CONTRACT FOR SERVICES
between
State of Wisconsin Department of Health Services (DHS)
and
PACE Organization
for
Program of All-Inclusive Care for the Elderly (PACE)

This Contract is between the State of Wisconsin Department of Health Services (DHS), at 1 West Wilson Street, Madison, Wisconsin 53703, and (PACE Organization). 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 in this amendment.
Contract Term: January 1, 2023 to December 31, 2023
Optional Renewal Terms: N/A

DHS Division: Division of Medicaid Services
DHS Contract Administrator:
DHS Contract Manager:

Contractor Contract Administrator:
Contractor Telephone:
Contractor Email:

Modification Description: **Effective January 1, 2023**
Modify the 2022 Contract language as described below and remove the following from the contract:

Remove:
Remove Article XII. P. Business Associate Agreement

The following changes are made to the contract through this amendment:

Article I. Definitions

Amend Article I to add the following definitions:

> **19. Certifying Agency:** an agency authorized by the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes or by the Department to certify and recertify Adult Family Homes.

Agencies authorized to certify AFHs using these standards include MCOs, POs, county agencies, the Department, or approved Department subcontractors.

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55. Functionally Equivalent: means a service provided via telehealth that meets both of the following criteria:

a) The quality, effectiveness, and delivery mode of the service provided must be clinically appropriate to be delivered via telehealth.

b) The service must be of sufficient quality as to be the same level of service as an in- person visit. Transmission of voices, images, data, or video must be clear and understandable.

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92. Member Incident: an event involving a PO member that the PO is required to report as identified in Article V.P.

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111. Placing Agency: an agency responsible for facilitating the placement of a resident in an Adult Family Home. Placing agencies may be POs, MCOs the IRIS (Include, Respect, I Self-Direct) program, and county agencies that certify and place individuals in certified 1-2 bed Adult Family Homes.

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135. Telehealth: The use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a certified provider and a recipient that consists solely of an email, text, or fax transmission.

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Amend Article I to replace the following definition:

78. Long Term Care Functional Screen or **LTCFS:** a uniform screening tool administered by the Department and certified functional screeners that is used to determine functional eligibility under Wis. Stat. §§ 46.286(1) (a) and (1m) and Wis. Admin. Code §§ DHS 10.32 and 10.33.

Article III. Eligibility

Amend Article III. C. 3. to read:

3. Monitoring Cost Share or Patient Liability

a. When the Department grants a cost share reduction due to financial hardship, the Department will provide the PO with a copy of the member's cost share reduction award letter.

i. Annually thereafter, if the reduction is still in effect, the PO shall verify whether the member continues to experience a financial hardship. The PO shall conduct this verification during the member's annual reassessment.

a) If the member indicates that they continue to experience a financial hardship and therefore need a cost share reduction, the PO's enrollment/eligibility staff shall verify whether the member's income and monthly necessary living expenses necessitate the continuation of their cost share reduction. PO staff may request any documentation needed to verify whether an ongoing hardship exists.

b) If the member indicates that they no longer need a cost share reduction or the PO is unable to verify that an ongoing financial hardship exists, the PO must ensure that this change is reported to the local IM agency.

ii. The PO is responsible for the ongoing monitoring of the cost share or patient liability amounts of its members. The PO is also responsible for knowing what the member's ongoing medical/remedial expenses are and reporting changes in those amounts to the income maintenance agency. The PO is also responsible to report changes in other circumstances of members that may affect the amount of cost share or patient liability to the income maintenance agency within ten (10) calendar days of the PO becoming aware of the change.

Amend Article III. E. to read:

E. Long Term Care Functional Screen

1. *Functional Screen Tool and Database*

   The tool used for determining level of care in PACE is the Long Term Care Functional Screen (LTCFS). Information about the LTCFS is found at: https://www.dhs.wisconsin.gov/functionalscreen/index.htm.

2. *Notification of Changes in Functional Eligibility Criteria*

   The Department will notify the PO of any changes in administrative code requirements related to functional eligibility, including, but not limited to, code changes that result in changes to the LTCFS algorithms or logic in determining functional eligibility for the programs.

3. *Reimbursement*

   If the trained screener administering the LTCFS is an employee, or under direct supervision, of the PO, no Medicaid administration reimbursement may be claimed for administration of the screen.

4. *Level of Care Re-Determinations*

   The PO shall develop procedures to assure that all members have a current and accurate level of care as determined by the LTCFS. Level of care re-determinations may only be completed by an individual trained and certified to administer the LTCFS.

   The responsibility to assure that all members have a current and accurate level of care shall include:

   a. Post-Enrollment Re-Determination

The PO may re-determine level of care for a new member shortly after enrollment if the interdisciplinary team believes that different or additional information has come to light as a result of the initial comprehensive assessment.

The PO shall consult with the ADRC or Tribal ADRS (if applicable) if the PO re-determines level of care for a newly enrolled member or when a newly enrolled member is found to be functionally ineligible or eligibility changes to a non-nursing home level of care within six (6) months of the submission of the most recent pre-enrollment screen. The PO shall review and compare the screens, attempt to resolve the differences, and contact the Department's LTCFS staff if differences cannot be resolved.

b. Annual Re-Determination

An annual re-determination of level of care shall be completed within 365 days of the most recent functional screen.

