IRIS CONTRACT

between

WISCONSIN DEPARTMENT OF HEALTH SERVICES DIVISION OF MEDICAID SERVICES

and

<<NAME OF FISCAL EMPLOYER AGENT>>

Issued January 1, 2026

Effective 1/1/2026 – 12/31/2026

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Preamble

Include, Respect, I Self-Direct (IRIS) is a program authorized under the Medicaid Home and Community-Based Services (HCBS) waiver section 1915(c) of the federal Social Security Act. The Wisconsin Department of Health Services (the Department) oversees administration of the program including contracting with fiscal employer agents (FEAs) to provide services as defined in this contract.

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.

IRIS was created in response to consumer demand and to offer individuals who are eligible for Medicaid-reimbursed long-term care services in Wisconsin, a fully self-directed option. Prior to IRIS, managed long-term care included Family Care, and, where available, Family Care Partnership and the Program for All-Inclusive Care for the Elderly (PACE). IRIS was designed and began in July 2008 as Wisconsin's fully self-directed support Medicaid health and community-based services waiver program.

Frail elders and adults with physical, intellectual, or developmental disabilities that are eligible for Medicaid may choose to participate in IRIS. A key feature of the program is the emphasis on participation. Individuals who choose IRIS are called participants because they, or their family participants or representatives, are able to actively participate in the program by making decisions about and effectively self-managing their long-term supports and services.

Participants are given a budget amount determined by the Long-Term Care Functional Screen (LTCFS) results. With the IRIS budget, participants develop an individualized plan that outlines which supports and services will help them achieve their long-term care goals.

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.

In IRIS, self-direction leads to self-determination through which participants take control of their long-term care outcomes and have the freedom to live a meaningful life at home, at work, and in their communities.

This contract and the following documents define the IRIS program's philosophy and implementation:

- IRIS Policy Manual (P-00708);
- IRIS Work Instructions (P-00708A);
- IRIS Service Definition Manual (P-00708B); and
- Addenda to Policy Manual and Work Instructions.

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;
- Individual Support and Services plan and service authorization creation;
- Support of participant rights;
- Responsiveness to grievance and appeals; and
- Quality management of IRIS services.

It is the Department's expectation under this contract that supports and services will foster opportunities for interaction and integration into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control over personal resources, and receive services in the community while supporting each participant's individual outcomes, recognizing each participant's preferences, and respecting participant decisions. The Department further expects that each participant will have the opportunity to make informed choices about where he or she will live, how he or she will make or maintain connections to the community, and whether he or she will seek competitive integrated employment.

Any FEA that delivers the IRIS benefit under this contract must first be certified by the Department. The Department then pays the FEA a fixed monthly payment for each participant.

This Contract describes the contractual relationship between the FEA and the Department, the Department's administrative requirements, performance standards and expectations, and how the Department will monitor each.

This contract is entered into with the State of Wisconsin represented by the Division of Medicaid Services in the Department of Health Services, whose principal business address is: 201 E Washington Ave, PO Box 309, Madison, Wisconsin, 53703, and <<Generic>>, a Fiscal Employer Agent, hereafter FEA, whose principal business address is: <<Address>>.

I. Definitions

Refer to the IRIS Service Definition Manual (P-00708B) for service definitions and codes.

1. **Abuse**: as defined by Wis. Stat. § 46.90(1)(a).
2. **Adult at Risk**: as defined by Wis. Stat. § 55.01(1e).
3. **Adult Family Home (1-2 bed AFH)**: An owner operated or corporate residence where one or two adult residents reside and receive support and services above the level of room and board.
4. **Adult Family Home (3-4 bed AFH)**: are licensed under Wis. Admin. Code Ch. DHS 88 and are places where 3 or 4 adults who are not related to the licensee reside, receive care, treatment or services that are above the level of room and board and that may include up to 7 hours per week of nursing care per resident.
5. **Adult Protective Services (APS)**: as defined by Wis. Stat. § 55.01(6r).
6. **Adverse Action Date**: by law, individuals must be given at least ten (10) calendar days advance notice before any adverse action (i.e., reduction or termination) can take effect relative to their Medicaid eligibility and benefits. The "Adverse Action Date" is the day during a given month by which an adverse action must be taken so as to assure that the participant has the notice in hand at least 10 (ten) calendar days before the effective date of the adverse action. The effective date of most Medicaid benefit reductions or terminations is the first day of a given month. Therefore, the Adverse Action Date is generally mid-month in the month prior. In a thirty-one (31) day month, adverse action is on or around the 18th; in a thirty (30) day month, it's on or around the 17th.
7. **Aging and Disability Resource Center (ADRC)** or **Aging Resource Center** or **Disability Resource Center** or **Resource Center**: an entity that meets the standards for the operation and is under contract with the Department of Health Services to provide services under Wis. Stat. § 46.283(3), or, if under contract to provide a portion of the services specified under Wis. Stat. § 46.283(3), meets the standards for operation with respect to those services. For the purposes of this contract, entity will be referred to as ADRC.
8. **Aging and Disability Resource Specialist (ADRS)**: a position authorized under Wis. Stat. § 46.283(1) and under contract with the Wisconsin Department of Health Services to assure that tribal members receive culturally appropriate information on aging and disability services and benefits and receive support to access publicly funded long-term care programs.
9. **Assets**: any interest in real or personal property that can be used for support and maintenance. "Assets" includes motor vehicles, cash on hand, amounts in checking and savings accounts, certificates of deposit, money market accounts, marketable securities, other financial instruments and cash value of life insurance.

10. **Business Day**: Monday through Friday, excluding days in which the office of the fiscal employer agent is closed.

11. **Centers for Medicare and Medicaid Services (CMS)**: the federal agency responsible for oversight and federal administration of Medicare and Medicaid programs.

12. **Claim**: A request for payment for services and benefits received by an IRIS participant that is authorized and program allowable.

13. **Confidential Information**: all tangible and intangible information and materials accessed or disclosed in connection with this contract, transferred or maintained in any form or medium (and without regard to whether the information is owned by the Department or by a third party), that consist of:

    a. Personally Identifiable Information (PII);

    b. Individually Identifiable Health Information;

    c. Non-public information related to the Department's employees, customers, technology (including databases, data processing, and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; and

    d. Information designated as confidential in writing by the Department.

14. **Conflict of Interest**: a situation where a person or entity other than the participant is involved in planning or delivery of services to the participant, and that has an interest in, or the potential to benefit from, a particular decision, outcome, or expenditure.

15. **Contract/the Contract**: the contractual agreement between the Wisconsin Department of Health Services and the fiscal employer agent.

16. **Corporate AFH**: A provider-controlled setting or a provider-owned or-operated residence where 1-2 or 3-4 residents reside and receive support and services above the level of room and board from staff employed by the entity (e.g., LLC) or agency that owns or operates the AFH. The staff employed by the entity or agency that owns or operates the AFH may reside in the residence. Homes classified as a provider-controlled setting must be certified or licensed as an AFH. A provider-controlled setting is a setting in which 1-2 or 3-4 residents who are not related to the provider or operator reside and receive support and services above the level of room and board, and:

    a. The provider has a direct or indirect financial relationship with the property owner but does not lease or own the property, or

    b. The landlord has influence over which service providers the resident uses, or

    c. The provider or operator of the AFH holds the lease or title to the home.

