CONTRACT FOR SERVICES MODIFICATION
between
State of Wisconsin Department of Health Services (DHS)
and
Vendor
for
Include, Respect, I Self-Direct (IRIS) 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: 435700-W23-IRISProvidr-
Contract Amount: Article XV. Payment to IRIS Contractors, in contract issued January 1, 2023
Contract Term: January 1, 2023 – December 31, 2024
Optional Renewal Terms: n/a

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

Contractor Contract Administrator:
Contractor Telephone:
Contractor Email:

Modification Description:

Preamble

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The goals related to the IRIS program are as follows:

- INCLUDE – Wisconsin frail elders and adults with physical, intellectual or developmental disabilities with long-term care needs who are Medicaid eligible are included in communities across Wisconsin.
- RESPECT – Participants are respected in that they are given the power to make choices about their lives; they choose where they live, the relationships they build, the work they perform, and the manner in which they participate in the community.
- I SELF-DIRECT – IRIS is a self-directed option in which the participant manages a service plan within an individual budget to help meet his or her long-term care needs.

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IRIS facilitates active participation by fostering another important key feature of the program, self-direction. Within the context of IRIS, self-direction means participants decide:

- Which goods, supports, and services are needed to achieve and maintain individual long-term care outcomes.
- The amount and location of goods, supports, and services provided, as well as who provides these services.
- How the IRIS budget is used to meet their needs responsibly and cost effectively.
- The amount of assistance needed in planning for required goods, supports and services.

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All services and supports within the benefit package are delivered through the IRIS program including:

- Integration and support for Medicaid eligibility determination and enrollment procedures;
- Participant-centered outcome-based planning;
- IRIS Consultant support navigating the IRIS program;
- Individual Support and Services plan and service authorization creation;
- Support of participant rights;
- Responsiveness to grievance and appeals; and
- Quality management of IRIS services.

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ARTICLE I. Definitions

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29. **Department's Enterprise Care Management System**: the web-based centralized case management system managed by DHS and utilized by all IRIS contracted agencies. The Department's enterprise care management system is the system of record for all information about IRIS participants and retains records of eligibility, contact information, service plans, service authorizations, care team, incidents, complaints and grievances, work requests, case notes, personal cares, service providers, etc. The system supports the operationalization of the IRIS program and IRIS SDPC services.

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36. **Encounter**: An electronic record of a good, service, or support provided to a participant. The record includes, but is not limited to:
    a) The participant's Medicaid ID assigned by the Department.
    b) The provider's Medicaid ID assigned by the Department.
    c) The nature of the good, service, or support, described by established coding standards.
    d) The authorization under which the good, service, or support was provided.
    e) The date on which the good, service, or support was provided.
    f) The number of units of the good, service or support provided, and its unit cost. For a service provided by a participant-hired worker, the unit cost is the wage per unit, plus any 7.65 percent employer FICA contribution for non-exempt employees.
    g) The total cost of the good, service, or support provided on that date. For a service provided by a participant-hired worker, the total cost is the amount of wages paid for that service on that date, plus any 7.65 percent employer FICA contribution for non-exempt employees.
    h) The date on which the good, service, or support was billed by the provider.
    i) The date on which payment for the good, service, or support was remitted.

37. **Encounter Reporting**: Submission of encounters by a fiscal employer agent (FEA) to the Department, using the format and system specified by the Department.

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56. **Individual Support and Service Plan (ISSP)**: A written plan developed by an IRIS participant and their legal decision maker (if applicable) that lists the IRIS waiver funded goods, supports, and services chosen by the participant to meet their long-term care needs and outcomes; the cost of services; their frequency; and the provider of each service. Unpaid goods, services, and supports, as well as Medicaid-funded services received, are also listed on the ISSP and the participant's Long-Term Care Needs Plan.

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64. **IRIS Long-Term Care Needs Panel (LTC Needs Panel)**: The Department's enterprise care management system user interface panel that the IRIS consultant uses to document the methods by which all the participant's identified long-term care service, and support needs are met. The IRIS consultant documents all the participant's IRIS waiver funded service and support needs within the participant's Individual Support and Service Plan (ISSP). All other identified long-term care needs funded through a different source or natural supports should be documented within the LTC Needs Panel or the ISSP.

65. **IRIS Self-Directed Personal Care (IRIS SDPC)**: the care provided to an IRIS participant by his or her participant-hired worker. This care specifically refers to the assistance provided in the areas of bathing, toileting, dressing, and transferring, feeding, and related tasks. IRIS SDPC provides flexibility in where the care is provided and also allows the participants to hire a spouse as caregiver. IRIS SDPC is governed by and defined according to the 1915(j) State Plan Amendment, and is overseen by the contracted IRIS SDPC Oversight Agency.

66. **IRIS Self-Directed Personal Care Oversight Agency (SDPC OA)**: a contracted agency with the Department to administer the IRIS SDPC program. Agency nurses perform clinical assessments and obtain the needed authorizations that enable the participant to employ his or her own workers for personal cares.

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73. **Master Client Index or MCI**: this index is a way to identify the same person between different computer systems. The Department's enterprise care management system, Client Assistance for Reemployment and Economic Support (CARES), the LTCFS and the ForwardHealth interChange Partner Portal system all use MCI.

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Article III

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H. Corrective Action for Non-Compliance and Non-Performance

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2. Targeted Corrective Action

Corrective action may be targeted at specific programmatic or fiscal aspects of non-compliance with this Contract and IRIS program requirements.

… **I. Sanctions for Violation, Breach, or Non-Performance**

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3. Types of Sanctions

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e. Imposition of a corrective action plan and/or intensive oversight of Contractor operations by DHS without appointment of a temporary manager.

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4. Notice of Sanctions

a. Notice to Contractor

i. DHS must give the affected Contractor written notice that explains the following:

a) The basis and nature of the sanction.

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

5. Amounts of Civil Monetary Penalties

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Article IV Contractor Administration

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A. General Administration Expectations

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2. The contractor must comply with all policies, procedures, and requirements specified and/or cited within the IRIS Policy Manual (P-00708), IRIS Work Instructions (P-00708A), and IRIS Service Definition Manual (P-00708B).

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6. In accordance with 42 CFR § 431.107 of the federal Medicaid regulations, the Department and the Contractor agrees to keep participant records and any records necessary to document the extent of services provided to recipients for a period of 7 years pursuant to Record Retention/Disposition Authorization (RDA) 297. If destroyed, records must be destroyed in a confidential manner. Upon request, the Contractor may be required to furnish to the Department, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the provider for furnishing services under the Wisconsin Medicaid Waiver program.

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10. Contractors are required to provide notice of significant IT system changes that will impact mission-critical processes and capabilities at least 180 days in advance of implementation. Significant changes may include, but are not limited to, acquiring new software packages, major system upgrades, or contracting with a third party. As part of its notice, the Contractor must include a project management plan to ensure no interruption in its fulfillment of contractual and other program requirements. The project management plan must address design, testing, notification to affected users, training, and implementation; it must be approved by the Department and completed successfully through implementation.

    Mission-critical processes and capabilities are those that involve:

    a. Payroll and accounts payable on behalf of participants.

    b. Timesheet collection and processing for participant-hired workers.

    c. Electronic Visit Verification.

    d. Collection, storage, and submission of encounter and cost share data.

    Contractors are not required to provide notice of system maintenance, security updates, feature enhancements, or other minor changes to IT systems, nor are contractors required to provide notice of significant IT system changes that do not impact mission-critical processes and capabilities. Contractors must ensure that affected users are informed of such changes, and that changes can be rolled back if mission-critical processes and capabilities are inadvertently impacted.

11. Contractor Form Letters

    a. Contractors must develop and maintain a library of form letters, approved by the Department, for communicating with IRIS participants, participant-hired workers, vendors, and other stakeholders.

    b. Contractors must organize their letter library in an accessible and easily understandable format to ensure their staff can access and understand which letter must be sent, if required by IRIS program policy.

    c. Contractors may not modify the forms without the consent from the Department.

    d. The language and letterhead for each letter must be approved by the Department prior to use. Any changes made to Department-approved letters, including letter content and letterheads, must also be approved by the Department prior to use.

    e. At the discretion of the Department, contractors found to be using unapproved letters, including letter contents and letterheads, will be subject to corrective action and sanction.

    f. All letters are discoverable, subject to public records requests, and could be included in a State Fair Hearing or other civil action.

g. Upon request, contractors are responsible for translating any letters into other languages. If a letter is translated, the English version of the letter must be uploaded to the participant's document console with the translated version.

h. If a letter is mailed to a participant-hired worker and the participant is copied on that communication, the letter must be uploaded to the participant's document console. If the communication is only sent to the participant-hired worker or an agency vendor, the FEA should retain that letter in their own system or upload it (without PII or PHI) to the provider console.

i. Upon distribution of a letter to the IRIS participant (or their legal decisionmaker), it must be uploaded to the participant's document console using applicable naming convention which indicates the purpose of the letter. This requirement does not apply to bulk mailings.

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C. Liability Insurance

3. Except personal vehicles driven by consultants and screeners that are used to carry out the requirements of this contract, motor vehicle insurance for all agency-owned vehicles that are used in carrying out this contract, must have a minimum coverage of one million dollars ($1,000,000) per occurrence combined single limit of automobile liability and property damage. It is the employee's responsibility to carry personal auto liability insurance. Recommended minimum limits of personal auto insurance coverage are $100,000 for bodily injury per person, $300,000 for bodily injury per accident when two or more people are injured, and $50,000 for property damage per accident.