If the level of care re-determination is not completed in the designated timeframe, the PO is required to inform the income maintenance agency of the lack of functional eligibility determination according to change reporting requirements. (The member will lose Medicaid eligibility if the re-determination is not done timely.)

c. Change of Condition Re-Determination

A re-determination of level of care should be done whenever a member's situation or condition changes significantly.

d. Level of Care Determinations and Redeterminations for Private Pay Individuals

Private pay individuals must meet the functional eligibility conditions for eligibility (see Article I for definition of ""Private Pay Individual"). The initial level of care determination for a private pay individual is performed by the resource center and the annual redetermination of level of care is performed by the PO.

5. *Accuracy of Information*

The PACE organization shall not knowingly misrepresent or knowingly falsify any information on the LTCFS. The PACE organization shall also verify the information it obtains from or about the individual with the individual's medical, educational, and other records as appropriate to ensure its accuracy.

6. *Long Term Care Functional Screener Certification*

a. Education and Experience

Before being allowed to administer the functional screen on individuals, PO staff or PO contractors must satisfy the following standards:

i. Be a representative of a PO with an official function in determining eligibility for a specific program area.

ii. Have a license to practice as a registered nurse in Wisconsin pursuant to Wis. Stat. § 441.06, or a Bachelor of Arts or Science degree or more advanced degree in a health or human services related field (e.g. social work, rehabilitation, psychology), and a minimum of one year of experience working with at least one of the target populations.

iii. Successfully complete the online screener certification training course(s) and become certified as a functional screener by the Department.

Information on the online web class can be found at: https://wss.ccdet.uwosh.edu/stc/dhsfunctscreen and

iv. Meet all other training requirements specified by the Department.

b. Certified Screener Documentation

Each PO shall maintain documentation of compliance with the requirements set forth in section (a) above and make this documentation available to the Department upon request.

7. *Administration of the Screening Program*

a. Listing of Staff with Access to Functional Screen Information Application (FSIA)

Each PO shall maintain an accurate, complete, and up-to-date list of all the staff members and/or PO contractors who have access to FSIA. POs shall submit to the Department requests to have a screener's security access deactivated as follows:

i. If the PO terminates the employment of a staff member or PO contractor with access to FSIA, the PO shall submit the deactivation request within one (1) business day of the terminated individual's termination.

ii. When a staff member or PO contractor with access to FSIA leaves the PO and/or no longer has a need for access to the functional screen application, the agency shall submit the deactivation request within three (3) business days of the departure or reassignment of the individual.

b. Communications

Each PO that administers functional screens shall ensure that each screener is able to receive communications from the Department's functional screen listserv(s).

c. Mentoring

Each PO that employs newly certified screeners shall have a formal program for mentoring new screeners (that is providing them with close supervision, on-the-job training, and feedback) for at least six months.

This program shall be described in internal policy and procedures documents that are made available to new screeners and to the Department upon request. Each PO will include activities that allow new screeners to:

i. Observe an experienced screener administering an actual screen;

ii. Complete practice screens using either the electronic or paper version of the LTCFS;

iii. Be observed by an experienced screener while completing screens and having their screens reviewed by an experienced screener; and

iv. Have the opportunity for discussion and feedback as a result of those observations or reviews.

d. Screen Liaison

Each PO shall designate at least one staff member as "Screen Liaison" to work with the Department in respect to issues involving the screens done by the PO. This person must be a certified functional screener and, at Department determined intervals, successfully pass the required continuing skills testing. This person's current contact information must be provided to the Department.

i. Screeners shall be instructed to contact the Screen Liaison with questions when they need guidance or clarification on the screen instructions, and shall contact the Screen Liaison whenever a completed screen leads to an unexpected outcome in terms of eligibility or level of care;

ii. The duties of the Screen Liaison are to:

a) Provide screeners with guidance when possible, or contact the Department's LTCFS Staff for resolution;

b) Consult with the Department's LTCFS staff on all screens that continue to have an unexpected outcome or that are especially difficult to complete accurately;

c) Oversee new screener mentoring program as listed in 7.c.

d) Act as the contact person for all communications between the Department's LTCFS staff relating to functional screens and the screening program;

e) Ensure that all local screeners have received listserv communications and updates from the Department;

f) Act as the contact person other counties/agencies can contact when they need a screen transferred;

g) Act as the contact person for technical issues such as screen security and screener access;

h) Consult with the ADRC or Tribal ADRS (if applicable) when the PO re-determines level of care for a newly enrolled member or a newly enrolled member is found to be functionally ineligible or eligibility changes to a non-nursing home level of care within six months of the submission of the most recent pre-enrollment screen. Review and compare the screens and attempt to resolve differences. Contact the Department's LTCFS staff if differences cannot be resolved.

iii. Either through the screeners' supervisor or through the Screen Liaison, or both, provide ongoing oversight to ensure that all screeners:

a) Follow the most current version of the WI Long Term Care Functional Screen Instructions and all documents issued by the Department. These are available and maintained at: https://www.dhs.wisconsin.gov/functionalscreen/index.htm.

b) Meet all other training requirements as specified by the Department.

8. *Screen Quality Management*

POs shall have a screen quality management program developed in internal policies and procedures. These policies and procedures shall be made available to the Department upon request.