17. **Contractor**: for purposes of this contract, Contractor is used to refer to contractual obligations that are applicable to fiscal employer agents.

18. **Corrective Action Plan (CAP)**: a step-by-step plan of action that is developed to achieve targeted outcomes for resolution of identified errors.

19. **Cost Share**: the contribution towards the cost of services required under 42 C.F.R. § 435.726 as a condition of eligibility for Medicaid for some participants who do not otherwise meet Medicaid categorical or medically needy income limits.

20. **County Agency**: a county department of aging, social services or human services, an aging and disability resource center, a long-term care district or a tribal agency that has been designated by the Department of Health Services to determine financial eligibility and cost sharing requirements.

21. **Crime**: conduct which is prohibited by state or federal law and punishable by fine or imprisonment or both. Conduct punishable only by forfeiture is not a crime.

22. **Critical Incident**: any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a participant. This can occur when the participant receives non-routine treatment in a hospital or urgent care facility, or when any other event occurs that places the individual's health and safety in jeopardy.

23. **Days**: calendar days unless otherwise noted.

24. **Department**: the Wisconsin Department of Health Services (DHS) or its designee.

25. **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.

26. **Developmental Disability**: a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome. This also includes an intellectual disability diagnosed before age 18 and characterized by below-average general intellectual function and a lack of skills necessary for daily living, or another neurological condition closely related to such intellectual disability or requiring treatment similar to that required for such intellectual disability, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the inflicted individual. "Development disability" does not include senility that is primarily caused by the process of aging or the infirmities of aging.

27. **DHS (the Department)**: the Wisconsin Department of Health Services.

28. **Dignity of Risk**: the idea that self-determination and the right to take reasonable risks are essential for dignity.

29. **Dual Eligible**: refers to an individual who meets the requirements to receive benefits from both the Federal Medicare Program and the Wisconsin Medicaid Program. "Dual eligibility" does not guarantee "dual coverage."

30. **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.

31. **Encounter Reporting**: Submission of encounters by an FEA to the Department, using the format and system specified by the Department.

32. **Enrollment Consultant**: the individual who performs enrollment counseling activities to potential enrollees, such as answering questions and providing information in an unbiased manner on available delivery system options, including the option of enrolling in an FEA and advising on what factors to consider when choosing among these options.

33. **Fair Hearing**: a de novo proceeding under Wis. Admin. Code. ch. HA3, before an impartial administrative law judge at the Division of Hearings and Appeals, in which the petitioner or the petitioner's representative presents the reasons why an action or inaction by the Department of Health Services, a county agency, a resource center, or an ICA in the petitioner's case should be corrected.

34. **Fee-for Service (FFS)**: a payment model where health care services are paid for separately, by each service performed.

35. **Financial Abuse**: a practice that is inconsistent with sound fiscal, business, or medical practices and results in unnecessary program costs or any act that constitutes financial abuse under applicable Federal and State law. Financial abuse includes actions that may, directly or indirectly, result in unnecessary costs to the fiscal employer agent, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Financial abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has knowingly and/or intentionally misrepresented facts to obtain payment.

36. **Financial Exploitation**: includes any of the following acts:

    a. Fraud, enticement or coercion;

    b. Theft;

    c. Misconduct by a fiscal employer agent;

    d. Identity theft;

    e. Unauthorized use of the identity of a company or agency;

    f. Forgery; or

    g. Unauthorized use of financial transaction cards including credit, debit, ATM, and similar cards.

37. **Fiscal employer agent (FEA)**: contracted agent to process payroll, manage Federal and State tax withholdings, and report obligations related to participant-hired workers in the IRIS program. FEAs also ensure provider qualifications, pay vendor claims, and collect participant Medicaid cost share payments.

38. **Fiscal Oversight**: the Department of Health Services section responsible for the analysis, review, and oversight of audited financial reports, financial projections, quarterly financial reporting, restricted reserve payments, and working capital requirements.

39. **Frail Elder**: an individual who is 65 years of age or older and has a physical disability or irreversible dementia that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.

40. **Group A**: persons age 18 and over who are financially eligible for full-benefit Medicaid on a basis separate from qualifying to receive home and community-based waiver services.

41. **Group B**: persons age 18 and over who are not in Group A, meet the non-financial requirements to receive home and community-based waiver services and have a gross monthly income no greater than a special income limit equal to 300% of the SSI federal benefit rate for an individual.

42. **Group B+**: persons age 18 or over not in Group A, meeting all requirements for Group B except for income, whose monthly income after subtracting the cost of institutional care is at or below the medically needy income limit.

43. **Harassment**: any unwanted offensive or threatening behavior, which is linked to one or more of the below characteristics when:

    a. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or eligibility for services;

    b. Submission to or rejection of such conduct by an individual is used as the basis for employment or service decisions affecting such individual; or

    c. Such conduct has the purpose or effect of substantially interfering with an individual's work performance, or of creating an intimidating, hostile, or offensive work or service delivery environment, which adversely affects an individual's opportunities.

    Harassing behavior may include, but is not limited to, demeaning or stereotypical comments or slurs, ridicule, jokes, pranks, name calling, physical or verbal aggression, gestures, display or possession of sexually graphic materials, cartoons, physical contacts, explicit or implicit threats separate from supervisory expressions of intention to use the disciplinary process as a consequence of continued inappropriate behavior, malicious gossip or any other activity that contributes to an intimidating or hostile work environment.

    Sexually harassing behavior is unwelcome behavior of a sexual nature which may include, but is not limited to, physical contact, sexual advances or solicitation of favors, comments or slurs, jokes, pranks, name calling, gestures, the display or possession of sexually graphic materials which are not necessary for business purposes, malicious gossip and verbal or physical behaviors which explicitly or implicitly have a sexual connotation.

    Harassment is illegal when it is a form of discrimination based upon age, disability, association with a person with a disability, national origin, race, ancestry or ethnic background, color, record of arrest or conviction which is not job-related, religious belief or affiliation, sex or sexual orientation, marital status, military participation, political belief or affiliation, and use of a legal substance outside of work hours.

44. **Income Maintenance** or **IM Agency**: a subunit of a county, consortia, or tribal government responsible for administering IM Programs, including Wisconsin Medicaid; formerly known as the Economic Support Agency.

45. **Individual at Risk**: an elder adult at risk (age 6o and over) or an adult at risk (age 18-59).

46. **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 participant's Long-Term Care Needs Panel.

47. **Individually Identifiable Health Information**: participant demographic information, claims data, insurance information, diagnosis information, and any other information that relates to an individual's past, present, or future physical or mental health or condition, provision of services and supports, or payment for health care that identifies the individual or could reasonably be expected to lead to the identification of the individual.