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F. Separation in Lines of Business

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2. The Contractor must create a policy addressing conflicts of interest and submit it to the Department for review and approval. The policy must prohibit the contractor's employees and agents from influencing a person's choice of Wisconsin long-term care programs. The Contractor's IRIS management and leadership must be separate from the administration of any other Wisconsin long-term care program.

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G. Conflict of Interest

The Contractor must create a policy addressing conflicts of interest and prohibited self-referrals and influence and submit it to the Department for review and approval. The Contractor must provide or arrange for initial and annual training for all staff, regarding conflict of interest and self-referral, to assure the Contractor's staff do not influence participant choice in Medicaid program enrollment. The policy must prohibit the contractor's employees and agents from influencing a person's choice of Wisconsin long-term care programs and/or influence of a person's choice of service and support providers within the area of business.

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H. Fraud

1. The Contractor shall report any suspected fraud, waste, or abuse involving the program to the Department as soon as possible, but within ten (10) business days. The Contractor must report to the reporting hotline: 1-877-865-3432 or the on-line reporting system at: https://www.reportfraud.wisconsin.gov.

2. The FEA shall suspend payments to a participant-hired worker or agency provider pursuant to 42 C.F.R. § 455.23 when it is informed by the Department that it has suspended fee-for-service Medicaid payments to the provider because of a credible allegation of fraud.

3. If the FEA believes there is not good cause for suspending its payments, the FEA shall contact the Department immediately upon identification.

4. The Contractor shall cooperate with any investigation of fraud and abuse, including directly conducting investigations as needed. The Contractor shall assist the Department and any other entity legally authorized to investigate fraud and abuse in determining any amounts to be repaid, and with other follow up as requested.

5. For suspected instances of fraud, the ICA and FEA are responsible for collaborating to complete the Fraud Allegation Review Assessment (FARA) process. The FARA process are defined and located in the IRIS program policy.

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J. Physical and Localized Presence

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3. FEA Expectations

   a. FEAs are not expected to maintain a localized presence in each service region in which they operate but must have at least one office located in Wisconsin. This location must comply with the Americans with Disabilities Act. It must have nearby accessible parking space(s), be easily accessible for persons using assistive devices such as wheelchairs, scooters, or walkers, and have an accessible meeting room with a door to ensure privacy.

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K. FEA Customer Service Standards

1. Contractors are expected to maintain staff knowledgeable of and dedicated to address IRIS program customer service calls and concerns.

   Contractors must request approval from the Department to co-employ personnel with another line of business owned or operated by the Contractor, its owner(s), or its parent company.

2. Contractors must implement and maintain a customer service telephone line with a toll-free number available, at minimum, during typical business hours 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday. The customer service telephone line must include a greeting and the option and ability for callers to leave a voicemail.

3. For inbound calls that cannot be immediately answered by staff, Contractors must maintain a voice greeting that, at minimum,

   a. Identifies the Contractor

   b. Provides instruction to leave a message, or, if during business hours, instructions to enter the call queue.

   c. Provides a means for contact outside of typical business hours such as email and voicemail options.

   d. A toll-free fax machine accepting inbound communications 24/7/365.

   e. A separate email address, at minimum, dedicated to participant and participant-hired worker timesheet and expense reimbursement submissions.

4. Contractors must maintain sufficient customer service telephone lines and dedicated IRIS-specific staff so that:

   a. All calls are answered by staff or are offered a call queue or voicemail option.

   b. The longest queue wait time for callers does not exceed twenty (20) minutes for answered calls. If queue wait times exceed twenty (20) minutes, the Contractor must, at minimum, provide options for the caller to either:

i. Enter a callback queue in which the caller may leave their phone number for a return call without losing their place in line. The instructions will remind caller to answer a call from an unknown number, if applicable.

ii. Leave a voicemail message where the caller is prompted to include their name, return phone number, reason for call, and two times caller will be available for a return call.

c. Using the caller's preferred return call times, the Contractor is expected to make a minimum of two attempts to reach the caller. If the caller is unavailable, the Contractor must leave a voicemail.

i. If a voicemail is left, callers must be provided with the direct phone number to Contractor personnel that can address or resolve the caller's question and concerns.

ii. Callers must not be instructed or required to call the Contractor's main customer service line again, thus restarting the process over.

iii. If the caller does not return the call within two business days, the Contractor must make one additional attempt to reach the caller and resolve the issue.

a) The exception to this would be if the caller's return call times are outside of normal business hours.

d. Contractors must respond to calls and contacts requiring further research within two business days of initial contact. The caller must be given a final response, or the caller must be informed further research is needed.

5. Contractors must ensure staff answering customer service calls:

a. Have access to and are using the most up-to-date handbooks, publications, forms, guides, manuals, and other Department-approved written communication materials.

b. Are capable of answering and triaging calls specific to the Wisconsin IRIS program line of business.

c. Provide accurate information pursuant to program policy, work instructions, and procedures.

d. Document contacts from participants that were made during non-business hours.

e. Utilize Department-approved scripts and workflow processes, as required.

6. Contractors must check email and voicemail messages twice daily during normal business hours and respond within two business days.

a. When preferred call times are provided, Contractors must make a minimum of two attempts to reach the caller and shall leave a voicemail regarding these efforts, when and if the option is available.

i. If the caller's preferred return call times fall outside normal business hours, a return call must be made within 24 hours of the original voicemail. If the caller is unavailable, and voicemail is available, the Contractor must leave a voicemail message reiterating business hours and offer an alternative means to communicate (i.e., email address) to accommodate communication outside business hours.

7. Contractors are expected to track calls and contacts received with basic identifying information, including, but not limited to:

a. Time and date of call or contact

b. Type of inquiry (e.g. ., phone, written, face-to-face, email)

c. Caller name and identifying information (e.g. ., MCI ID)

i. If the caller is not the participant but is seeking information about the participant, Contractors must determine and document the caller's relationship to the participant and verify that a valid, up to date Release of Information is on file for said caller, before any personally identifiable or personal health information is disclosed.

d. Nature and details of the call or contact

e. Name of the staff member that received and addressed the caller's concerns or questions

f. Response given by the staff member

8. Contractors must be capable of producing, upon Department request, at minimum, files or reports that contain summary information on all calls and contacts received:

a. Daily, weekly, monthly

b. After hours calls and contacts

c. Cumulative calls and contacts answered

d. Total calls abandoned

e. Abandoned or lost rate percent

f. Average wait time

g. Average hold time in queue

h. Call topic

i. Average length of calls

j. Turnaround time to closure

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L. Company Structure and Leadership

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1. The contractor must notify the Department at least 30 days prior to the proposed date of a change to its organizational structure. Documentation of the changes may include, but are not limited to one or more of the following:

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e. Organizational chart (Executive leadership, parent organization name, as applicable, along with any subsidiary organization(s) and/or related entities with CEO and directors cited),

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M. Administrative Services Agreements and Subcontracts

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N. Business Associate Agreement

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O. Business Continuity

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P. Commercial Leases

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Q. Electronic Visit Verification (EVV)

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1. Please see the IRIS EVV policy for further information at https://www.dhs.wisconsin.gov/library/collection/p-03053.

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3. ICA Responsibilities

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c. IRIS consultants must use EVV case note types for documenting conversations related to EVV compliance.

d. Confirm, when applicable, that the IRIS Participant-Hired Worker Relationship Identification Form (F-01201A) is completed and that the required supporting documentation is provided to the fiscal employer agency before listing a participant-hired worker as a live-in worker on an authorization.

e. Evaluate whether the participant needs a fixed visit verification devices (only when using the DHS-provided Sandata EVV system and there is no other EVV collection method available).

f. Communicate with the fiscal employer agency when a participant needs a fixed visit verification device.

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R. Participant Records

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1. Confidentiality of Records and HIPAA Requirements

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c. Unauthorized Use, Disclosure, or Loss

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iv. Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as determined by the Department.

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2. Record and Documentation Standards

The contractor shall maintain individual participant records in accordance with any applicable professional and legal standards.
Documentation in participant records must reflect all program contact including documentation of assistance with transitional care in the event of disenrollment from the program. Participant records must be readily available for encounter reporting and for administrative purposes.

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3. Record Retention

The FEA must retain, preserve, and make available upon request timesheets, mileage reimbursement logs, vendor claims/invoices, and employee fiscal material (e.g., garnishment requests, subpoenas, status change forms, terminations) for not less than ten years following the end of this calendar year.

The FEA must retain, preserve, and make available upon request background check applications and results for not less than eight years following the end of this calendar year.

Incomplete, returned, or incorrect timesheets or onboarding documentation that are no longer pending may be destroyed at the end of this contract period. If destroyed, material(s) must be destroyed in a confidential manner.

Upon confidential destruction of any information, the FEA must generate an inventory of documents to be destroyed, have it signed by the agency's Records Officer or agency director and retained for 25 years, pursuant to Admin 510. Inventories must be made available to the Department upon request.