Activities documented in these policies and procedures shall include:

a. Monitoring Screeners

The policies and procedures shall describe the methods by which the Screen Liaison(s) monitors the performance of individual screeners and provides each

screener with prompt guidance and feedback. Minimum monitoring methods include:

i. Participation of the Screen Liaison(s) in staff meetings where screeners discuss and consult with one another on recently completed functional screens;

ii. Identification of how the accuracy, completeness, and timeliness of annual and change-in-condition screens submitted by screeners will be monitored;

iii. Identification of how changes of condition are communicated between IDT staff and screeners when screens are completed by non-IDT staff; and

iv. Identification of the methods that will be employed to improve screener competency given the findings of the monitoring.

b. Continuing Skills Testing

The PO shall require all of its certified screeners to participate in continuing-skills testing required by the Department. The Department requires each screener to pass a test of continuing knowledge and skills at least once every two years, in order to maintain their certification. The PO will:

i. Provide for the participation of all certified screeners in any continuing-skills training and testing that is required by the Department.

ii. Administer continuing-skills testing required by the Department in accordance with instructions provided by the Department at the time of testing.

iii. Cooperate with the Department in planning and carrying out a plan of correctionif the results of the continuing-skills testing indicate performance of any individual screener or group of screeners is below performance standards set for the test result, including retesting if the Department believes retesting to be necessary.

c. Annual Review

At a minimum, annually review a sample of screens from each screener. This is to determine whether the screens were done in a complete, accurate, and timely manner and whether the results were reasonable in relation to the person's condition.

d. Remediation

Review and respond to all quality assurance issues detected by the Department's LTCFS staff. The PO shall correct errors in evaluating level of care within 10 days of notification by the Department's LTCFS staff.

e. Quality Improvement

Implement any improvement projects or correction plans required by the Department to ensure the accuracy and thoroughness of the screens completed by the agency.

f. Subcontracts

PO that subcontract with another entity or organization to conduct functional screens on behalf of the PO must adopt policies and procedures to ensure subcontractor screen quality.

Article V. Care Management

Amend Article V. B. to read:

B. Interdisciplinary Team Composition

The interdisciplinary team (IDT) is the vehicle for providing member-centered care management. The full IDT always includes the member and other people specified by the member, as well as IDT staff. Throughout this article the term "IDT staff" refers to the social worker, registered nurse and any other staff who are assigned or contracted by the PO to participate in the IDT and is meant to distinguish those staff from the full IDT.

1. *The member receives care management through designated IDT staff, which at a minimum include the following:*
    a. Primary care provider,
    b. Registered nurse,
    c. Master's level social worker,
    d. Physical therapist,
    e. Occupational therapist,
    f. Recreational therapist or activity coordinator,
    g. Dietician,
    h. PACE center manager,
    i. Home care coordinator,
    j. Personal care attendant or their representative,
    k. Driver or their representative.
    l. The team may include additional persons with specialized expertise for assessment, consultation, ongoing coordination efforts and other assistance as needed.
2. The IDT staff shall have knowledge of community alternatives for the target populations served by the PO and the full range of long-term care resources. IDT staff shall also have specialized knowledge of the conditions and functional limitations of the target populations served by the PO, and of the individual members to whom they are assigned.
3. The PO shall establish a means that ensures ease of access and a reasonable level of responsiveness for each member to their IDT staff during regular business hours.

Amend Article V. C. to read:

C. Assessment and Member-Centered Planning Process

Member-centered planning is an ongoing process and the member-centered plan (MCP) is a dynamic document that must reflect significant changes experienced in members' lives. Information is captured through the initial comprehensive assessment and changes are reflected through ongoing re-assessments.

Member-centered planning reflects understanding between the member and the IDT staff and will demonstrate changes that occur with the member's outcomes and health status. The member is always central to the member-centered planning and comprehensive assessment process. The IDT staff will ensure that the member is at the center of the member-centered planning process. The member will actively participate in the planning process, in particular, in the identification of personal outcomes and preferences. All aspects of the member-centered planning and

comprehensive assessment process involving the participation of the member must be timely and occur at times and locations consistent with the requirements of Article V. C and H. The member-centered plan incorporates the following processes:

1. *Comprehensive Assessment*

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c. Documentation

The comprehensive assessment will include documentation by the IDT staff of all of the following:

i. The registered nurse on the IDT is responsible to assure that a full nursing assessment is completed. This assessment identifies risks to the member's health and safety, including but not limited to risk assessments for falls, skin integrity, nutrition and pain as clinically indicated. The nursing assessment also includes an evaluation of a member's ability to set-up, administer, and monitor their own medication. This includes medication review and intervention.

ii. A member of the IDT staff is responsible for reviewing and documenting in the comprehensive assessment the member's medications every six months or whenever there is a significant change in the member's health or functional status. When a complex medication regimen or behavior modifying medication or both are prescribed for a member, the IDT staff nurse or other appropriately licensed medical professional shall ensure the member is assessed and reassessed, as needed, but at least every six months for the desired responses and possible side effects of the medication, and understands the potential benefits and side effects of the medication and that all assessments results and follow-up have been completed and documented in the member record. If a complex medication regimen or behavior modifying medication or both are prescribed, the IDT staff nurse or other appropriately licensed medical professional shall ensure that the comprehensive assessment includes the rationale for use and a detailed description of the behaviors which indicate the need for administration of the complex medication regime or behavior modifying medication.

iii. When there is a discrepancy between medications prescribed and medications being taken, the IDT staff is responsible, in accordance with state and professional standards, to assure that efforts are made to clarify and reinforce with the member the correct medication regimen.