48. **Institution for Mental Disease**: a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

49. **IRIS (Include, Respect, I Self-Direct)**: Wisconsin's self-directed long-term care program for frail elders and adults with physical and/or developmental disabilities to get the services they need to remain in their homes whenever possible and maintain independence. IRIS is available to Wisconsin residents determined financially and functionally eligible for Medicaid who met a level of care eligible for admittance to a nursing home (i.e., frail elders and individuals with a physical disability) or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

50. **IRIS Budget Allocation (base budget)**: the budget that is allocated to an IRIS participant based on their identified needs. The participant is responsible for managing their budget allocation to fund their long-term care services; however, it excludes the cost for approved one-time expenses, budget amendments, and any items that are unapproved, non-allowable, or not cost-effective. Each participant receives a budget estimate following their enrollment in IRIS.

51. **IRIS Consultant Agency (ICA)** and **IRIS Consultant (IC)**: IRIS consultant agencies hire and support a staff of IRIS consultants. IRIS consultants provide flexible and specialized support that is responsive to a participant's needs and preferences for long-term care services. The IRIS consultant's roles and responsibilities focus on supporting the participant in self-direction, which includes enrollment and orientation, service planning, plan development, quality monitoring, coordination with FEAs, ongoing support and assistance, and continued eligibility assistance.

52. **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 IRIS Service Plan (service plan). All other identified long-term care

needs funded through a different source or informal supports should be documented within the LTC Needs Panel.

53. **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.

54. **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.

55. **IRIS Service Plan (service plan)**: the participant's person-centered service plan, which includes the following components:

    a. Individual Support and Service Plan (ISSP);

    b. Long-Term Care Needs Panel (LTC Needs Panel);

    c. Individualized back-up plan; and

    d. HCBS Settings Rule Modification documentation (if applicable) for participants receiving residential services in provider-owned or provider-controlled residential settings.

56. **Legal Decision Maker**: a participant or potential participant's legal decision maker is a person who has legal authority to make certain decisions on behalf of a participant or potential participant. A legal decision maker may be a guardian of the person or estate (or both), a conservator appointed under Wis. Stat. Chapter 54, a person designated power of attorney for health care under Wis. Stat. Chapter 155, or a person designated durable power of attorney for finances and property under Wis. Stat. Chapter 244. A legal decision maker may have legal authority to make certain kinds of decisions, but not other kinds of decisions. A participant may have more than one legal decision maker authorized to make different kinds of decisions. In any provision of this contract in which the term "legal decision maker" is used, it applies only to a person who possesses the legal authority relevant to that provision. A person designated by the participant or potential participant as an "authorized representative" under 42 C.F.R. § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker. If the participant has a legal decision maker who has the authority to make decisions on their behalf, the legal decision maker is required to assume and fulfill the same required self-direction roles and accompanying responsibilities on behalf of the participant. The legal decision maker, on behalf of the participant, is required to comply with all IRIS programmatic policies.

57. **Limited English Proficient (LEP)**: a potential participant and participants who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

58. **Marketing/Outreach**: any communication, sponsorship of community events, or the production and dissemination of marketing/outreach materials from an FEA, including its employees, agents, subcontractors, and providers, to an individual who is not enrolled in that entity that can reasonably be interpreted as intended to influence the individual to enroll in or not to enroll in a particular ICA, FEA, or Managed Care Organization (MCO) or to disenroll from another ICA, FEA, or MCO. This further includes materials and presentations to community participants/groups, participants, stakeholders, non-profit organizations, professional conferences, etc. on topics related to the IRIS program or their agency's role as a Contractor.

59. **Marketing/Outreach Materials**: materials in all mediums, including but not limited to, internet websites, brochures and leaflets, newspapers, newsletters, magazine, radio, television, billboards, yellow pages, advertisements, other printed media and presentation materials, used by or on behalf of an FEA to communicate with individuals who are not participants, and that can be reasonably interpreted as intended to influence the individuals to enroll or reenroll in the FEA, as well as those materials that are intended to inform on the IRIS program, its policies, or a Contractor's role as an FEA. Marketing/Outreach Materials also refer to social media postings.

60. **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.

61. **Medicaid**: the Wisconsin Medical Assistance program operated by the Wisconsin Department of Health Services under Title XIX of the Federal Social Security Act, Wis. Stats. Ch. 49 and related state and federal rules and regulations. The term "Medicaid" will be used consistently in this contract. However, "Medicaid" is also known as "MA," "Medical Assistance," and "Wisconsin Medical Assistance Program," or "WMAP."

62. **Medical Assistance Personal Care Program (MAPC)**: a benefit of the Wisconsin Medicaid State Plan provided by a Medicaid certified agency that provides personal care in-home assistance with the ADLs to eligible State residents.

63. **Medicaid Provider Agreement**: a written agreement between a provider and the Department.

64. **Medicaid Recipient**: any individual receiving benefits under Title XIX of the Social Security Act and the Medicaid State Plan as defined in Wis. Stats. Ch. 49.

65. **Monthly Rate of Service (MROS)**: A contractually specified dollar amount paid to an FEA each month for each Medicaid eligible person enrolled in the IRIS program on the first of the month for whom the contractor is providing services to perform the FEA-contracted services.

66. **Owner Operated AFH**: A primary residence of the owner or operator who provides AFH services and supports above the level of room and board for 1-2 or 3-4 residents.

67. **Participant**: an individual enrolled in the IRIS program and/or their legal decision maker if applicable.

68. **Participant-hired worker (PHW)**: a caregiver that provides supports and services to an IRIS participant when the participant is also the employer of record. The FEA functions as employer agent for the participant, as the worker is not associated with an agency.

69. **Participant materials**: materials in any medium intended to inform participants of benefits, procedures, providers, budget calculations, including but not limited to brochures or other materials used by or on behalf of a Contractor to communicate with participants.

70. **Personally Identifiable Information**: an individual's last name and the individual's first name or first initial, in combination with and linked to any of the following elements, if the element is not publicly available information and is not encrypted, redacted, or altered in any manner that renders the element unreadable:

    a. The individual's Social Security number;

    b. The individual's driver's license number or state identification number;

    c. The individual's date of birth;

    d. The number of the individual's financial account, including a credit or debit card account number, or any security code, access code, or password that would permit access to the individual's financial account;

    e. The individual's DNA profile; or

    f. The individual's unique biometric data, including fingerprint, voice print, retina or iris image, or any other unique physical characteristic.

71. **Physical Abuse**: the willful or reckless infliction of bodily harm. Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

72. **Provider**: any individual or entity that has a MA provider agreement with DHS.

73. **Program Integrity Abuse**: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and which result in unnecessary cost to Medicaid funded programs; or the reimbursement for services that are not

medically necessary or that fail to meet professionally recognized standards for health. Abuse also includes beneficiary practices that result in unnecessary costs to Medicaid funded program.

74. **Program Integrity Fraud**: An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to themself, itself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law. For reference, please see 42 CFR § 433.304 and 42 CFR § 455.2.

75. **Program Integrity Waste**: Practices that, directly or indirectly, result in unnecessary costs to Medicaid funded programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the inappropriate utilization of services or the misuse of resources.

76. **Provider**: any individual or entity that has a MA provider agreement with the Department.

77. **Residential Care Apartment Complex** or **RCAC**: a place where 5 or more adults reside that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, including a stove, and individual bathroom, sleeping and living areas, and that provides, to a person who resides in the place, not more than 28 hours per week of services that are supportive, personal and nursing services. "Residential care apartment complex" does not include a nursing home or a community-based residential facility, but may be physically part of a structure that is a nursing home or community-based residential facility.