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S. Civil Rights Compliance and Affirmative Action Plan Requirements

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T. Cultural Competency

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U. Policy and Procedure Manual

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1. Specific topics that are essential to the ICA Policy and Procedures Manual, at minimum, include:

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e. The Department's enterprise care management system training, resources, and best practices;

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h. Monitoring of participant spending and budget amendment and one-time expense request guidelines;

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w. Case notes and corrections, standards, and timelines.

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2. Specific topics that are essential to the FEA Policy and Procedures Manual, at minimum, include:

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f. Implementation of the Department's enterprise care management system changes for FEA personnel, as it relates to the FEA's internal system(s);

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V. ICA-Specific Staff Expectations

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4. IRIS Consultant-specific Training

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b. An overview of self-determination, including the principles of self-determination and the domains of self-determination.

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l. The Department's enterprise care management system.

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r. Budget issues, including how to request additional funds for a one-time expense request, addressing a participant who is overspending, and effectively monitoring and helping a participant manage their budget

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6. Long Term Care Functional Screen Liaison Expectations

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m. Maintain an accurate, complete, and up-to-date list of all personnel with approved access to the LTCFS SharePoint site. Screen Liaisons must submit to the Department requests to have a staff member's security access deactivated as follows by emailing the Department's LTCFS staff:

i. If the ICA terminates the employment of a staff member who has approved access to the Adult LTCFS SharePoint site, the liaison shall submit the deactivation request within one (1) business day of the individual's termination.

ii. When a staff member leaves the ICA and/or no longer has a need for access to the Adult LTCFS SharePoint site, the liaison shall submit the deactivation request within three (3) business days of the departure or reassignment of the individual.

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7. Long-term Care Functional Screener & Liaison Training

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c. Continued Skills Testing (CST)

The ICA shall require all of its certified screeners to participate in continued 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 ICA will:

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

ii. Administer continued skills testing as 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 correction (POC) if the results of the continued skills testing indicate performance of any individual screener or group of screeners is below performance standards set for the test result, including re-testing if the Department believes retesting to be necessary.

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W. Participant Materials

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2. The Contractor may provide participants with materials using electronic media only if all of the following requirements are met:

a. Permission to Receive Materials Electronically

i. Prior to sending materials electronically, contractors must obtain the participant's, participant-hired worker's, and vendor's written or verbal consent to receive materials electronically.

a) Written consent must be uploaded to the participant's record in the Department's enterprise care management system.

b) Verbal consent must be documented in a case note within the participant's record in the Department's enterprise care management system.

ii. Communications regarding eligibility, decisions, or enrollment must be mailed to the participant. Letters sent to participants from ICAs cannot be provided using electronic media.

iii. Contractor must have safeguards in place to ensure delivery of electronic materials is in compliance with confidentiality laws, and:

d. All marketing/outreach materials must be easily understood and readable for the average participant by utilizing plain language (https://www.plainlanguage.gov/) at a 4th - 6th grade reading level.

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

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

g. Educational materials (e.g., health, safety, fall prevention, etc.) prepared by the Contractor or by their contracted providers and sent to the Contractor's other participants do not require the Department's approval, unless there is specific mention of Medicaid or IRIS. Educational materials prepared by outside entities do not require Department approval.

h. The Contractor shall have all participant materials approved by the Department before distribution. The Department will review participant materials within thirty (30) calendar days of receipt.

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X. Marketing/Outreach Plans and Materials

The Contractor agrees to engage only in marketing/outreach activities and distribute only those materials that are pre-approved in writing, as outlined in this section; marketing/outreach and marketing/outreach materials are fully defined in Section 0, Definitions.

Marketing/outreach materials are defined, in part, as any communication, from the Contractor to an individual who is not being provided services from the Contractor, which can reasonably be interpreted as intended to influence the individual or group to choose or not choose a specific ICA or FEA, or intended to influence the individual or group to choose one long-term care program over another. This further includes materials and presentations to community participants, participants, stakeholders, non-profit organizations, professional conferences, etc. on topics related to the IRIS Program.

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4. All marketing/outreach materials must be easily understood and readable for the average participant by utilizing plain language (https://www.plainlanguage.gov/) at a 4th - 6th grade reading level.

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8. Websites

b. Website must have a participant-friendly design with written materials in plain language (https://www.plainlanguage.gov/) English.

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Article V.

A. Individual Eligibility Requirements

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2. Medicaid Eligibility

An individual must be eligible for full-benefit Medicaid, as described in Chapter 21.2 of the Medicaid Eligibility Handbook

(http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm). The contractor must verify eligibility for Medicaid using member eligibility information in the Department's ForwardHealth interChange system; participants enrolled in limited-benefit Medicaid plans are not eligible to be enrolled in IRIS. Additional information is included in the IRIS Waiver Agency User Guide, in Section 16.1. Included in the Benefit Plan section is a listing of full-benefit Medicaid plans, limited-benefit Medicaid plans, Other Medicaid plans and Medical Status Codes that are not valid for IRIS program enrollment. This IRIS Waiver Agency User Guide is available on the secure Waiver Agency ForwardHealth portal.

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5. Residency and Eligible Living Arrangements

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b. Ineligible living arrangements include, but are not limited to:

i. A hospital, hospice facility, nursing home, rehabilitation facility, or institution for mental disease (IMD);

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C. Cost Share Collection, Monitoring, and Reporting

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2. The ICA must ensure that cost share information assessed by Income Maintenance is entered accurately in the Department's enterprise care management system

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D. Room and Board

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1. Determining the Participant's Room and Board Obligation (effective 10/1/2024)

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Article VI. Program Enrollment

A. Referral Process

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2. Once the participant chooses an ICA and FEA, the ADRC representative facilitates the referral process by submitting a referral packet to the ICA the participant has chosen. Immediately upon creating the participant's record in the Department's enterprise care management system, the ICA must notify the FEA of the referral.

3. ICA and FEA transfers are subject to IRIS Program Policy.

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6. ICA Transfers

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b. After a participant transfers to a new IRIS consultant within the same ICA, reassignment of the participant in the Department's enterprise care management system to the new IRIS consultant should be completed within one business day of the change.

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7. FEA Transfers

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b. Participants may request to transfer FEAs at any time, transfers will take effect pursuant to the FEA transfer calendar (F-02239).

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C. Service Timeline Expectations

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Welcome Call	3 business days from referral date

IRIS Consultant Selection	3 business days from welcome call
IRIS Consultant Auto-assign	4 business days from welcome call
Initial In-Person Visit	14 calendar days from referral date
Implementation of Approved IRIS Service Plan	60 calendar days from the date of the referral (with the exception of youth transitioning to IRIS in special circumstances)

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D. Enrollment and Orientation Services

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1. Welcome Call & IRIS Consultant Selection

   a. The ICA will enter the referral into the Department's enterprise care management system within one business day.

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2. Enrollment and Orientation Meeting

   The enrollment and orientation meeting must be conducted within 14 calendar days from the referral date. The details of the meeting must also be documented in the Department's enterprise care management system within 2 business days.

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E. Individual Support and Service Plan Development

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2. IRIS consultants discuss with the participant their desired outcomes and the assistance or services that the participant needs to address their long-term care need in order to reach those outcomes. IRIS consultants support the participant to identify supports, services, and goods which address identified outcomes specific to the participant's disability or qualifying condition, to ensure community-based services prevent the need for institutional-based services. Supports, services, and goods can be any combination of natural supports, services paid for by other funding sources, as well as services and supports funded through the IRIS individual budget allocation.

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   h. The IC is responsible for ensuring that the ISSP and LTC Needs Panel for each participant includes the following:

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      iii. The participant's completed IRIS Long-Term Care Needs Panel.

      iv. Behavior support plans and restrictive measures applications in accordance with DHS policy and the IRIS policy.

      v. The 24-hour backup and preparedness plan for services that ensure the health and safety of participants, per IRIS policy.

      vi. Mitigation of any issues of conflict of interest.

      vii. Any required cost share or medical remedial costs.

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   i. The IRIS consultant must complete the participant's Long-Term Care Needs Panel (LTC Needs Panel) during the completion of the ISSP. The LTC Needs Panel is accessible to IRIS consultants within the

Department's enterprise care management system. The IRIS consultant documents all the participant's IRIS waiver funded service and support needs within the participant's ISSP. All other identified long-term care needs funded through a different source or natural supports should be documented within the LTC Needs Panel or ISSP.

…

3. Service Authorizations:

a. Each IRIS consultant must ensure appropriate service authorizations are in place for each service or support on the participant's ISSP, at usual and customary rates and those service authorizations do not exceed the participant's budget allocation without an approved budget amendment or one-time expense request.

…

F. Orientation Service Level Expectations

…

4. The minimum requirements for the ICA, during the orientation service level phase, include:

…

j. A review of the complaints, grievances, and appeals process, including related resources. This review should include contacts specific to the Contractor, as well as the third-party Contractors, such as the EQRO or ombudsman.

…

G. Disenrollment

…

1. Processing Disenrollments

The Contractors shall adhere to the state Long-Term Care Programs: Enrollment and Disenrollment Resource Guide (P-02997) and Enrollment and Disenrollment Process Desk Aid for Publicly Funded Long-Term Care Programs (P-02915), incorporated by reference herein, for the accurate processing of disenrollments. These documents shall ensure:

…

d. That disenrollments are accurately entered in the Department's enterprise care management system so that correct monthly rate of service payments are made to the ICA and FEA.