iv. An exploration with the member of the member's understanding of self-directed supports and any desire to self-manage all or part of the member's care plan.

v. An exploration with the member of the member's preferences in regard to privacy, services, caregivers, and daily routine, including, if appropriate, an evaluation of the member's need and interest in acquiring skills to perform activities of daily living to increase the member's capacity to live independently in the most integrated setting.

vi. An assessment of mental health and alcohol and other drug abuse (AODA) issues, including risk assessments of mental health and AODA status as indicated.

vii. An assessment of the member's overall cognition and evaluation of risk of memory impairment.

viii. An assessment of the availability and stability of natural supports and community supports for any part of the member's life. This shall include an assessment of what it will take to sustain, maintain and/or enhance the member's existing supports and how the services the member receives from such supports can best be coordinated with the services provided by the PO.

ix. An exploration with the member of the member's preferences and opportunities for community integration including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.

x. An exploration with the member of the member's preferred living situation and a risk assessment for the stability of housing and finances to sustain housing as indicated.

xi. An exploration with the member of the member's preferences for educational and vocational activities, including supported employment in a community setting.

xii. An assessment of the financial resources available to the member.

xiii. An assessment of the member's understanding of the member's rights, such as control of money, freedom of speech, freedom of religion, right to vote, right to privacy, freedom of association, right to possessions, right to employment, right to education, access to healthcare, and right to choose leisure and rest, the member's preferences for executing advance directives and whether the member has a guardian, durable power of attorney or activated power of attorney for health care.

xiv. An assessment of vulnerability and risk factors for abuse and neglect in the member's personal life or finances including an assessment of the member's potential vulnerability/high risk per Article V.J.1. and an assessment of the member's understanding of abuse, neglect, and exploitation.

2. IDT staff will work with the member to identify and document in the comprehensive assessment and MCP the long-term care and personal experience outcomes.

3. Member-Centered Planning

a. Purpose

i. Member-centered planning is a process through which the IDT identifies appropriate and adequate services and supports to be authorized, provided and/or coordinated by the PO sufficient to assure the member's health, safety, and well-being including being free from abuse, neglect, and exploitation.

ii. Member-centered planning results in a member-centered plan (MCP) which identifies the long-term care and personal experience outcomes. The plan identifies all services and supports whether authorized and paid for by the PO, or provided by natural and/or community supports that are consistent with the information collected in the comprehensive assessment and are:

a) Sufficient to assure the member's health, safety and well-being;

b) Consistent with the nature and severity of the member's disability or frailty; and

c) Satisfactory to the member in supporting the member's long-term care outcomes.

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Amend Article V. G. to read:

G. Reassessment and MCP Update

1. *Reassessment*

IDT staff shall routinely reassess, and as appropriate update, all sections of the member's comprehensive assessment and MCP as the member's long-term care outcomes change. At a minimum, the reassessment and MCP review shall take place no later than the end of the sixth month after the month in which the previous comprehensive assessment was completed. The reassessment shall include a review of previously identified or any new member long-term care outcomes and supports available. At a minimum:

a. The PCP, IDT social worker, registered nurse, and any other IDT members that the PCP, RN, or IDT social worker determine are actively involved in the development or implementation of the MCP shall participate in the reassessment, which is completed no later than the end of the sixth month after the month in which the previous comprehensive assessment was completed. The reassessment includes an in-person interview with the member by the IDT social worker and registered nurse. IDT staff may complete in-person interviews at different times. For vulnerable/high risk members, the reassessment shall occur in the member's current residence;

b. The IDT staff conducting the re-assessment shall ensure that the other IDT members are updated and involved as necessary on the reassessment;

c. When a complex medication regime or behavior modifying medication or both are prescribed for a member, the requirements in C.1.c.ii. shall be met.

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Amend Article V. H. to read:

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 a minimum, IDT staff is required to conduct in-person visits with all members every three months. The PCP is required to conduct an in-person visit, and the IDT social worker, and registered nurse are further required to visit the member in the member's residence at minimum:

a. Every twelve (12) months, for all members as part of the reassessment; and

b. Every six (6) months for vulnerable/high risk members as part of the reassessment. The scheduled reassessment visits count for two of the in-person contacts required

by this subsection. The PO shall notify the Department contract coordinator about members who meet the vulnerable/high risk criteria but refuse in person visit(s) in their primary residence.

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Amend Article V. K. to read:

K. Service Authorization

1. *Service Authorization Policies and Procedures*

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f. 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 Article 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 VI.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 is functionally equivalent to in-person service

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 PO 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.

POs must include the modifier 95 when the PO submits claims that are delivered remotely.

The following services in Addendum VI.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 VI.B 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.