78. **Self-Direction**: a person-centered and cost-effective service delivery model utilized by participants enrolled in the IRIS program. Participants exercise decision-making authority over their waiver services and assume a direct role in managing their waiver services within a person-centered planning process. Participants are the employers for the workers who provide their care. Participants must assume the required role of "employer authority", which includes multiple responsibilities such as recruiting, hiring, training, supervising, and discharging their staff. If a participant chooses to employ participant-hired workers (PHWs), it is the participant's responsibility to establish their PHWs' work schedules to ensure that their PHWs do not work more than the participant's service plan will allow. A participant hires and manages enrolled and qualified service providers to provide the waiver services included in their service plan within their home or community. A participant must assume the required role of "budget authority", which means that the participant exercises decision-making authority and assumes management responsibility for their spending choices. Because the participant has increased choice about selecting their waiver services and assumes a direct role in managing their service plan, they also accept the risk and increased responsibility

for their spending choices. IRIS participants are required to comply with all programmatic policies.

79. **Secretary**: means the secretary of the Wisconsin Department of Health Services.

80. **Service Area**: the service area also relates to the geographic service region in which specific FEAs operate.

81. **Sexual Abuse**: sexual conduct in the first through fourth degree as defined in Wis. Stat. § 940.225.

82. **Subcontract**: as defined in 41 CFR § 60-1.3.

83. **Supported Decision-Making**: a set of strategies that help individuals understand their options when making choices and communicating their own decisions through the use of an agreement designed to help the person interact and communicate their decisions with third parties. The agreement will include a list of decisions the person wants assistance in making and identifies a supporter(s) they want to help them, as detailed and defined in Wis. Stat. Ch. 52.

84. **Target Group** or **Target Population**: any of the following groups that an FEA has contracted with DHS to serve:

    a. Frail elderly.

    b. Adults with a physical disability.

    c. Adults with a developmental disability.

85. **Third Party Delegate**: a FEA employee who upon request by the vendor or individual provider, in extenuating provider circumstances, completes the initial Medicaid enrollment, re-enrollment, revalidation, demographic maintenance, or makes changes to programs or services in the ForwardHealth Portal on the vendor or individual provider's behalf.

86. **Timesheet**: The document containing the participant-hired worker's name and ID number (if applicable), participant name and ID number (if applicable), hours worked each day, total hours worked within the pay period, code for the service that was provided, and the FEA-developed attestation language.

II. Functions and Duties of the Department

A. Declaration of National or State Emergencies or Disasters

In the event of a federal- or state-declared emergency or disaster, the Department has the ability to modify or waive contractual obligations and regulations that are necessary to address the emergency or disaster. The Department will maintain documentation of any modifications to or waivers of contract requirements. Contractors must follow all relevant ForwardHealth updates and other Department communications issued during a federal or state emergency or disaster.

B. Department of Health Services

The Division of Medicaid Services (DMS) is the primary point of contact among the Department, the Contractor, and the Department's contracted agencies responsible for the administration and operation of the IRIS program. DMS staff may assist the Contractor in identifying system barriers to implementation of the programs and may facilitate intra-and interagency communications and work groups necessary to accomplish full implementation.

C. Notification of Changes in Functional Eligibility Criteria

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

D. Reports from the Contractors

The Department will acknowledge receipt of the reports required in this contract. The Department shall have systems in place to ensure that reports and data required to be submitted by the Contractor shall be reviewed and analyzed by the Department in a timely manner. The Department will respond with any concerns.

E. Right to Monitor

The Department shall have the right to review any program related records, documentation, and materials and to request any additional information. The Department may also monitor any of the processes and expectations outlined in this contract at any time to ensure compliance and quality performance.

F. Technical Assistance

The Department shall review reports and data submitted by the Contractor and shall share results of this review with the Contractor. In conjunction with the Contractor, the Department shall determine whether technical assistance is needed to assist in improving performance in any identified areas. The Department, in consultation with the Contractor, may develop a technical assistance plan and schedule to assure compliance with all terms of this contract and quality service to participants of the Contractor.

G. Conflict of Interest

The Department employees are subject to safeguards to prevent conflict of interest as set forth in Wis. Stats. Ch. 19.

III. Contractual Relationship

A. Contract

The Contractor acknowledges it is subject to certain federal and state laws, regulations, and policies, including those related to Title XIX of the Social Security Act, those pertinent to Wisconsin's Medicaid program, official written policy as transmitted to the Contractor in the Wisconsin Medicaid program handbooks and bulletins, the standards for the specific Medicaid waiver service the Contractor will deliver and the other requirements as defined in these criteria and the 1915(c) Home and Community Based Services (HCBS) Waiver.

The Contractor acknowledges that it is responsible for knowing the provisions of federal and state laws, regulations, this contract, the IRIS 1915(c) HCBS Waiver, and policies that apply, as well as for complying with applicable federal and state law as a condition of its participation as a provider of FEA services under Wisconsin's Medicaid program.

B. Precedence When Conflict Occurs

In the event of any conflict among the following authorities, the order of precedence is as follows:

1. Federal law, state statutes, administrative code, and the accompanying IRIS 1915(c) Waiver;
2. DHS numbered memos;
3. This contract;
4. IRIS program governing documents, e.g., the IRIS Policy Manual, IRIS Work Instructions, IRIS Service Definition Manual, and Addenda to the IRIS Policy Manual and IRIS Work Instructions; and
5. IRIS contractor certification documents.

C. Cooperation of Parties and Dispute Resolution

1. Agreement to Cooperate

   The parties agree to fully cooperate with each other in connection with the performance of their respective obligations and covenants under this contract.

2. Contract Dispute Resolution

   The parties shall use their best efforts to cooperatively resolve disputes and problems that arise in connection with this contract. When a dispute arises that the Contractor and the Department have been unable to resolve, the Department reserves the right to final interpretation of contract language.

3. Reconsideration

Contractors may request reconsideration of any decisions regarding certification, contracting, or corrective action plans by submitting a request for reconsideration, in writing, to the Department. It is the responsibility of the Contractor to provide sufficient documentation and justification to refute the Department's decision(s).

The Contractor must first exhaust the reconsideration process before resorting to any other legal remedy it may have available.

The request for reconsideration must be received within 30 days of receiving notice of the Department's decision. The request must state the reason the contractor believes the decision was made in error. Additionally, the contractor is encouraged to provide documentation with accompanying narrative to explain the documentation. The Department will review the information and issue a reconsideration decision within 30 days of receipt of the Contractor's request. The Department's reconsideration decision shall be considered final.

4. Performance of Contract Terms During Reconsideration

The existence of a dispute notwithstanding:

a. Both parties agree to continue without delay to carry out all their respective responsibilities, which are not affected by the dispute; and

b. The Contractor further agrees to abide by the interpretation of the Department regarding the matter in dispute while the Contractor seeks further review of that interpretation.

D. IRIS Contractor Certification

To be eligible to enter into a contractual relationship with the Department, the FEA must be certified by the Department.