2. Contractor Influence Prohibited

Neither the ICA, nor the FEA, shall counsel or otherwise influence a participant due to the participant's life situation (e.g., homelessness, increased need for supervision) or condition in such a way as to encourage disenrollment.

…

3. Types of Disenrollment

…

b. Disenrollment Due to Loss of Eligibility

…

i. Fails to meet functional eligibility requirements;

ii. Declines to complete a functional screen or sign their ISSP.

iii. Fails to meet financial eligibility requirements;

iv. Fails to pay, or to make satisfactory arrangements to pay, any cost share amount due to the FEA pursuant to IRIS Policy;

v. Initiates a move out of the State of Wisconsin;

vi. If the participant moves into a geographic service region not served by the ICA, the ICA must inform the participant that they will need to contact the ADRC, or Tribal ADRS if applicable, in the new county of residence to enroll with another ICA or another long-term care program. The ICA must communicate the move to the new geographic service region to the participant's current ADRC, or Tribal ADRS if applicable, according to program policy. If the participant does not choose a new ICA, the ICA must disenroll the participant from the program according to program policy.

vii. Is incarcerated as an inmate in a public institution;

viii. Is relocated to a hospital, nursing home, hospice facility, or rehabilitation facility for long-term or permanent care;

ix. If a participant age 21-64 is admitted to an Institution for Mental Disease (IMD) for longer than 90 days, or

x. Dies.

…

c. Program-Requested Disenrollment for Cause

…

Article VII.

…

A. Service Levels

…

5. Only an IRIS consultant or IRIS consultant supervisor can perform and complete monthly, quarterly, or annual visits.

6. After the orientation phase, the participant and the IRIS consultant must have a conversation discussing the participant's level of confidence, comprehension, and security in self-directing their long-term care support needs within the IRIS program.

…

B. Competency Standards for IRIS Consultants

…

10. Core professional competencies, such as the abilities to:

…

e. Utilize basic computer functions surrounding the internet and word processing, with the capacity to learn the Department's enterprise care management system, and

…

C. Ongoing Service Level Requirements

…

1. Minimum Service Requirements

…

f. Completion of individual support and service plan updates which includes service authorizations that do not exceed the total amount permitted under the participant's budget allocation, approved budget amendments, or one-time expense requests.

…

2. Ongoing Service Level Requirements

…

h. Process requests for additional funding for either a one-time expense request or a budget amendment, and justification for payment above the range of rates is completed and submitted as needed and in the format prescribed in the Department's enterprise care management system or SharePoint.

…

3. Monthly Contact Requirements

a. All discussions with participants must be documented in concise detail in the participant's case notes, within the Department's enterprise care management system. These case notes must be entered into the system within 2 business days of the contact or meeting.

viii. If applicable, review EVV requirements and compliance.

…

D. Increased Service Levels

…

1. Certain actions or activities involving the IRIS participant may demonstrate the need for an increased ICA service level. DHS has an obligation to ensure the health and safety of IRIS participants, while ensuring the highest quality of service and integrity of the IRIS program. If any of the following circumstances occur, an increased level of consulting service from the ICA will be required:

…

g. Meeting the criteria defined herein as a vulnerable high-risk participant.

…

Contractors shall adhere to the Vulnerable and High-Risk Participant policy (P-03128) found at https://www.dhs.wisconsin.gov/publications/p03128.pdf. At a minimum once per year and when there is a change in condition of the participant, ICs must document in the Department's enterprise care management system that a VHRP determination has been completed for the participant. If the participant has been determined to be VHRP, the ICs must complete the VHRP Determination Form (F-02879) and upload it into the Department's enterprise care management system. The VHRP Determination Form (F02879) must be completed at a minimum once per year or when there is a change in condition of the participant.

…

E. Participant Provider Service Agreement Language

…

1. Requirements

…

e. Participant Incidents

As required by Reporting and Follow-Up for Immediate Reportable and Critical Incidents (P-03131) policy, ICAs must notify the Department by documenting incidents in the Department's enterprise care management system. Immediate reportable incident must be reported to DHS IRIS Quality mailbox: DHSIRISQuality@dhs.wisconsin.gov. FEAs must relay immediate reportable incidents to the appropriate IRIS consultant.

…

F. Elder Adults/Adults at Risk Agencies and Adult Protective Services

…

1. Policies and Procedures

…

e. Notify the Department by documenting incidents as required by the Reporting and Follow-up for Immediate Reportable and Critical Incidents (P-03131) policy. Only ICAs are responsible for documenting incidents, but FEAs, if identifying concerns, should relay them to the appropriate IC as soon as possible.

f. To address the immediate or ongoing health and safety concerns, ICAs must complete an incident report and make referrals to Adult Protective Services agencies and submit reports to the Division of Quality Assurance, if a worker or service provider puts a participant's health and/or safety at risk. Contractors will be notified by the Department if follow up action is necessary.

g. Follow-up to ensure that participant's needs are addressed on an ongoing basis.

…

2. Memorandum of Understanding (MOU)

The ICA is responsible for the following MOU requirement:

a. ICAs must have a signed MOU with all APS agencies within their regions.

b. For ICA expansions into new regions, ICAs must have a signed MOU with all APS agencies within the new region within 30 days of expansion. If the county or the ICA requires additional time, the ICA must notify the Department.

c. ICAs must notify the Department if any APS agency is non-compliant.

d. All new and renewed MOUs must be provided to the Department. For MOUs with an expiration date, the MOU must be updated accordingly.

e. ICAs must provide updated MOUs to the Department if any county-level infrastructure change designates a new agency or group for APS within their regions.

…

H. Service Authorization Accuracy

1. The ICA is responsible for ensuring the accuracy of service authorizations created by IRIS consultants.

2. Service authorizations must be:

a. Within the scope and duration of the participant's individual support and services plan;

b. For authorized providers meeting IRIS program and policy requirements; and

c. In total, no more than the amount permitted under the participant's budget allocation, approved budget amendments, and approved one-time expense requests included in the participant's individual support and services plan.

3. Service authorizations for self-directed personal care must be within the scope, duration, and number of units of care specified in the prior authorization, and at a wage rate no greater than the maximum allowed for self-directed personal care.

4. Effective April 1, 2024, for any individual support and services plan based upon a completed functional screen with eligibility determined on or after January 1, 2024, if an IRIS consultant creates service authorizations in excess of the total amount permitted for the duration of the participant's individual support and services plan or prior authorization

for self-directed personal care, and payments are made under those authorizations in excess of the amount permitted, the Department may recoup some or all of the portion of those payments in excess as withholding(s) from the ICA's MROS payments, unless the portion was either:

a. Required by law, order, or remand; or

b. A result of fraud identified in a FARA process with the timely and active participation of the ICA.

…

I. Self-Directed Personal Care

…

3. ICA and IRIS Consultant Communication with Primary Care Providers, Home Health Agencies, or Hospitals

Only the participant, their designated health care or legal representative, SDPC RNs, or the IRIS Nurse Consultants may contact primary care providers like medical doctors, physician assistants, or advanced practice nurses; home health agencies; or hospitals to obtain or clarify orders or to discuss health status. Certified Long-Term Care Functional Screeners may contact clinics to verify diagnosis and any discrepancies with needs being reported for completion of the Long-Term Care Functional Screen. IRIS consultants may not speak with primary care providers, home health agencies, or other providers to clarify or obtain orders or letters of need.

If a participant has SDPC, that RN may clarify needed information for cares or needed DME or other related services and obtain physician orders for personal care services. IRIS Nurse Consultants should be involved when someone does not have an SDPC RN involved in their care when clarification is needed or required.

…

5. Nurse Consultation

…

a. Reasons for Individual Consultation

…

vii. Consult with nurse on issues a person may encounter when entering hospice care or experiencing progression of dementia.

…

Article VIII.

…

A. General Expectations

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3. Utilize the Department’s enterprise care management system.

…

D. Deposit Account

…

5. The code must be provided or US Bank will reject the deposit.

…

G. Payment Accuracy

The FEA is responsible for ensuring accuracy of payments for services.

1. Payments must be:

a. For authorized services under the participant's individual support and services plan;

b. To authorized providers specified in the participant's individual support and services plan; and

c. Within the units and rates authorized for the services.

2. If the FEA causes an error resulting in inaccurate, delayed, erroneously issued, or erroneously omitted payments, the FEA is responsible for resolving the error as soon as possible, but no more than 5 business days after a payment error is identified. The FEA must inform the Department after a payment error is identified no later than 3 p.m. on the next business day.

3. If an FEA issues payments to a vendor in excess of the amount authorized, the Department may recoup some or all of the portion of those payments in excess as withholding(s) from the FEA's MROS payments, unless the portion of those payments in excess is required by law.

a. Required by law, order, or remand; or

b. A result of fraud identified in a FARA process with the timely and active participation of the FEA.

…

H. Federal Employee Identification Number (FEIN)

Upon program enrollment, the FEA will assist the participant to ensure they obtain a FEIN number. The FEA may only pay providers that have a current FEIN. Two exceptions exist whereby the FEA may pay a provider without a FEIN:

…

Article IX.

…

A. Service Provider Setup

…

4. The FEA must maintain records that meet or exceed the following criteria:

…

b. All records, whether paper or electronic, must be maintained pursuant to the record retention guidelines in Article IV.R.4 of this Agreement.