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Amend Article V. O. to read:

O. PACE Organization Duty to Immediately Report Certain Member Incidents

1. *The PO is required to report immediately to its DHS Member Care Quality Specialist any of the following:*

a. Upon learning a member's whereabouts are not known for 24 hours or more, under any of the following circumstances:

i. The member is under guardianship/protective placement;

ii. The member has been identified as a vulnerable/high risk member as defined under Article I. 135;

iii. The PO has reason to believe that the member's health or safety is at risk;

The member is a potential threat to the community or self;

The member has a significant medical condition that would deteriorate without medications/care;

The member lives in a residential facility; or

The area is experiencing potentially life-threatening weather conditions.

b. Upon learning a member has died under any of the following circumstances:

i. Death involving unexplained, unusual, or suspicious circumstances;

ii. Death involving apparent abuse or neglect;

iii. Apparent homicide;

iv. Apparent suicide;

v. Apparent poisoning;

vi. Apparent accident, whether the resulting injury is or is not the primary cause of death; or

vii. When a physician refuses to sign the death certificate.

c. Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances:

i. When unexplained, unusual, or suspicious circumstances exist;

ii. When physical abuse, sexual abuse, or neglect exist;

iii. When the member has been poisoned; or

iv. When law enforcement, Adult Protective Services (APS) or a court of law have investigated and/or are involved;

d. Upon learning a member has been admitted to a state IMD or Intensive Treatment Program (ITP). A list of both county and privately operated IMDs in Wisconsin can be found in section 27.11 of the Medicaid Eligibility Handbook.

e. Upon learning that an Emergency Restrictive Measure, as defined in Wis. Stat. § 46.90(1)(i), was used on a member regardless of injury:

2. The PO is required to notify the contract coordinator and MCQS within 24 hours of being made aware of a news story or social media story involving a PO member, the PACE program, the PO, or the Department, by email when a member(s) or the PO is involved or mentioned in a newsworthy event and/or received media attention. A submission of an Immediately Reported Incident is only required if it also meets a circumstance in a-e above.

3. In addition to the immediate reporting requirements provided by Article V.O.1., the PO 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/2020-report-reqs.pdf

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Article VIII. Provider Network

Amend Article VIII. D. to read:

D. Provider Agreement Language

In addition to the requirements in 42 C.F.R. § 460.70, the provider must agree to abide by all applicable provisions of this contract. Provider compliance with this contract specifically includes, but is not limited to, the following requirements (except for specific areas that are inapplicable in a specific provider agreement):

1. *Purpose of the Program*

The provider agreement clearly defines the purpose of the program.

2. *Term and Termination*

a. The provider agreement specifies the start date of the provider agreement and the means to renew, terminate and renegotiate. The provider agreement specifies the PO's ability to terminate and suspend the provider agreement and a process for the provider to appeal the termination or suspension decision.

b. The PO will ensure that provider agreements reflect all current PO contract and provider agreement requirements.

c. The Department is primarily responsible for monitoring and terminating providers from the Medicaid program for reasons listed under Wisconsin Admin. Code § DHS 106.06 as well as the reasons listed below in Art. VIII.D.5.e and h. The Department will inform the PO when a provider is terminated from the Wisconsin Medicaid program for cause and the PO must terminate that provider from its network.

d. The PO is primarily responsible for monitoring and terminating waiver service providers for the reasons listed below in Art.VIII.D.2.e.i-vi and Art. VIII.D.2.h.i-viii.

e. The PO must terminate a provider for cause in all the following circumstances:

   i. Criminal Conviction. The provider or any person with a 5 percent or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted (as defined in 42 CFR § 1001.2) of a Federal or State criminal offense related to that person's involvement with Medicare, Medicaid or CHIP. This requirement applies unless the PO receives permission from the Department to not terminate the provider as identified in VIII.D.5.e.

   ii. Failure to Comply with Screening Requirements. Where any person with a 5 percent or more direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR § 455.416(a).

   iii. Failure to Submit Fingerprints. Where the provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Department within 30 days of a CMS or the Department's request. This requirement applies unless the PO receives permission from the Department to not terminate the provider as identified in VIII.D.5.e.

   iv. Failure to Submit Timely and Accurate Information. The provider or a person with an ownership control interest, an agent, or managing employee of the provider fails to submit timely and accurate information. This requirement applies unless the PO receives permission from the Department to not terminate the provider as identified in VIII.D.5.e.

   v. Onsite Review. The provider fails to permit access to provider locations for any site visit. This requirement applies unless the PO receives permission from the Department to not terminate the provider as identified in VIII.D.5.e.

   vi. Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment. The provider's enrollment has been terminated or revoked "for cause" by Medicare or another state's Medicaid program.

f. The PO must terminate a provider due to a reason in Article VIII.D.5.e.i and iii. through v., unless the PO obtains approval from the Department to not terminate the provider. This process is not available for an PO when a provider must be terminated due to a reason in Article VIII.D.5.e.ii and vi. The PO must contact its contract coordinator to request permission to not terminate the provider. The contractor coordinator shall alert the DHS OIG of the request. The DHS OIG will determine whether the termination can be waived.

g. As required in Article VIII.J.1.a.i., the PO is required to notify the Department at DHSDMSLTC@dhs.wisconsin.gov within seven (7) calendar days when any notice is given by the PO to a provider, or any notice given to the PO from a provider, of a provider agreement termination, a pending provider agreement termination, or a pending modification in provider agreement terms that have potential to limit member access or compromise the PO's ability to provide necessary rights.

h. The PO may terminate a provider for cause in all the following circumstances:

i. Abuse of Billing Privileges. The provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service including when the beneficiary is deceased, where the directive physician or the beneficiary is not in the state when the services were furnished unless otherwise authorized by telehealth rules, or when the equipment necessary for testing is not present where the testing is said to have occurred.

ii Billing with Suspended License. Billing for services furnished while the provider's license is in a state of suspension.

iii Improper Prescribing Practices. The PO determines that a provider has a pattern of practice of prescribing drugs that is abusive, as defined in 42 C.F.R. § 455.2, or represents a threat to the health and safety of members.

iv Misuse of Billing Number. The provider knowingly sells to or allows another individual or entity to use its billing number, other than a valid reassignment of benefits.

v Noncompliance with Licensure Standards. When the provider has been subject to an adverse licensure action resulting in the loss of license. This does not include license expiration.

vi Prescribing Authority. The provider's Drug Enforcement Administration Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any state in which the provider practices suspends or revokes the provider's ability to prescribe drugs.

vii Provider Conduct. The provider or any owner, managing employee, or medical director of the provider is excluded from the Medicare or Medicaid programs.

