previously paid to the hospital for those same qualifying claims.
- f. The payments calculated by the Department will be for all qualifying claims that have been paid by the HMO and submitted as encounters to the Department as of dates determined by the Department.
- g. The Department will issue payment to the HMO in the amount the HMO must distribute to the hospitals. The HMO must send payments to hospitals within 15 calendar days after the HMO receives payment from the Department. The HMO’s

payments to the hospitals are in addition to any amount the HMO is required by agreement to pay the hospital for provision of services.

- h. At the end of the rating period, the Department will recalculate hospital access payment rates.
 - i. The Department will recoup funds from or make additional payments to the HMO to ensure that the total hospital access payment funding that the HMO receives is equal to the total amount that the HMO needs to pay to eligible hospitals with the recalculated hospital access payment rates.
 - ii. The Department will calculate the amount that the HMO must recoup or pay to eligible hospitals to ensure that the total payments that each hospital receives equals the amount that the hospital would have received in hospital access payments if the recalculated hospital access payment rates had been in effect as of January 1, 2025.
 - iii. The HMO will recoup from or make additional payments to eligible hospitals within 15 days of the Department recouping or paying the HMO for the recalculated hospital access payments.
- i. The HMO must recoup access payments made to long term care acute hospitals after January 1, 2025 within 15 days of the first payment from the Department.

3. Reporting Requirements

a. Reporting Requirements to the Department

Within 30 calendar days of receipt of payment from the Department, the HMO must email to DHSDMSBRS@dhs.wisconsin.gov the HMO Access Payment template provided by the Department to report qualifying claims and hospital access payment amounts the HMO paid to each hospital.

- i. The HMO must attest that based on the information, knowledge, and belief, the data, documentation, and information provided is accurate, complete, and truthful.
- ii. The HMO Access Payment submission must reflect the actual amount that the HMO paid to each hospital.

b. Reporting Requirements to Eligible Hospitals

- i. The HMO must send a report with its payment to each eligible hospital that contains the following information:
 - a) That hospital's number of qualifying inpatient discharges;
 - b) That hospital's number of qualifying outpatient claims;
 - c) Access payment rate per qualifying inpatient discharge;
 - d) Access payment rate per qualifying outpatient claim;
 - e) Total access payment amount for that hospital's qualifying inpatient discharges;
 - f) Total access payment amount for that hospital's qualifying outpatient claims;
 - g) The amount of the total payment to that hospital.

- c. After the rating period, when the Department finalizes hospital access payment rates, the HMO must send an updated report to each hospital with the information required in Article XVI.I.3. that includes the entire calendar year and the final hospital access payment rates.
4. Noncompliance
- a. The Department may audit any records of the HMO to determine if the HMO has complied with the requirements in this section I.
 - b. If at any time the Department determines that the HMO has not complied with any requirement in this section I., the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department’s determination of noncompliance.
 - c. If the HMO fails to comply after an order, the Department may terminate the contract as provided under Article XIV.E.2.
 - d. Upon request, the HMO must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.
 - e. If the HMO fails to send payment to the hospital within 15 calendar days of receiving the hospital access payment from the Department, the HMO will pay an assessment to the Department equal to three percent of the delayed payment.

5. Payment Disputes

If the hospital disputes the monthly amount that the HMO is required to pay the hospital, the hospital may choose to use the provider appeal process in Article VIII.

6. Resolution of Reporting Errors

- a. If an error is discovered, the HMO must notify the Department by emailing DHSDMSBRS@dhs.wisconsin.gov within 15 calendar days of the discovery
- b. The HMO must adjust prior hospital access payments that were based on an inaccurate counting of qualifying claims.
- c. When a report is amended, the HMO must notify the Department by emailing DHSDMSBRS@dhs.wisconsin.gov within 15 calendar days of when the report was amended. The HMO must make corrections using an amended HMO Access Payment template submission. The HMO is responsible for making these adjustments.
- d. The HMO must send an amended report with the information in Art. XVI.I.3.b. to the eligible hospital within 15 calendar days of when the report was amended.