…

B. Onboarding Packets

…

7. The FEA must upload the entire onboarding packet, which must include the WI Medicaid Provider Agreement, into the Department’s enterprise care management system provider document console.

…

9. The FEA must notify the provider within five business days of the details of the authorized service(s) to be provided to the participant, both when a new authorization is created and when there is a change in an existing authorization, such as a change in rate or units allowed. This notification must include the following:

…

C. Payment Processing

…

1. The FEA is responsible for processing payments to vendors and workers according to program policy. The Department is the funder and the FEA is the processor.

…

c. Vendors and participant-hired workers must submit claims for payment within 365 calendar days after the date of service. Claims submitted more than 365 calendar days after the date of service will result in denial of payment by the fiscal employer agent (FEA) with only limited exceptions.

Effective 1/1/2023, the only limited exception reasons to the 365-day timely filing deadline are permitted, as follows:

…

2. The FEA is responsible for verifying that invoices, timesheets, and other claims for payment are for services and periods of time authorized by participants' service plans. If an error other than a duplicate submission is identified during verification of invoices, claims for payment, and timesheets, the FEA must:

…

d. Notify the vendor or worker of the invoice, timesheet, or other claim for payment within five (5) business days from the date the error was identified and provide directions on how to correct the error and resubmit the claim;

e. Notify the Department when they detect duplicate payments or payment errors; and

f. Provide information to the Department upon request on identified errors, including a listing of invoices, timesheets, and other claims for payment, for which payment has been pended, including whether they have been corrected and resubmitted, and resolved. Listings should include the participant, participant's Medicaid ID, service, and service dates(s) or amount(s) under review.

…

E. Payments to Workers

…

3. Timesheets

a. FEAs must receive timesheets from workers for payment. Timesheets may be paper, web-based, or kept with another electronic system.

b. Effective April 1, 2024, timesheets must show times in and out, including times out and in for unpaid meal periods, if taken.

…

c. The FEA must establish an annual payroll calendar with deadlines for workers to submit timesheets to participants for approval, for participants to approve timesheets, and for approved timesheets to be submitted to the FEA. Deadlines must be established to meet the requirement that wages be paid within 31 days of each day worked (Wis. Stat. § 109.03(1)) and allow sufficient time for timesheet submission, approval, payroll processing, and submission of payment data to the Department.

d. The FEA must provide the payroll calendar to all participants or legal decision makers approving timesheets. The participant or legal decision maker is responsible for informing workers of payroll deadlines, and for timely approval of timesheets submitted by workers by the participant's timesheet approval deadline for the pay periods in which timesheets are submitted. If a worker does not submit a timesheet to the participant for approval by the participant's timesheet approval deadline for wages to be paid within 31 days of each day worked, the participant, activated financial power of attorney, guardian of the estate, or an appointed authorized representative is responsible only for approval by the next participant's timesheet approval deadline.

…

f. FEAs must report to ICAs monthly, a list of participants with at least two instances of failing to meet participant approval deadlines for timesheets in the previous six months to the ICA. ICAs must follow up with those participants and work with them to ensure timely approval of timesheets.

…

4. Taxes and Withholdings

…

G. Claims Adjudication

…

5. When receiving a provider agency invoice or claim, the FEA must:

…

b. Validate the provider is an approved provider and set up in the Department's enterprise care management system;

…

H. Ineligible Service Providers

1. In implementing this section the FEA shall check at least monthly the federal DHHS OIG List of Excluded Individuals /Entities (LEIE), the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), and the System for Award Management (SAM), as required by 42 C.F.R. § 455.436, as well as any other databases that may be required by the federal DHSS or the Department. Referenced to the "Act" in this section refers to the Social Security Act.

…

6. Disclosure of Excluded Individuals or Entities

Within ten days (10) the FEA shall disclose to the Department any individual or entity described herein. This disclosure shall be made to DHSLTCFiscalOversight@dhs.wisconsin.gov and DHSDMSIRISFiscal@dhs.wisconsin.gov.

…

I. Home and Community-Based Settings Requirements Compliance

Participants shall use only a licensed or certified residential provider in which residential supported employment services are provided, if the setting has been determined by the certification agency or the Department to be in compliance with the home and community based setting requirements under 42 C.F.R. § 441.301(c)(4).

…

J. Criminal History and Background Investigation

…

2. Background checks must be completed before initial employment, every four-years after, and as needed. The FEA, using the initial submitted background check paperwork, shall have the authority to run subsequent background checks of a participant-hired worker and an individual provider without requiring them to resubmit background check paperwork every four years, unless there has been a substantial change.

3. FEAs are required to communicate the applicant's eligibility to the participant and the applicant. Applicants may also request a copy of their background check. The FEA shall notify the participant and the participant-hired worker of a failed background check and provide information on how to access the background check appeals process. It is the responsibility of the participant and applicant to complete and submit the form for appeal.

For four-year background checks, it is the responsibility of the participant and participant-hired worker to complete and submit the form for appeal.

4. As needed, the FEA interacts with the participant, participant-hired workers, ICAs, and the Department on background check results.

…

Article X.

The IRIS program utilizes the Department's enterprise care management system which provides standardized operational functionality for all Contractors. The Department's enterprise care management system is the system of record for participant documentation including but not limited to, ISSPs, service authorizations, provider document, program enrollment, case notes, contacts, addresses, and the storage of program required documents. The Department's enterprise care management system is a web-based application that utilizes role-based permissions and organizational hierarchies to ensure that Contractors have access to information that they have a business need to access. Any information stored outside of, the Department's enterprise care management system on the Contractor's network or internal information systems must comply with HIPAA, including all pertinent regulations (45 CFR Parts 160 and 164) issued by the U.S. Department of Health and Human Services, as well as security, and data retention requirements identified below. The CMS standard acceptable risk safeguards (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/CIO-Directives-and-Policies/CIO-IT-Policy-Library-Items/STANDARD-ARS-Acceptable-Risk-Safeguards.html) and the standard for encryption of computing devices and information (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Info-Security-Library-Items/HHS-Standard-for-Encryption-of-Computing-Devices-and-Information.html) documents are available online, with greater detail, for Contractor reference on increased safeguards.

Contractors are responsible for having at least one designated IT Security Officer/Chief Information Security Officer responsible for documenting and addressing the security requirements specified in this section. This staff is required to review and submit to the Department's enterprise care management system access requests. This staff must ensure all staff have the appropriate roles and permissions and inform DHS if there is an inappropriate level of access. This staff is responsible for ensuring that each system user account is associated to a specific individualized email account that is provided and owned by the Contractor.

…

A. General Requirements

…

2. All new user set-up forms for the Department's enterprise care management system or SharePoint, as well as user termination emails shall be submitted to the Department's enterprise care management system administration inbox: DHSWISITS.SystemAdmin@dhs.wisconsin.gov.

…

b. When a Contractor's staff with access to the Department's enterprise care management system ends their relationship with the contracted agency, the security officer must inform of this date and DHS will process the deactivation with as much advanced notice as possible.

…

d. Contractors must complete the relevant Conflict of Interest (F-01310) disclosure forms prior to submitting access requests to any systems owned or operated by the Department, including but not limited to SharePoint, the Department's enterprise care management system, ForwardHealth interChange, CARES, or FSIA.

e. Contractors are responsible to maintain a list of all individuals possessing any access to SharePoint, the Department's enterprise care management system, ForwardHealth interChange, CARES, or FSIA, to ensure appropriate termination of access upon resignation or termination of personnel. At any point the Contractor can request a list from DHS of their current user accounts for these systems.

f. The Contractor must ensure that all employees requested access to these systems have completed the appropriate onboarding training required by the Department prior to requesting access. This includes but is not limited to: HIPAA initial and annual training. Additionally, each new employee must have a personal, agency-owned email address and phone number prior to requesting access.

…

3. Contractor Systems

Contractors must be capable of and willing to grant viewing access or provide guided demonstrations to Department staff, as necessary, for the purpose of recertification, security compliance, and the Department's enterprise care management system utilization and compatibility. Contractor must be able to provide and/or demonstrate their data security and encryption methods at the request of DHS.

…

5. Data Security and Encryption

…

c. Once data has been extracted from DHS systems, including the Department's enterprise care management system, it is the responsibility of the Contractor to manage and maintain said data and the secure access of the data.

…

D. Department's Enterprise Care Management System

All Contractors must use the Department's enterprise care management system to access IRIS participant data, generate reports, and maintain/document information related to participants, participant-hired workers, and service providers/vendors.

1. In utilizing the Department's enterprise care management system, ICAs must be capable of meeting the core IT functions related to:

…

2. Utilizing the Department's enterprise care management system, as well as their internal system, FEAs must be capable of meeting the core IT functions related to:

…

3. FEAs are required to have at least one staff available and in attendance for monthly teleconference meetings for the Long-Term Care Technical Workgroup. FEAs will further ensure that at least one appropriately knowledgeable staff is in attendance at all meetings initiated by the Department related to the Department's enterprise care management system.