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 PO and provider.

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

iii. 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 PO 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 12-month period.

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

…

Amend Article VIII. G. to read:

G. Provider Certification and Standards

1. *Wisconsin Provider Standards*

The PO shall use only providers that meet Department requirements, and

a. For waiver services in Addendum VIII.A.:

i. Meet the provider standards in Wisconsin's approved s. 1915 (c) home and community-based waiver,

ii. Meet all required licensure and/or certification standards applicable to the service provided,

iii. Are enrolled with the Department; and

iv. Are a licensed or certified residential provider or a non-residential setting in which adult day care, prevocational, adult day habilitation or group supported employment services are provided, if the setting has been determined by the certification agency or the Department to be in compliance and remains in compliance through ongoing assessment with the home and community-based setting requirements under 42 C.F.R. § 441.301(c)(4). An exception to this requirement is a setting that was operating prior to March 17, 2014 that is subject to heightened scrutiny and is awaiting a determination of compliance from CMS. Or

…

Amend Article VIII. H. to read:

H. Equity and Inclusion

1. *Equity and Inclusion*

The PO shall encourage and foster Equity and Inclusion among PO staff and providers.

The PO shall incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs, being sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity, and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds.

The PO shall have specific policy statements on these topics and communicate them to subcontractors and providers.

2. *Cultural Preference and Choice*

The PO shall permit members to choose providers from among the PACE network of providers based on cultural preference, including the choice of Indian members to choose to receive services from any Indian health care provider in the network as long as that provider has capacity to provide the services.

Amend Article VIII. I. to read:

I. Access to Providers

…

5. *Assuring Network Adequacy*

a. The PO shall demonstrate that its provider network complies with the state developed network adequacy standards as specified in the PO Provider Adequacy Policy (https://www.dhs.wisconsin.gov/publications/p02542.pdf).

b. The Department may grant an exception to these standards if the PO requests an exception and provides all of the following to the Department:

i. The number of and availability of providers in the particular specialty who are practicing in the county.

ii. The PO's ability to contract with available providers

iii. The impact to members in the proposed county and the surrounding areas

iv. The PO plan for how the PO will serve its members despite network adequacy deficiencies.

c. The Department will require the PO to submit documentation to address the factors listed above. If the Department grants an exception, the Department will monitor member access to affected provider type(s). Further, if the Department grants an exception, the PO will be required to provide updates on its efforts to meet network adequacy requirements every 90 days or upon the Department's request.

…

Amend Article VIII. L. to read:

L. Payment

…

10. 2022 American Rescue Plan Act Rate Increase

a. For purposes of this section, "ARPA eligible service provider" are providers of:

- adult day care services,
- alcohol and other drug abuse (AODA) services,
- AODA Day Treatment,
- Assistive technology
- consultative clinical and therapeutic services for caregivers,
- consumer directed supports (self-directed supports) broker,
- consumer education and training,
- counseling and therapeutic,
- financial management services,
- habilitation services (daily living skills training and day habilitation resources),

- home delivered meals,
- home health services,
- housing counseling,
- mental health day treatment,
- mental health services,
- nursing provided in the home,
- occupational therapy provided in the home,
- personal care,
- physical therapy provided in the home,
- prevocational services,
- residential care,
- respiratory care,
- respite
- self-directed personal care,
- skilled nursing services (RN/LPN) ,
- speech and language pathology services provided in the home,
- supported employment - individual employment support, supported employment - small group employment support,
- supportive home care (SHC),
- training services for unpaid caregivers,
- transportation as defined in Wis. Admin. Code DHS § 107.23, excluding ambulance,
- transportation (specialized transportation) - community transportation,
- transportation (specialized transportation) - other transportation, and
- vocational futures planning and support (VFPS).

b. Providers of services not listed, including but not limited to retail providers, nursing homes, community support program, common carrier transportation, and POs are not ARPA eligible service providers under this section.

c. POs are required to provide a unit rate increase to all eligible providers equal to 5% of each eligible provider's rates for Family Care and Family Care Partnership covered services effective January 1, 2022. This increase shall remain in effect for 2023 provider rates. The 5% unit rate increase on covered services equates to a unit rate increase of 4.13% when calculated on covered and non-covered services for residential providers. POs will need to identify this unit rate increase in their contracts with providers as a separate line item from other components of the PO's contracted rate with the provider. This line item will be labeled "2022 American Rescue Plan Rate Increase" and contracts with the provider must include a line item for this same per unit amount. POs may not modify the amount of the American Rescue Plan Rate Increase line item.

d. The PO shall provide to the Department the following items by deadlines established by the Department:

   i. Financial reporting documenting:

      a) The number of provider rate increases implemented as of the time period covered in the financial reporting,

      b) The number of provider rate increases still to be implemented as of the time period covered by the financial reporting,

      c) An estimate of the funding paid out to providers as of the 2022 American rescue Plan Rate Increase, and

d) An estimate of the increased funding received from the Department through capitation payments for this 2022 American Rescue Plan Rate Increase. Amounts must document actual amount paid and not accrued.

ii. A signed attestation that all of the funding paid to the PO by the Department for this purpose was paid to ARPA eligible service providers in accordance with VIII.10. of this contract.

e. The PO shall send all required documents and reports to the Department to DHSLTCFiscalOversight@dhs.wisconsin.gov with "Attention: 2022 American Rescue Plan Rate Increase MCO Submission" in the subject line.