E. Reporting Deadlines

It is expected that the Contractor will meet the reporting deadlines outlined in this contract and any other Department program materials. If the Contractor is unable to meet the deadlines set forth, they will be expected to provide a request for extension, which must include the reason for the requested extension, as well as the specific date of the extended deadline being requested. This request must be submitted prior to the reporting deadline. The Department will review and approve or deny the request for extension.

F. Modification of the Contract

This Contract will be modified if changes in federal or state laws, regulations, rules, or amendments to Wisconsin's CMS approved waivers or the MA state plan require modification to the contract. In the event of such change, the Department will notify the Contractor in writing. If the change materially affects the Contractor's rights or responsibilities under the contract and the Contractor does not agree to the modification, the Contractor may provide the Department with written notice of termination at least ninety (90) days prior to the proposed date of termination.

This contract may be modified at any time by written mutual consent of the contractor and the Department. Unless otherwise agreed to, the effective date of any modification(s) of this contract is the later of the dates signed by authorized persons from the contractor and the Department.

G. Increased Oversight

1. The Department may implement increased oversight of the Contractor's operations in order to assist the Contractor to come into compliance with performance expectations and reporting requirements. When increased oversight is imposed, the Department may place Department staff or require the agency to temporarily engage a third party, pending DHS approval, to assist the Contractor in meeting its performance expectations by providing technical guidance and correcting deficiencies.

2. The Department may implement increased fiscal monitoring of the Contractor to assist the Contractor in addressing financial risks and ensure fiscal stability. Increased fiscal monitoring includes monthly financial reporting by the Contractor and technical assistance by the Department.

   The Department will implement increased fiscal monitoring based upon review and analysis of information provided by the Contractor in its financial data submissions, or other information provided by the Contractor or a third party, indicating that the Contractor has an increased level of financial risk in IRIS program or overall organizational operations. Criteria indicating an increased level of financial risk include, but are not limited to:

   a. Fiscal volatility, including unplanned decline in liquidity or unexplained fiscal trend fluctuations;

   b. Significant variances between budgeted and actual expenses;

   c. Expansion to a new region;

   d. Significant change in the Contractor's business structure, ownership, or operations; and

e. Operational issues such as staff turnover, untimely processing of invoices or claims for service, or untimely bank reconciliation

3. If increased oversight does not result in improved performance or reduced financial risks, then the Department may require corrective action.

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

If the Contractor fails to meet the requirements or performance expectations described in this contract, the Department may impose a Corrective Action Plan (CAP) to ensure that the Contractor comes into compliance with the contract.

1. Corrective Action Plan

Developed in collaboration with the Department and the Contractor, a corrective action plan (CAP) is a step-by-step plan of action that is developed to achieve targeted outcomes for resolution of identified errors and contractual non-compliance in an effort to:

a. Identify the most cost-effective actions that can be implemented to correct the identified deficiency;

b. Develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient;

c. Achieve measurable improvement in the highest priority areas;

d. Eliminate repeated deficient practices; and

e. Bring the Contractor back into compliance with the contract.

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.

a. Corrective Action on Recertification

Corrective action may be required for non-compliance identified in the required annual site visit for recertification. Any such corrective action remaining unresolved by the next annual recertification may result in decertification of the Contractor.

b. Fiscal Corrective Action

Corrective action may be required for fiscal non-compliance including, but not limited to:

i. Failure to fulfill fiscal reporting requirements.

ii. Inability to achieve stability or provide a satisfactory plan for stability with supporting documentation.

iii. Failure to meet working capital or restricted reserve requirements, without prior notice and approval of a shortfall.

iv. Operational weaknesses in critical processes, procedures, or internal controls.

v. Untimely bank reconciliation; and

vi. A missed deadline for payroll, tax filing and reporting, or year-end employee tax and other disclosures.

Fiscal corrective action will include monthly fiscal reporting, examination of the Contractor's business and operations, and performance expectations, as well as submission of financial projections, analyses, or other documentation identified by the Department to demonstrate improvement.

c. Enhanced Fiscal Corrective Action

Enhanced fiscal corrective action may be required for more serious and significant aspects of fiscal non-compliance including, but not limited to:

i. A deficiency in the working capital or restricted reserve requirements;

ii. Sudden failure of critical fiscal or operational systems of human resources and information technology that puts the operations and management of the Contractor at significant risk; or

iii. Failure to address or resolve fiscal corrective action (see 2.b., Fiscal Corrective Action, of this section).

Enhanced fiscal corrective action will include all of the components of fiscal corrective action under 2.b., Fiscal Corrective Action, of this section, as well as a site visit by Department staff, weekly updates with the Contractor's management, and a meeting with the Contractor's governing board or parent organization leadership.

3. Penalties and Authority to Impose Sanction

a. Corrective actions can be short or long-term, and it remains at the State's discretion for completion and resolution of corrective action.

b. If a Contractor is under Corrective Action, they may not expand into additional geographic service regions. After completion of a CAP, as indicated by a formal letter from the Department,

Contractors must wait an additional 90 days before requesting expansion, provided no other corrective actions are pending.

c. If improvement is not made, or a CAP is not resolved by the time indicated on the plan without prior approval for an extension, additional corrective action may be necessary, up to and including a formal sanction and/or termination of the contract.

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

1. Authority to Impose Sanctions

a. If DHS determines the Contractor has violated or breached the contract, through failure to meet performance expectations or comply with substantive terms of the contract, it may impose sanctions, as set forth herein. DHS may base its determinations on findings from any source.

b. DHS may pursue all sanctions and remedial actions with the Contractor consistent with those taken with Medicaid fee-for-service providers, including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997, § 4707(a). If a basis for imposition of a sanction exists, the Contractor may be subject to sanctions.

2. Basis for Imposing Sanctions

DHS may impose sanctions if it determines the Contractor has failed to meet any of the following requirements and expectations:

a. The Contractor shall provide all required services under law and the contract to any participant covered under the contract.

b. The Contractor shall not impose premiums or charges on participants that are in excess of the premiums or charges permitted under the Medicaid program.

c. The Contractor shall not act to discriminate among participants on the basis of their health status or need for health care services. This includes, but is not limited to, termination of enrollment or refusal to reenroll a participant, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by participants whose medical condition or history indicates probable need for substantial future contractual services.

d. The Contractor shall not misrepresent or falsify information that it furnishes to CMS or to DHS.

e. The Contractor shall not misrepresent or falsify information that it furnishes to a participant, potential participant, or a provider.

f. The Contractor shall not directly or indirectly distribute materials that have not been approved by the Department or materials that contain false or materially misleading information through any agent or independent contractor.

g. The Contractor shall meet financial performance expectations for solvency and financial stability as set forth in this contract.

h. The Contractor shall meet the quality standards and performance criteria of this contract such that participants are not at substantial risk of harm.

i. The Contractor shall meet all contractual obligations described herein in order to prevent the unauthorized use, disclosure, or loss of confidential information.

j. The Contractor shall meet all other obligations described in federal law, state law and the contract not otherwise described above.

k. FEAs shall meet the encounter reporting submission and data certification requirements (See Appendix I**Error! Reference source not found.**).

3. Types of Sanctions

DHS may impose the civil monetary penalties for the violations described above, as well as one or more of the following sanctions:

a. Appointment of temporary management for Contractor.

b. Notifying the affected participants of their right to disenroll.