4. Department's enterprise care management system does not contain payroll or claims processing functionality, it does not determine tax-withholding information, and is not the system of record for documenting this information. These are the responsibility of the FEA. Any information stored outside of the Department's enterprise care management system on the FEA's network or internal system must meet the security and HIPAA-compliance requirements identified in this section. With regard to these responsibilities, FEAs must:

a. Have the ability to extract and download the eligibility, enrollment, and authorization file from the Department's enterprise care management system. The authorization number, as documented in the Department's enterprise care management system, should match the authorization number input into the FEA's internal system and the DHS Encounter system.

b. Have the ability to upload the eligibility, enrollment, and authorization file from the Department's enterprise care management system into the FEA's payroll system in a way that allows the FEA to carry out the requirements of this contract.

c. Set up participant-hired workers, providers, and individual reimbursement providers in the Department's enterprise care management system and associate the provider to the correct serve type and when applicable, the correct participant.

…

E. Functional Screen Information Access (FSIA), ForwardHealth Secure Waiver Agency Portal, and CARES

…

2. ForwardHealth Secure Waiver Agency Portal – Contractor Responsibilities

…

b. Contractors are responsible to maintain an accurate, complete, and up-to-date list of all staff or contractors with approved access to the Portal. Portal Administrators are responsible for to ensuring that only authorized users have access to data and functions provided. Portal Administrators shall have security access deactivated as follows:

…

ii. When staff leave and/or no longer have a need for access to Portal, the agency shall submit the deactivation request within three (3) business days of the departure or reassignment.

c. All Contractors must use the Secure ForwardHealth Portal account to access data and reports and to maintain information with the Department.

d. Contractors must ensure all users log in to the Secure Waiver Agency Portal to submit or retrieve agency or participation information that may be sensitive and/or fall under the requirements of the Health Insurance Portability and Accountability Act (HIPPA) regulations.

3. Access to Cares Data

…

Article XI.

…

B. Definitions

…

1. An "action" is any of the following:

…

d. A denial in IRIS consultant agency or fiscal employer agent transfer.

…

C. Overall Policies and Procedures for Grievances and Appeals

…

2. Provision of Case File

Contractor must ensure that the participant is aware that they have the right to access their case file, free of charge, and be provided with a free copy of their case file. 'Case file' in this context means all documents, records and other information relevant to the ICA's determination or action and the participant's appeal of the determination or action; this includes, but is not limited to, the participant's Department's enterprise care management system document library, case notes, and SharePoint records.

…

D. Notice of Action

…

1. The ICA shall provide written notice of action to the participant when a decision is made to:

…

c. Deny transfer between IRIS consultant or fiscal employer agencies; or

…

2. The notice of action must be mailed or hand delivered. An oral, email, text, or other nominal reference to the information in the IRIS Policy Manual, Work Instructions, or other materials does not meet the requirement to provide notice of action.

3. ICA is required to upload a copy of any notice of action issued into the Department's enterprise care management system and the accompanying SharePoint Notice of Action site (until such time as this site is no longer used).

4. Content of Notice of Action

a. The ICA shall use their agency's appropriate DHS-approved notice of action form letters for:

i. Notice of Action – Denial,

ii. Notice of Action – Limit,

iii. Notice of Action – Reduction,

iv. Notice of Action – Termination,

v. Notice of Action – ICA Transfer Denial

vi. Notice of Action – FEA Transfer Denial.

…

E. State Fair Hearing Process

…

5. The FEA is required to provide the DHS and/or the participant's ICA with any documentation requested for the Wisconsin State Fair Hearing process. This requirement is applicable both when the ICA issues the NOA on behalf of DHS or when the NOA is issued from DHS as a result of a budget amendment, one-time expense request, or other termination, denial, limitation, or reduction of service.

…

Article XII.

…

A. Working Capital

…

3. Working capital must be maintained at a level not less than 2% of the base of IRIS revenues.

4. Working capital funds may not be used to support non-IRIS operations, as collateral for a loan, or for other purposes that would be recorded as a liability under Generally Accepted Accounting Principles (GAAP).

5. For the purposes of initial certification, the base is defined as the projected calendar year IRIS revenues. For an entity under contract the base is defined as the most recent 12 months of actual IRIS revenues. If the entity has less than 12 months of IRIS revenues, the 12-month base will be calculated by annualizing actual months of IRIS revenues.

6. Failure to maintain and report the working capital requirement will result in heightened monitoring and/or fiscal corrective action as determined by DHS.

…

B. Restrictive Reserve

…

1. Purpose and Requirements

…

e. Any income or gains generated by the restricted reserve funds are to remain within the account until the required balance is met as set forth in the restricted reserve requirement.

f. Restricted reserve funds may not be used to support non-IRIS operations, as collateral for a loan, or for other purposes that would be recorded as a liability under Generally Accepted Accounting Principles (GAAP).

…

5. Disbursement Requests

…

f. This plan must be emailed to: DHSIRIS@dhs.wisconsin.gov, DHSLTCFiscalOversight@dhs.wisconsin.gov, and DHSDMSIRISFiscal@dhs.wisconsin.gov.

…

C. Financial Reporting

…

7. Quarterly Financial Reporting Document Submission Requirements:

…

b. A signed certification of the truth, accuracy, and completeness of the financial report, in a form specified by the Department,

…

8. Financial Reporting submissions should be made to DHS IRIS Main mailbox at: DHSIRIS@dhs.wisconsin.gov, DHS DMS IRIS Fiscal mailbox at DHSDMSIRISFiscal@dhs.wisconsin.gov, and to DHS Long-Term Care Fiscal Oversight at: DHSLTCFiscalOversight@dhs.wisconsin.gov.

…

D. Annual Financial Audit

…

1. Deadline for Submission of Financial Audit Report

…

b. Statements should be submitted to the DHS IRIS Main mailbox at DHSIRIS@dhs.wisconsin.gov, DHS DMS IRIS Fiscal mailbox at DHSDMSIRISFiscal@dhs.wisconsin.gov, and to DHS Fiscal Oversight at DHSLTCFiscalOversight@dhs.wisconsin.gov.

…

3. Audit Report Submission

a. The full audit report will include the following:

…

ii. Consolidated financial statements in a comparative format to support full reporting for the Contractor and all related companies.

…

v. A supplemental financial report that demonstrates the financial results and segregated reserves of the entity's IRIS program operations, as well as state program contract where the organization operates under multiple Medicaid contracts and/or other lines of business. The report shall be in columnar format for the various programs as required.

…

b. Submission of the final audit results in the IRIS financial reporting template and a signed certification of the truth, accuracy, and completeness of the financial report, in a form specified by the Department. If the audit

resulted in adjustments to preliminary calendar year-end financial reporting. If no adjustments to the preliminary calendar year-end financial reporting were made it should be stated in the email submission of the audit report submission.

c. The audit report documents should be submitted electronically to DHSIRIS@dhs.wisconsin.gov, DHSDMSIRISFiscal@dhs.wisconsin.gov, and DHSLTCFiscalOversight@dhs.wisconsin.gov.

…

E. Annual Financial Projections Submission

…

2. Annual Financial Projections Document Submission Requirements:

…

b. Financial Projections submissions should be made to the DHS Long Term Care Fiscal Oversight at: DHSLTCFiscalOversight@dhs.wisconsin.gov as well as the DHS DMS IRIS Fiscal mailbox at DHSDMSIRISFiscal@dhs.wisconsin.gov.

…

Article XIII.

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A. Department Oversight Activities

…

2. Program Record Review process

…

a. Participant records within the Department's enterprise care management system focusing on health and welfare, Individual Support and Service Plan (ISSP) development, administrative authority and best practice.

b. Compliance related to contractual requirements detailed in the IRIS Record Review Tool and IRIS Record Review Instructions. These documents are provided by the IRIS program's External Quality Review Organization, but are not published publicly.

…

3. Contractor Recertification Site Visit

Department representatives travel to each contractors Wisconsin base of operations to conduct the annual site visit. The site visit consists of the following activities:

a. Review of contractor's pre-submitted documentation as requested by the Department; and

b. Discussion regarding contractor's current practices, procedures, policies and methodologies related to the IRIS program.

4. IRIS Participant Satisfaction Survey

…

6. Performance Improvement Project (PIP)

a. PIPs are projects identified and led by the contractor, that positively impact participant experience in the IRIS program. Using the prescribed IRIS PIP Proposal format, contractors are annually required to develop one PIP related to generating improvement in at least one of the following areas:

…

b. The overall purpose of a PIP is to improve participant outcomes based on analysis of existing outcomes or needs of a contractor's participants, including input from participants and other applicable support resources, as appropriate.

c. PIPs are not intended for development of contractually required services nor for implementation of contractor corrective action or remediation.

d. PIPs are not pay-for-performance projects.

e. A PIP proposal submission must clearly define the following:

   i. PIP topic relevant to participant characteristics and quality improvement needs as identified by the contractor;

   ii. Evidence inclusive of quantitative and/or qualitative needs analysis conducted by the contractor prior to PIP proposal submission that demonstrates the proposed project topic is relevant to the needs of the contractor's participants;

   iii. PIP aim statement that is concise, answerable, and measurable;

   iv. PIP improvement strategy;

   v. PIP goal(s) and project indicators that indicate a baseline measure and are objective, clearly defined, measurable, and time-specific;

   vi. PIP population;

   vii. PIP timeframe;

   viii. PIP data collection and analysis plan.

f. A contractor may conduct a PIP at any time for any purpose. All PIPs that are submitted in fulfillment of contract requirements must be approved by the Department before initial project interventions are implemented.

g. As specified by the Department, the contractor must submit an annual report to the Department regarding the status and results of any approved PIP. In addition, the Department may request results of any PIP at any time.

h. The contractor may request technical assistance from the Department or the External Quality Review Organization for any PIP at any time.

i. If a contractor wishes to continue a currently approved PIP, the contractor must submit a continuing PIP proposal for a new approval. The proposal must include the justification for continuing the PIP.

j. Collaborative PIP

   i. A contractor may satisfy its PIP requirement by actively participating in a collaborative PIP in conjunction with one or more contractor agencies.

   ii. The topic for a collaborative PIP may be specified by the Department or by consensus agreement of the participating contractors.

   iii. The topic must be developed and based on a sufficient needs analysis reflective of each participating contractor's participants.

   iv. If a project topic is determined by the Department, project performance measures may also be specified.

   v. The participating contractors must establish the parameters of the project design, implementation, data analysis, evaluation, and sustainability of improvements as achieved.

   vi. The project plan must be submitted to the Department for approval prior to project implementation.

vii. If a contractor is participating in a collaborative PIP, each contractor must provide a separate annual report to the Department as required in 6.g. of this subsection.