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O. University of Wisconsin Medical Foundation State Directed Payment

- 1. For dates of services between January 1, 2025, and December 31, 2025, the HMO must pay an additional percentage increase of 358% for BadgerCare Plus members and 370% for SSI members on claims for qualifying professional services.
 - a. “Qualifying professional services” are professional services that
 - i. Are provided to BadgerCare Plus and SSI members,

- ii. Are provided by qualified licensed professionals who are enrolled as Wisconsin Medicaid providers, and
- iii. List the University of Wisconsin Medical Foundation as the billing provider. (NPI is 1598784555 and TIN is 391824445).

Qualifying professional services do not include services for members who are enrolled in Medicare, services for members that have third-party insurance coverage, and services for which the HMO does not make any payment.

- 2. The HMO must pay the additional percentage increase on all clean claims for qualifying professional services that have dates of services between January 1, 2025, and December 31, 2025, including claims that the HMO has already paid.
- 3. Payment Process
 - a. All payments for dates of service between January 1, 2025, and December 31, 2025, must be made by June 1, 2026.
- 4. Reporting Requirements
 - a. Reporting to the Department
 - i. The HMO must send a monthly report to DHSDMSBRS@dhs.wisconsin.gov by the first business day of the month. The report must include the following information:
 - a) The total amount paid during the previous month for claims of qualifying professional services at the negotiated rate, and
 - b) The amount of the percentage increase payments for the University of Wisconsin Medical Foundation.
 - b. Reporting to the Provider
 - i. Within 30 days of the end of the quarter, the HMO must send a quarterly report to the University of Wisconsin Medical Foundation including the following information
 - a) The claims included in the quarterly payment, and
 - b) The amount of the percentage increase payment for each claim.
- 5. Dispute Resolution

If the provider disputes the amount of the payment received from the HMO, the provider may choose to use the provider appeal process in Article VIII.

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ADDENDUM IX

CY 2025 Rates

- A.** SSI Medicaid Only Rate Exhibits
- B.** SSI Dual Eligible Rate Exhibits
- C.** BadgerCare Plus Standard Rate Exhibits
- D.** BadgerCare Plus Childless Adult (CLA) Rate Exhibits

State of Wisconsin

Department of Health Services

Authorized Representative
Name

Title

Signature

Date

Contractor

Entity Name

Authorized Representative
Name

Title

Signature

Date

SUPPLIER DIVERSITY AMENDMENT

After completing any contract under this subchapter, the contractor shall report to the agency that awarded the contract any amount of the contract that was subcontracted to minority businesses and any amount of the contract that was subcontracted to disabled veteran-owned businesses.

Each agency shall report to the department at least semiannually, or more often if required by the department, all of the following for the reporting period specified by the department:

- a. The total amount of money it has expended for contracts and orders awarded to minority businesses.
- b. The total amount of money and the percentage of the total amount of money it has expended for contracts and orders awarded to disabled veteran-owned businesses.
- c. The number of contacts with minority businesses in connection with proposed purchases.
- d. The number of contacts with disabled veteran-owned businesses in connection with proposed purchases.

Pursuant to Wis. Stat. 16.75(3m)(c), upon completion of the contract Contractor shall report to DHS any amount of the contract that was subcontracted to minority businesses and any amount of the contract that was subcontracted to disabled veteran-owned businesses. Contractor shall report this information periodically throughout the contract at the direction of DHS.

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.

WEB CONTENT ACCESSIBILITY GUIDELINES (WCAG) 2.1

As required by the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.) and the Rehabilitation Act of 1973 (29 U.S.C. § 791 et. seq.), specifically Sections 504 and 508, Section 1557 of the Affordable Care Act (42 U.S.C. § 18116 et. seq.), and the Nondiscrimination in Healthcare Programs and Activities Rule (89 F.R. 37522) published on April 24, 2024, the Contractor must adhere to the specific Federal requirements therein, ensuring that all web content and mobile applications (apps) are accessible to people with disabilities. To meet those regulations, the Contractor must adhere to the Web Content Accessibility Guidelines (WCAG) 2.1 in the fulfillment of the contract.