The Contractor shall provide assistance to any participant electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's participant record to new providers and/or a participant's new FEA, or Managed Care Organization (MCO) if the participant enrolls in the Family Care or Family Care Partnership programs.

DHS shall ensure that a participant who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new ICA, FEA, or MCO of the participant's choosing.

c. Suspension of all new enrollments after the effective date of the sanction. The suspension period may be for any length of time specified by the Department or may be indefinite.

d. Suspension of monthly rate of service (MROS) payments for participants enrolled after the effective date of the sanction and until CMS or DHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

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

f. Withholding or recovering of MROS payments.

g. Termination of the contract.

h. Any other sanctions that DHS determines, in its sole discretion, to be appropriate.

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

Civil monetary penalties may be imposed as follows:

a. A maximum of $25,000 for each of the following violations, as defined above:

i. Failure to provide services.

ii. Misrepresentation or false statements to participants, potential participants, or providers.

iii. Marketing violations.

b. A maximum of $100,000 for each violation of:

i. Discrimination.

ii. Misrepresentation or false statements to CMS or DHS.

c. A maximum of $15,000 for each participant DHS determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

d. A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for premiums or charges in excess of the amounts permitted under the Medicaid program. DHS must deduct from the penalty the amount of overcharge and return it to the affected participant(s).

e. A maximum of $50,000 per incident for a violation of HIPAA confidentiality and security described herein, consisting of:

i. $100 for each individual whose confidential information was used, disclosed, or lost; and

ii. $100 per day for each day that the Contractor fails to substantially comply with the directives described herein;

iii. In addition, in the event of a federal citation for a breach of confidentiality caused by an action or inaction of the Contractor, the Contractor is responsible for the full amount of any federal penalty imposed without regard to the limit set forth above.

f. A maximum of $100,000 for any other violation described above.

6. Recovery of Damages

In any case under this contract where DHS has the authority to withhold Monthly Rate of Service (MROS) payments, DHS also has the authority to use all other legal processes for the recovery of damages.

DHS may withhold or recover portions of the MROS payments in liquidated damages or otherwise recover damages from the Contractor notwithstanding the provisions of this contract. The withholding or recoveries will be made absent the Contractor's prompt and reasonable efforts to remove the grounds described.

7. Authority to Terminate Contract

The Department has the authority to terminate a Contractor's contract and enroll that entity's participants in other Contractor agencies of the participant's choosing, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the Contractor has failed to carry out the substantive terms of the contract.

J. Termination of the Contract

1. Termination

a. Mutual Agreement for Termination – The contract may be terminated at any time by mutual written consent of both the Contractor and the Department (collectively referred to as the "Parties" and independently each a "Party").

b. Contract Non-Renewal – Either Party may decide to not renew this contract by providing written notice to the other Party indicating its intent to not renew the contract at least ninety (90) days prior to the termination date.

c. Declaration of National or State Emergencies or Disasters – In the event of a federal- or state-declared emergency or disaster, the Department may modify or waive contractual obligations and

regulations that are necessary to address the emergency or disaster. The Department will maintain documentation of any modifications to or waivers of contract requirements. The Contractor must follow all relevant ForwardHealth updates and other Department communications issued during a federal or state emergency or disaster.

d. Unilateral Termination – The contract may be unilaterally terminated only as follows:

i. Termination for Convenience – Either Party may terminate this contract at any time, without cause, upon at least a ninety (90) days' prior written notice to the other Party of its intent to terminate this contract.

ii. Changes in Federal or State Law – The contract may be terminated at any time, by either Party, due to modifications mandated by changes in federal or state law or regulations that materially affect either Party's rights or responsibilities under this contract. In such case, the Party initiating such termination procedures must provide at least a ninety (90) days' prior written notice to the other Party, of its intent to terminate this contract

iii. Changes in Reporting Requirements – If the Department proposes additional reporting requirements during the contract term, the Contractor will have thirty (30) days to review and comment on the fiscal impact of the additional reporting requirements. The Department will consider any potential fiscal impact on the Contractor before requiring additional reporting. If the change has significant fiscal impact, the Contractor may provide the Department with a ninety (90) days' prior written notice to termination. The Contractor will not be required to provide the additional reporting.

iv. Termination for Cause – If either Party fails to perform under the terms of this contract, the other Party may terminate the contract by providing written notice of any defects or failures to the non-performing Party.

a) The initiating Party must provide a sixty (60) days' prior written notice of its intent to terminate the contract, including its reasons for termination.

b) The non-performing Party will have thirty (30) days from the receipt of termination notice date to cure the failures or defects established within the initiating Party's notice.

c) If the failures or defects are not cured within thirty (30) days of the non-performing Party receiving the notice, the other Party may terminate the contract.

v. Termination when Federal or State Funds are Unavailable

a) Permanent Loss of Funding

This contract may be terminated by either party, in the event federal or state funding of contractual services rendered by the Contractor becomes permanently unavailable and such lack of funding would preclude reimbursement for the performance of the Contractor's obligations. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the Contractor will become unavailable, the Department shall immediately notify the Contractor, in writing, identifying the basis for the anticipated unavailability of funding and the date on which the funding will end. In the event of termination, the contract will terminate without termination costs to either party.

b) Temporary Loss of Funding

In the event funding will become temporarily suspended or unavailable, the Department will suspend the Contractor's performance of any or all of the Contractor's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of these obligations. The Department shall attempt to give notice of suspension of performance of any or all of the Contractor's obligations sixty (60) days prior to said suspension, if possible; otherwise, such notice of suspension should be made as soon as possible. Once the funding is reinstated, the Contractor will resume the suspended services within thirty (30) days from the date the funds are reinstated. The contract will not terminate under a temporary loss of funding.

vi. Immediate Termination – The Department may immediately terminate this contract if the Contractor:

a) Or its Parent Company files a petition in bankruptcy, becomes insolvent (i.e., insolvency

event), dissolves, or otherwise takes action to dissolve as a legal entity;

1) "Insolvency Event" means, with respect to either Party or its Parent Company (defined as any entity that directly or indirectly controls, is controlled by, or is under common control with the Party, including its ultimate holding company), any of the following:

   A) Such entity (a) is unable to pay its debts as they become due, (b) admits in writing its inability to pay its debts, or (c) makes an assignment for the benefit of creditors.

   B) Such entity commences a voluntary case or proceeding under any bankruptcy, insolvency, reorganization, debt arrangement, dissolution, or similar law, or any other law providing for the relief of debtors.

   C) An involuntary case or proceeding is commenced against such entity under any bankruptcy, insolvency, reorganization, debt arrangement, dissolution, or similar law, and such case or proceeding is not dismissed within sixty (60) days of its commencement.

   D) A receiver, trustee, liquidator, administrator, or similar official is appointed for such entity or for any substantial part of its assets, and such appointment is not discharged or stayed within sixty (60) days.

   E) Such entity takes any corporate action to authorize any of the foregoing.