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7. Documentation of Oversight Activities

The Department will rely upon each Contractor's Quality Management Plan to track the oversight activities. The layout of this plan shall outline the contractor's responsibilities for each oversight activity and will track, at minimum, the following information:

…

8. Quarterly Contractor Oversight Meetings

The Department will meet with each Contractor at least quarterly to discuss quality oversight activities, and the contractor will meet with the Department in calendar quarter four to conduct the Contractor Recertification Site Visit.

…

Article XIV.

…

B. General FEA Reporting Expectations

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5. Monthly submission of reports related to overspending and nonspending to each ICA and the Department that include:

a. Data aggregated at the participant level to clearly indicate whether a participant is spending more than authorized in total for goods, services, and supports, or to indicate whether a participant is not spending at all, in that month; and

b. Data on the specific transactions and authorizations included in the participant-level aggregations.

6. Monthly notices to participants regarding their spending against their individual budget allocation. All overspending and nonspending reports that the FEAs send to ICAs should also copy DHS IRIS Quality mailbox: DHSIRISQuality@dhs.wisconsin.gov.

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C. Encounter and Cost Share Reporting

1. The FEA is required to collect electronic data regarding participant encounters and cost share payments and submit those data to the Department, as described in Appendix IV. Data are used for required federal reporting, program evaluation and analysis, program integrity monitoring, and other purposes.

2. The FEA is required to maintain a system capable of generating accurate and timely submissions of encounter and cost share data in a format and using a system specified by the Department, as described in Appendix IV.

3. The FEA is required to submit all encounter and cost share data for a calendar month no later than the 30th day after the last day of the month, or the next business day if that 30th day is not a business day, as described in Appendix IV.

4. The FEA is required to ensure and maintain compliance with HIPAA and other laws governing the collection, storage, use, and submission of data regarding participant encounters and cost share payments.

5. The FEA is required to conduct all necessary internal checks, audits, and testing procedures to ensure that encounter and cost share data submissions are true, complete, and accurate; to verify that data submissions have been accepted by the

Department's system; and to certify the accuracy of their data submissions as required by law and described in Appendix IV.

6. FEA is required to actively cooperate with Department staff in development and implementation of changes to the submission process for encounter and cost share data to improve the efficiency and quality of submissions or as required by law. Active cooperation includes participation in workgroups, meeting established testing and certification deadlines, and implementing changes to FEA systems in support.

7. The FEA is required to provide notice of system changes that will impact its processes and capabilities for collection, storage, and submission of encounter and cost share data to the Department at least 180 days in advance of implementation. Changes may include, but or not limited to, acquiring new software packages, major system upgrades, or contracting with a third party to fulfill data collection and submission requirements. As part of its notice, the FEA must include a testing plan that meets with Department standards and requirements to ensure no interruption in its fulfillment of data collection and submission and other contractual requirements. The testing plan must be completed successfully before the FEA implements the system changes.

8. The Department may conduct a data integrity and systems assessment of the FEA if it has cause to believe that the FEA's submissions of data regarding participant encounters and cost share payments are incomplete, inaccurate, improperly formatted, inconsistent with the FEA's financial or other records, or non-compliant with this Agreement.

    a. The assessment will include review of relevant records, reconciliation between data sources, and an on-site or virtual visit by the Department's assessment team.

    b. The Department will communicate to the FEA its determination that an assessment is required and schedule the on-site or virtual visit no less than 30 and no more than 60 days after the communication.

    c. When an assessment is required, the FEA will identify primary and backup contacts for the assessment, accommodate the on-site or virtual visit, make available any relevant records during that visit, and provide any other relevant information requested by the Department's assessment team within five business days of the request.

    d. The Department will develop a draft report of its findings and share it with the FEA within 30 days of the on-site or virtual visit, schedule a meeting with the FEA to discuss and review the report within 15 days of its being shared, and provide a final written report within 45 days of the meeting to the FEA and the Department's contract oversight manager. The report will specify whether the cause for the assessment was substantiated; identify risks, vulnerabilities, or contractual non-compliance; and recommend corrective action, if warranted.

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E. Reports from the Department

1. Monthly Enrollment and Gross Enrollment Totals

   On or around the 15th day of each month DHS will generate and distribute summary totals by email to all Contractors.

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3. Quality Assurance – SharePoint Reports REMOVED

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G. FEA Data Integrity and Systems Assessments REMOVED

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Article XV.

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A. Monthly Rate of Service (MROS)

1. As payment for performance of services in accordance with the terms and conditions of the IRIS Provider Agreement, ICAs, and FEAs will receive monthly rate of service (MROS) payments for Medicaid-eligible IRIS participants in enrolled status, or for participants in suspended status for no more than 90 days, on a calendar month basis as follows:
   a. ICAs will receive a standard MROS payment of $230.52 per participant.
   b. FEAs will receive a standard MROS payment of $65.56 per participant.
   c. FEAs will receive a supplemental MROS payment of $18.18 per participant receiving self-directed personal care (SDPC) services.
2. An ICA or FEA that provides services to a participant for an entire calendar month will receive a full MROS payment. An ICA or FEA that provides services for part of a calendar month will receive a prorated payment. Adjustments will be made for retroactive enrollment changes in prior months; a negative adjustment will be applied as a receivable against the next MROS payment.
3. Payments will be based upon enrollment and SDPC data recorded in the Department's Medicaid Management Information System (MMIS).
4. Payments will be determined and remitted electronically by MMIS. The ICA or FEA will be able to access remittance advices and MROS payment detail reports through the ForwardHealth Waiver Agency Portal.
5. Payments for the current month will be calculated on the first Friday of the month for deposit by the second Friday of the month (or next business day after the Friday if a holiday). Adjustments for participants incorrectly included or omitted in prior months will be calculated every Friday for deposit by the next Friday (or next business day after the Friday if a holiday).

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Appendix I.

Unless earlier terminated, as provided herein, this Contract shall remain in full force and effect until December 31, 2024.

In WITNESS WHEREOF, the State of Wisconsin and the Contractor have executed this agreement:

Executed on behalf of Name of Contractor	Executed on behalf of Department of Health Services
_____ Authorized Signer Title	_____ Jamie S. Kuhn Medicaid Director
_____ Date	_____ Date

…

Appendix III

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Form Name/Number	Form Title/Purpose
Internal Revenue Service Form SS-4	Application for new or activation of existing FEIN. The FEA verifies that an FEIN is not already assigned and submits the application to the IRS when the participant employer needs to obtain a FEIN.
Internal Revenue Service Form 2678	Employer/Payer Appointment of Agent (executed by both employer and FEA).
Internal Revenue Service Form 8821	Tax Information Authorization. Authorizes information exchanges between the FEA and IRS.
Guardianship or Power of Attorney paperwork	This documentation must be uploaded and retained in the participant's document console. FEAs shall check the Department's enterprise care management system prior to requiring said documentation from the participant.

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Appendix IV. FEA Encounter and Cost Share Reporting

This appendix describes the formats, processes, and certification requirements for submission of encounter and cost share data by an FEA, as required by section XIV.C. of this Provider Agreement.

1. The Department will transition encounter reporting from its Long-Term Care Information Exchange System (IES) to its Medicaid Management Information System (MMIS). The transition will take effect for dates of service on or after a Transition Date specified by the Department as follows:
    a. A Transition Date will be specified after all FEAs demonstrate the capability for encounter reporting in MMIS. Capability for encounter reporting in MMIS is demonstrated by completion of all testing and certification milestones and successful submission of encounters without errors to the Department's MMIS user acceptance testing (UAT) system.
    b. If all FEAs have demonstrated the capability for encounter reporting in MMIS by November 30, 2023, the Transition Date will be January 1, 2024.
    c. The Transition Date will be the first day of a calendar month.
    d. The Transition Date will be no fewer than 28 and no more than 59 days after the Department determines that all FEAs have demonstrated the capability for encounter reporting in MMIS.
    e. The Transition Date will be communicated to FEAs with at least 28 days' notice.
    f. Notwithstanding any other provision of this section, the Transition Date will be no later than January 1, 2025.
    g. An FEA that has not demonstrated the capability for encounter reporting in MMIS by January 1, 2024, will have its MROS payment reduced by $1.48 per participant until the first day of the month on or after which it has demonstrated the capability for encounter reporting in MMIS.
2. For all encounters with dates of service on the Transition Date or later, encounter and adjustment data must be submitted to MMIS. Submissions of encounters to

MMIS with dates of service earlier than the Transition Date will be denied. All submissions must be in a HIPAA-compliant ASC X12 transaction format and include all data elements required for encounter submission. The FEA must:

a. Follow the data specifications defined in The Adult Long Term Care Encounter User Guide and must submit encounters that conform to national standards as well as specific Departmental requirements;

b. Enter itself as an "other payer" on the encounter; and

c. Process all the FEA-specific files as defined in the report matrix on the ForwardHealth Waiver Agency Portal. All enrollment, encounter, response, capitation, provider, error reports and special program files must be processed in a timely and accurate manner.