Amend Article VIII. N. to read:

N. Standards for PACE Organization Staff

…

6. Certification and Contracting with 1-2 Bed Adult Family Homes

a. PO must adhere to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes: https://www.dhs.wisconsin.gov/publications/p0/p00638.pdf

b. Placing POs are required to notify a 1-2 bed certifying agency of all new placements in a 1-2 bed AFH.

c. Placing POs are required to notify the certifying agency of any incidents, identified in Article V.H.2.ii, iii, and v., that occur in a 1-2 bed AFH within 24 hours.

d. Certifying POs are required to inform all placing agencies of any incidents that may jeopardize the health and safety of residents residing in a 1-2 bed AFH they certify within 24 hours.

e. Certifying POs are required to investigate and follow up when incidents, identified in Article V.H.2.ii, iii, and v., take place in the homes they certify.

f. Certifying and Placing POs are responsible for assuring that 1-2 bed AFHs are notifying both the placing agencies and certifying agency of all incidents, identified in Article V.H.2.ii, iii, and v.

g. Certifying POs are responsible for tracking all incidents identified in Article V.H.2.ii, iii, and v and the incident outcomes that take place in the homes they certify.

h. Certifying POs are required to submit their training plans and policies to the Department on how the PO ensures their staff have the knowledge and capability to certify and contract with 1-2 bed AHFs.

i. Certifying POs must inform contracting agencies immediately if the certification will be revoked or the certifying PO plans to let the certification lapse without renewal.

Article IX. Marketing and Member Materials

Amend Article IX. D. to read:

D. Provider Network Directory and Information

1. *The PO must develop and maintain up-to-date provider network directories and information.*

    a. An electronic version of the PO's provider network directory must be maintained with complete and current information on the PO's website. To be considered current, electronic versions of provider network directories, including internet directories, must be updated no later than thirty (30) calendar days after the PO receives updated provider information.

    b. The paper version of the provider network directory must be updated at least monthly.

    c. The PO must make the updated provider directories available to members upon initial enrollment and upon request.

    d. When significant changes occur in the provider network, the PO must provide members a revised directory, an addendum to the directory or other written notification of the change.

2. Provider directories must be made available on the PO's website in a machine readable file and format as specified by the Department.

3. The PO must make current information on the PO's provider network available to IDT staff for care planning and appropriate authorization of services.

4. The PO must provide all ADRCs in its service area with electronic access to complete and up-to-date provider network information, so that ADRCs can access the information at any time for the purpose of enrollment counseling.

5. The provider directory shall include providers that are under contract with the PO, including physicians, hospitals, pharmacies, behavioral health providers, and long-term care providers. The directory will include the following information for providers under contract with the PO:

    a. Provider name as well as any group affiliation (individual practitioner, clinic or agency as appropriate) including primary care physicians, specialists and hospitals

    b. Provider street address(es), telephone number(s), website URL, (as appropriate), and for in-home service providers, the service area;

    c. Services furnished by the provider;

    d. Provider specialty (as appropriate);

    e. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract;

    f. Whether the provider is accepting new PACE members. If a preferred provider is not accepting new members, the PO will assist the member in obtaining an alternate provider;

    g. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or skilled medical interpreter at the provider's office, and whether the provider has completed training in an equity and inclusion framework such as cultural competence, cultural humility, and other types of equity inclusion training; and

    h. Accessibility of the provider's premises (if the member will be receiving services at the provider's premises), including offices, exam rooms and equipment.

Amend Article IX. E. to read:

E. Accessible Formats, Languages, and Cultural Respect

The PO shall provide member and marketing/outreach materials in a manner and format that may be easily understood and is readily accessible. Materials shall be understandable in language and format based on the following:

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

   b. Material directed at a specific member shall be in the language understood by the individual or oral interpretation shall be provided to the individual free of charge.

   c. Written materials that are critical to obtaining services, including provider directories, handbooks, appeal and grievance notices, and denial and termination notices shall include taglines and be available in prevalent non-English languages in the PACE service area.

2. *Materials Easily Understood and Accessible*

   All materials produced and/or used by the PO must:

   a. Use easily understood language and format.

   b. Use a font size no smaller than 12 point.

   c. Be available in alternative formats and through the provision of auxiliary aids and services upon request and at no cost.

   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 PO's member/customer service unit.

3. *Cultural Respect*

   Materials for marketing/outreach and for health-promotion or wellness information produced by the PO must be appropriate for its target population and reflect sensitivity to the diverse cultures served.

   If the PO uses material produced by other entities, the PO must review these materials for appropriateness to its target population and for sensitivity to the diverse cultures served.