2) Obligation to Notify – Each Party must immediately notify the other Party in writing upon the occurrence of any Insolvency Event with respect to itself or its Parent

Company, or any event or circumstance that could reasonably be expected to lead to an Insolvency Event or a material adverse change in its or its Parent Company's financial condition that could impair its ability to perform its obligations under this contract. Such notice shall include full particulars of the event or circumstance and any proposed remedial actions.

3) Rights Upon Notification or Discovery – Upon receiving notice of, or otherwise becoming aware of, an Insolvency Event or a material adverse change in the financial condition of the other Party or its Parent Company as described in Article III.J., the non-notifying Party shall have the right, but not the obligation, to:

A) Demand adequate assurance of future performance within a reasonable time (not to exceed ten (10) business days). Failure to provide such adequate assurance, to the reasonable satisfaction of the demanding Party, constitutes a material breach of the contract.

B) Suspend its performance under this contract, in whole or in part, until adequate assurances are provided or the Insolvency Event is resolved.

C) Exercise any other rights or remedies available under this contract (including, without limitation, the right to terminate this contract pursuant to Article III.J. if the Insolvency Event or material adverse change materially impairs the defaulting Party's ability to perform its obligations) or at law or in equity.

b) Is excluded, debarred, or otherwise ineligible to participate in or receive payment from the federal healthcare programs including but not limited to Medicaid and Medicare;

c) Fails to maintain and keep in force all required insurance, permits, and licenses as provided in this contract;

d) Fails to maintain the confidentiality of the Department's information that is considered Confidential Information, proprietary, or containing Personally Identifiable Information; or

e) Contractor performance threatens the health or safety of a state employee or state customer.

2. Contractual and Transition Obligations of the Parties

When termination or non-renewal of the contract occurs, the following obligations shall be met by the Parties:

a. Both Parties remain responsible, and shall continue providing, the services in accordance with this contract, and all terms and conditions of the contract shall apply during the termination and transition process.

b. Notice to Participants – The Department shall be responsible for developing the format for notifying all participants of the date of termination and the process by which the participants continue to receive services;

c. Contractor Responsibilities – The Contractor shall be responsible for duplication, mailing, and postage expenses related to the notification;

d. Transfer of Information – The Contractor shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims; and

e. Recoupments – Recoupments will be handled through a payment by the Contractor within ninety (90) days of the end of the contract.

3. Transition Requirements – The Contractor shall submit a written Transition Plan, subject to the Department's approval, to ensure uninterrupted delivery of services to participants and their successful transition to applicable programs (e.g., Family Care, new FEA, Medicaid fee-for-service). The Transition Plan will include provisions for the transfer of all participant-related information held by the Contractor or its providers. The Transition Plan will include provisions for reasonable and necessary costs to end operations, specifying the categories of costs to be addressed and outlining the methodology for cost calculation and allocation. While the precise apportionment may be adjusted by mutual agreement based on the specific circumstances of termination, these costs

do not include ongoing expenses such as lease payments due after the date of termination. Upon Department approval of the Transition Plan, this contract terminates no sooner than ninety (90) days from the date of Department approval.

4. Transition Plan and Participant Transition:

   a. Submission of the Transition Plan – The Contractor shall submit the Transition Plan at one of the following times, depending on which applies:

      i. For contract non-renewal: No less than ninety (90) days prior to the contract's expiration;

      ii. Within ten (10) business days of the Department's termination notification to the Contractor; or

      iii. Along with the Contractor's termination notice.

   b. Management of the Transition – The Contractor shall designate a person responsible for coordinating the transition plan and will assign staff as the Department determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as the Department determines is necessary.

   c. Continuation of Services – If the Contractor has been unable to successfully transition all participants to applicable programs or agencies by the time specified in the approved Transition Plan, the Contractor shall continue operating as an FEA under this contract until all participants are successfully transitioned. The Department will determine when all participants have been successfully transitioned to applicable programs or agencies.

   d. Financial Closeout Activities – The transition plan must include and describe the process and timeline in which the FEA will adhere to the required financial closeout responsibilities, which include but are not limited to:

      i. The FEA is required to maintain all responsibilities for processing and paying claims under Articles VII. and VIII. for all dates of service during which each participant was enrolled with the FEA.

      ii. The FEA is required to meet post-payment claim responsibilities, which may span into the new calendar year, under Articles VII., VIII., and XIII., which include but are not limited to:

         a) Bank account reconciliation;

         b) Tax reporting and payment; and

c) Encounter reporting.

e. Extension – If the Department determines it necessary to do so, the Contractor will agree to extend this contract, in order to continue providing services to participants until they are successfully transitioned to applicable programs. During this period the Contractor remains responsible, and shall provide, the services identified within this contract, and all terms and conditions of the contract will apply during this period.

f. Transfer of Participants

i. After the Department notifies the Contractor that it intends to terminate the contract, the Department shall do the following:

a) Give the Contractor's participants written notice of the Department's intent to terminate the contract and notify participants of the requirement to transfer to another FEA.

b) Notify the Contractor's participants of their right to disenroll.

ii. The Contractor shall assist any participant electing to terminate their enrollment, by making appropriate referrals and providing the individual's participant record to new providers and/or a participant's new Contractor or MCO.

iii. The Department shall ensure that a disenrolled participant receives appropriate choice counseling and is permitted to enroll with a new Contractor or MCO of the participant's choosing.

iv. Contractors are encouraged to refer to the Transition of Care between Medicaid Programs or Between Agencies within a Medicaid Program (P-02364) for additional information.

K. Indemnification

1. Contractor and the Department's Liability

The Contractor will indemnify, defend if requested and hold harmless the State and all of its officers, agents, and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the Contractor or any of its contractors, in prosecuting work under this contract.

The Department acknowledges that the State may be required by Wis. Stat. § 895.46(1) to pay the cost of judgements against its officers, agents

or employees, and that an officer, agent or employee of the State may incur liability due to negligence or misconduct. To the extent protection is afforded under Wis. Stat. §§ 893.82 and 895.46(1), the Department agrees to be responsible to the Contractor and all of its officers, agents and employees from all suits, actions or claims of any character brought for on account of any injuries or damages received by any persons or property resulting from the negligence of the Department, its employees, or agents in performing under this contract.

2. Pass Along Federal Penalties

   a. The Contractor shall indemnify the Department for any federal fiscal sanction taken against the Department or any other state agency which is attributable to action or inaction by the Contractor, its officers, employees, agents, providers, or subcontractors that is contrary to the provisions of this contract.

   b. Prior to invoking this provision, the Department agrees to pursue any reasonable defense against federal fiscal sanction in the available federal administrative forum. The Contractor shall cooperate in that defense to the extent requested by the Department.

   c. Upon notice of a threatened federal fiscal sanction, the Department may withhold monthly rate of service (MROS) payments otherwise due to the Contractor to the extent necessary to protect the Department against potential federal fiscal sanction. The Department will consider the Contractor's requests regarding the timing and amount of any withholding adjustments.

L. Independent Capacity of the Contractor

The Department and the Contractor agree that the Contractor and its officers, agents, providers, subcontractors, or employees in the performance of the contract and these criteria, shall act in an independent capacity and not as officers or employees of the Department.