3. For all encounters with dates of service earlier than the Transition Date, including encounters or encounter adjustments submitted on or after the Transition Date with dates of service earlier than the Transition Date, encounter and adjustment data must be submitted to IES. All submissions must be in the XML format specified for IES and include all data elements required for encounter submission.

4. Cost share data must be submitted to IES. All submissions must be in the XML format specified for IES and include all data elements required for encounter submission.

5. The Department will provide user guides on data submission to MMIS and IES.

6. The FEA must certify each data submission, in the form prescribed by the Department in the system used for the data submission.

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A. Encounter Data Certification Removed

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B. Financial Certification Removed

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Appendix V.

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i.

Report	Reporting Period	Due Date	Submit To
1. Year to Date Financial Reporting (to include completed reporting template, signed Financial Statement Certification, investment/bank statement for segregated Restrictive Reserve account)	1/1/2024 – 3/31/2024	4/30/2024	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2024 – 6/30/2024	7/30/2024	
	1/1/2024 – 9/30/2024	10/30/2024	
2. Preliminary Year End Financial Reporting (to include completed reporting template, signed Financial Statement Certification, investment/bank statement for segregated Restrictive Reserve account)	1/1/2023 – 12/31/2023	3/1/2024	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2024 – 12/31/2024	3/1/2025	

3.1 Audited Year End Financial Reporting* (with the audit report, required schedules, letters, updated financial reporting template, financial statements, and signed Financial Statement Certification) **see contract for comprehensive list of required submission files.*	1/1/2023 – 12/31/2023	6/1/2024	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2024 – 12/31/2024	6/1/2025	
3.2 Accountants Letter of Qualifications	Same as 3.1 above	Same as 3.1 above	Same as 3.1 above
3.3 CPA Checklist	Same as 3.1 above	Same as 3.1 above	Same as 3.1 above
4. Annual Financial Projections	1/1/2025 – 12/31/2025	10/15/2024	DHSLTCFiscalOversight@dhs.wisconsin.gov cc: DHSIRIS@dhs.wisconsin.gov

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ii.

Report	Reporting Period	Due Date	Submit To
1. Encounter Reporting Submission and Data Certification form, as applicable.	12/1/2023 – 12/31/2023	1/30/2024	DHS LTC IES: https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html
	1/1/2024 – 1/31/2024	2/29/2024	
	2/1/2024 – 2/29/2024	4/1/2024	
	3/1/2024 – 3/31/2024	4/30/2024	
	4/1/2024 – 4/30/2024	5/30/2024	
	5/1/2024 – 5/31/2024	7/1/2024	
	6/1/2024 – 6/30/2024	7/30/2024	
	7/1/2024 – 7/31/2024	8/30/2024	
	8/1/2024 – 8/31/2024	9/30/2024	
	9/1/2024 – 9/30/2024	10/30/2024	
	10/1/2024 – 10/31/2024	12/2/2024	
	11/1/2024 – 11/30/2024	12/30/2024	
	12/1/2024 – 12/31/2024	1/30/2025	
2. Funding Files	Weekly Pay Cycles, pursuant to the Payroll and Vendor Schedule (P-01740)	See P-01740	DHSDMSIRISFiscal@dhs.wisconsin.gov
3. Deposit and Disbursement Accounts Bank Reconciliation	12/1/2023 – 12/31/2023	1/16/2024	IRIS Contract Specialist(s) and DHSDMSIRISFiscal@dhs.wisconsin.gov
	1/1/2024 – 1/31/2024	2/15/2024	
	2/1/2024 – 2/29/2024	3/15/2024	

	3/1/2024 – 3/31/2024	4/15/2024	
	4/1/2024 – 4/30/2024	5/15/2024	
	5/1/2024 – 5/31/2024	6/17/2024	
	6/1/2024 – 6/30/2024	7/15/2024	
	7/1/2024 – 7/31/2024	8/15/2024	
	8/1/2024 – 8/31/2024	9/16/2024	
	9/1/2024 – 9/30/2024	10/15/2024	
	10/1/2024 – 10/31/2024	11/15/2024	
	11/1/2024 – 11/30/2024	12/16/2024	
	12/1/2024 – 12/31/2024	1/15/2025	
4. Reimbursement Files	12/1/2023 – 12/31/2023	1/11/2024	DHSDMSIRISFiscal@dhs.wisconsin.gov
	1/1/2024 – 1/31/2024	2/8/2024	
	2/1/2024 – 2/29/2024	3/14/2024	
	3/1/2024 – 3/31/2024	4/11/2024	
	4/1/2024 – 4/30/2024	5/9/2024	
	5/1/2024 – 5/31/2024	6/13/2024	
	6/1/2024 – 6/30/2024	7/11/2024	
	7/1/2024 – 7/31/2024	8/8/2024	
	8/1/2024 – 8/31/2024	9/12/2024	
	9/1/2024 – 9/30/2024	10/10/2024	
	10/1/2024 – 10/31/2024	11/14/2024	
	11/1/2024 – 11/30/2024	12/12/2024	
	12/1/2024 – 12/31/2024	1/9/2025	
Report	**Reporting Period**	**Due Date**	**Submit To**
5. Cost Share Arrearage Report	12/1/2023 – 12/31/2023	1/10/2024	To each IRIS Consultant Agency with impacted participants.
	1/1/2024 – 1/31/2024	2/12/2024	
	2/1/2024 – 2/29/2024	3/11/2024	
	3/1/2024 – 3/31/2024	4/10/2024	
	4/1/2024 – 4/30/2024	5/10/2024	
	5/1/2024 – 5/31/2024	6/10/2024	
	6/1/2024 – 6/30/2024	7/10/2024	
	7/1/2024 – 7/31/2024	8/12/2024	
	8/1/2024 – 8/31/2024	9/10/2024	
	9/1/2024 – 9/30/2024	10/10/2024	
	10/1/2024 – 10/31/2024	11/11/2024	
	11/1/2024 – 11/30/2024	12/10/2024	
	12/1/2024 – 12/31/2024	1/10/2025	
6. Cost Share Statement	Same as 5 above	Same as 5 above	To each IRIS participant with cost share obligation
7. Cost Share Aging Report	Same as 6 above	Same as 6 above	DHSDMSIRISFiscal@dhs.wisconsin.gov

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iii.

Employment Reporting	**Contract Year**	**Review Period**	**IES Spreadsheet from DHS available for ICAs** (2nd Friday after the quarter)	**ICA IES Info Due to DHS** (6 weeks after receiving spreadsheet)	**Submit To**

	2023	Q1 Jan, Feb, Mar	Apr 14, 2023	May 26, 2023	DHS LTC IES: https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html
		Q2 Apr, May, June	July 14, 2023	Aug 25, 2023	
		Q3 July, Aug, Sept	Oct 13, 2023	Nov 24, 2023	
		Q4 Oct, Nov, Dec	Jan 12, 2024	Feb 23, 2024	
	2024	Q1 Jan, Feb, Mar	Apr 12, 2024	May 24, 2024	
		Q2 Apr, May, June	July 12, 2024	Aug 23, 2024	
		Q3 July, Aug, Sept	Oct 11, 2024	Nov 22, 2024	
		Q4 Oct, Nov, Dec	Jan 10, 2025	Feb 21, 2025	

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.

FEDERAL AWARD INFORMATION

FOR THIS SECTION: If there is no federal funding then please delete this contract section.

Federal Award Information	
FAIN	If unknown, contact DHS Managerial Accountant
Federal Award Date	Date Federal Award was Granted to DHS
Subaward period of Performance Start Date	Contract Start Date
Subaward period of Performance End Date	Contract End Date
Amount of Federal Funds obligated (committed) by this action	Total Amount of Federal Funds being awarded in this Contract
Total Amount of Federal Funds obligated (committed)	Total Amount of Federal Funds being awarded in this Contract
Federal Award Project Description	DHS Program Name
Federal Awarding Agency Name (Department)	Federal Awarding Agency
DHS Awarding Official Name	DHS Deputy Secretary, Debra K. Standridge
DHS Awarding Official Contact Information	DHSContractCentral@dhs.wisconsin.gov
Assistance Listing Number	If unknown, contact DHS Managerial Accountant
Assistance Listing Name	If unknown, contact DHS Managerial Accountant
Total made available under each Federal award at the time of disbursement	Total amount of the Federal Award
R&D?	Yes No
Indirect Cost Rate	Indirect Cost Rates for each program area can be found on page 3 and 4 of the DHS Accounting Policy and Procedures Manual Section 14 – Federal Funds 4.1