Article X. Member Rights and Responsibilities

Amend Article X. E. to read:

E. Provision of Interpreters

The PO shall provide interpreter services for members, as necessary, to ensure availability of effective communication regarding treatment, medical history, health education and information provided to members. The PO must offer an interpreter, such as a primary non-English language or a sign language interpreter or a translator, in all crucial situations requiring language assistance

as soon as it is determined that the member is of limited English proficiency or needs other interpreter services. (For related information, refer to Article IX.E., Accessible Formats and Languages and Cultural Sensitivity. The PO shall meet the following requirements in the provision of interpreter services.

…

Article XI. Grievances and Appeals

Amend Article XI. E. to read:

E. Notification of Appeal Rights in Other Situations

1. *Requirement to Provide Notification of Appeal Rights*

   The PO must provide members with written notification of appeal and grievance rights in the following circumstances.

   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 PO and the member's right to request a State Fair Hearing following the PO's appeal decision or the PO's failure to issue a decision within the timeframes specified in Article XI.F.5.e. and f. The PO shall provide for functional eligibility re-screening by a different screener within ten (10) calendar days of a request by a member or a member's legal decision maker.

      The PO does not need to provide notification of change in level of care if the member is found to no longer meet the nursing home 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.

   …

…

Amend Article XI. F. to read:

F. PACE Organization Grievance and Appeal Process

…

5. *PACE Organization Process for Appeals*

   …

   e. Standard Appeal Resolution Timeframe

      i. Unless the member requests expedited resolution, the PO must mail or hand-deliver a written decision on the appeal no later than thirty (30) calendar days after the date of receipt of the appeal.

   …

…

Article XII. Quality Management (QM)

Amend Article XII. C. to read:

C. Activities of the QM Program

…

6. *Monitoring Restrictive Measures*

The PO shall have policies and procedures to ensure:

a. Review and decision on all requests for restrictive measures respective to its members prior to submission of the request to the designated state level approving entity.

b. Maintenance of data related to all restrictive measures requests and decisions respective to its members regardless of the state level entity utilized for restrictive measures review and approval.

c. Education of all individuals involved in the administration of restrictive measures by the Department, designated restrictive measures expert(s), and/or designated competent PACE staff.

d. PO report of member restrictive measures data to the Department in accordance with the Department's restrictive measures report specifications. Member restrictive measures data is submitted to the Department on a quarterly basis as described in Article XIV.C.3. The report shall be submitted electronically as specified by the Department.

…

Article XIII. PACE Organization Administration

Amend Article XIII. A. to read:

A. Member Records

1. In addition to the requirements in 42 C.F.R. § 460.200(d),(e), the PO shall:

…

c. *Unauthorized* Use*, Disclosure, or Loss*

If the PO becomes aware of any threatened or actual use or disclosure of any confidential information that is not specifically authorized by this contract, or if any confidential information is lost or cannot be accounted for, the PO shall notify the Department's Privacy Officer and the contract coordinator within one day of the PO becoming aware of such use, disclosure, or loss. The notice shall include, to the best of the PO's understanding, the persons affected, their identities, and the confidential information that was disclosed.

The PO shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The PO shall reasonably cooperate with the Department's efforts, if any, to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its confidential information, including complying with the following measures, which may be directed by the Department, at its sole discretion:

…

…

…

Remove Article XIII. P. Business Associate Agreement

Article XIV. Reports and Data

Amend Article XIV. C. Reports: Regular Interval to add:

C. Reports: Regular Interval

…

4. Semiannual IMD Report

The PO shall track all IMD stays and submit a Semiannual IMD Report that includes all IMD stays within the applicable reporting period (January 1 through June 30, or July 1 through December 31). The Semiannual IMD Report is due forty-five (45) calendar days after the reporting period or the following business day. The PO shall complete the report using an excel spreadsheet e-mailed to each PO. The report spreadsheet shall be returned, password-protected, via encrypted e-mail to DHSIMDRI@dhs.wisconsin.gov

…

Article XVI. Contractual Relationship

Amend Article XVI. E. to read:

E. Sanctions for Violation, Bread, or Non-Performance

…

2. *Sanctions*

…

c. Notice of Sanctions

i. Notice to PO

Except as provided in Article XVI.E.2.e.iv. before imposing any of the sanctions described in Article XVI.E.2., the Department must give the affected PO written notice that explains the following:

a) The basis and nature of the sanction.

b) Any other due process protections that the Department elects to provide.

ii. Notice to CMS

The Department must notify CMS no later than thirty (30) calendar days after imposing or lifting those sanctions listed in XVI.E.2.i-viii. . The notice shall include the name of the PO, the kind of sanction and the reason for the Department's decision to impose or lift the sanction.

…

Article XIX. PACE Specific Contract Terms

Amend Article XIX. E. to read:

E. Capitation Rate

Level of Care	Target Group	Administrative	Long Term Care	Medical

Nursing Home – Monthly (Dual Eligible)	Physically Disabled	$	$	$
	Frail Elder	$	$	$
	Developmentally Disabled	$	$	$
Nursing Home – Monthly (Non-Dual Eligible)	Physically Disabled	$	$	$
	Frail Elder	$	$	$
	Developmentally Disabled	$	$	$

State of Wisconsin

Department of Health Services

Authorized Representative

Name: ______________________

Title: ______________________

Signature: ______________________

Contractor

Contractor Name: ______________________

Authorized Representative

Name: ______________________

Title: ______________________

Signature: ______________________

Date: ______________________ 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.