M. Omissions

In the event that either party hereto discovers any material omission in the provisions of the contract and these criteria that are essential to the successful performance of the contract, the discovering Party will inform the other party in writing. The parties hereto will thereafter promptly negotiate the issues in good faith in order to make reasonable adjustments necessary to perform the objectives of the contract.

N. Choice of Law

The contract and these criteria shall be governed by and construed in accordance with the laws of the State of Wisconsin. The Contractor shall be required to bring all legal proceedings against the Department in the state courts in Dane County, Wisconsin.

O. Waiver

No delay or failure by the Contractor or the Department to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement contained herein or within the contract.

P. Severability

If any provision of the contract or these criteria is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to participants and if the remainder of the contract and these criteria shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

Q. Force Majeure

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of the contract or these criteria as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

R. Headings

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation thereof.

S. Assignability

This contract is not assignable by the Contractor either in whole or in part without the prior written consent of the Department.

T. Right to Publish

The Department agrees to allow the Contractor to write and have such writings published, provided the Contractor receives prior written approval from the Department before publishing writings on subjects associated with the work under the contract and these criteria. The Contractor agrees to protect the privacy of individual participants, as required under 42 C.F.R. § 434.6(a)(8).

U. Survival

The terms and conditions contained in the contract that by their sense and context are intended to survive the performance by the parties shall so survive the completion of the performance, expiration, or termination of the contract. This specifically includes, but is not limited to recoupments and confidentiality provisions. All rights and remedies of the parties provided under the contract and these criteria, including but not limited to any and all sanctions for violation, breach or non-performance, survive from one contract year to the next, and survive the completion of the performance, expiration, or termination of the contract.

IV. Contractor Administration

A. General Administration Expectations

1. The Contractor must comply with all applicable federal, state, and waiver regulations, as well as all policies and procedures governing services and all terms and conditions of the contract.
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), Addenda to Policy and Work Instructions, and IRIS Service Definition Manual (P-00708B).
3. If a Contractor identifies a discrepancy or requires clarification of existing policies, procedures, or requirements, the Contractor is expected to contact the Department.
4. The Contractor must have internal control procedures in place to ensure separation of duties for financial and bank account transactions.
5. The Contractor shall claim reimbursement only for the services provided to individual waiver participants that are eligible for and enrolled in IRIS.
6. In accordance with 42 CFR § 431.107 of the federal Medicaid regulations, the Department and the Contractor agree 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.
7. The Contractor agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, the Contractor shall furnish to the Department in writing:
    a. The names and addresses of all vendors of drugs, medical supplies or transportation, or other vendors in which it has a controlling interest or ownership;
    b. The names and addresses of all persons who own or have a controlling interest in the Contractor;
    c. Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d. The names and addresses of any subcontractors, as defined in 42 CFR 455.101, who have had business transactions, as reportable under 42 CFR 455.105, with the Contractor; and

e. The identity of any person, named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

8. The Contractor consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Contractor to the Medicaid program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

9. Contractors are required to have on staff either a certified public accountant or an individual meeting the educational and work experience qualifications for the examination for licensure as a certified public accountant in the State of Wisconsin, or to have a current contract with a certified public accountant or accounting firm, to oversee the fiscal operations, to ensure internal controls are sufficient to safeguard the assets, and to ensure accurate and credible financial reporting. The staff member or contracted accountant or accounting firm must not be the same one that is used by the contractor to perform its annual financial audit.

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 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 decision maker), 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.

B. FEA Administration Expectations

1. Internal Revenue Service Registration

   The FEA is responsible for registering and maintaining good standing with the United States Treasury, Internal Revenue Service Revenue, Proc. 70-06 (Form 2678).

C. Liability Insurance

Contractors are required to maintain specific forms of insurance for their agency. If operating under a subsidiary or related party organizational structure, Contractors must maintain required coverage at the subsidiary or related party level. Annually, during the recertification site visit, contractors will be required to provide to their Contract Specialist current certificate(s) of insurance demonstrating the following forms of coverage:

1. Documentation of Workers Compensation insurance or applicable exemption, if the contractor is self-insured.
2. Commercial liability, bodily injury and property damage insurance against any claim(s), which might occur in carrying out this contract with a minimum coverage of one million dollars ($1,000,000) per occurrence liability for bodily injury and property damage including products liability and completed operations.
3. Professional Liability (malpractice) with a minimum coverage of one million dollars ($1,000,000) per occurrence.
4. Director and Officers liability or equivalent coverage specific to the Contractor's structure.
5. Umbrella coverage; and Employee Dishonesty or Fidelity Bond as a stand-alone policy or included under the Contractor's Commercial property coverage.
6. Documentation that contractors are complying with applicable Unemployment Insurance laws.

D. Wisconsin Department of Financial Institutions Status

The Department reserves the right to ad hoc require the Contractor to provide a Certificate of Status (e.g. certificate of "good standing") from the Wisconsin Department of Financial Institutions indicating current status and status date.

E. Duplication of Services

1. The Contractor is prohibited from providing any paid Wisconsin Medicaid supports or services to participants for whom they provide FEA services

without the expressed prior written approval of the Department. This prohibition includes agencies that the Contractor, their parent organization, or owner(s) has any direct or indirect financial or fiduciary relationship.

2. If determined as unallowable, the participant will be required to make a choice of receiving services from the Contractor or receiving paid Medicaid supports or services from the Contractor's affiliate entity providing services.

3. This excludes administrative contracts that do not provide direct service or eligibility and enrollment for services, as well as agencies that provide accessibility assessments.

F. Separation in Lines of Business

1. The Contractor must maintain business separation from any agency involved with enrollment counseling and/or ADRCs, functional and/or financial eligibility determination, including Income Maintenance consortia, administration of any other Wisconsin long-term care programs, and any paid supports or services it provides for any Wisconsin Medicaid programs or recipients.

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.

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.

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, including IRIS payments, 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 FEA is responsible for collaborating to complete the Fraud Allegation Review Assessment (FARA) process. The FARA process is defined and located in the IRIS program policy.

I. Physical and Localized Presence

1. The FEA must maintain an office within Wisconsin. The FEA is not expected to maintain a localized presence in each service region in which they operate, but the FEA 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.

2. The FEA must have signage present and visibly posted to indicate to participants and visitors of the FEA's name and/or association with the IRIS program.

   a. Signage may be posted on the exterior of the building, on an internal directory sign, and/or posted on the entrance door/window to the FEA's office(s).

   b. The signage must state the name of the IRIS Contractor.

3. The FEA must provide documentation to the Department indicating the number of FEA staff physically based in Wisconsin and the services they will be providing.

J. FEA Customer Service Standards

1. Contractors are expected to maintain staff knowledgeable of and dedicated to addressing 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 contacting the Contractor 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 questions 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 if 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 contracts 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

K. Company Structure and Leadership

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:

a. Articles of Incorporation,

b. Articles of Organization,

c. Partnership Agreement,

d. Bylaws (if operating with a Board of Directors),

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),

f. Transition of assets and liabilities, and

g. Comparable documentation, including but not limited to: identification of positions, responsibilities, and descriptions of how internal contractors are used for separation of duties between entities and/or unrelated operations are established, maintained, and verified; percentage of allocation to IRIS and other lines of business (and method used to establish and validate the identified percentage); and staff oversight responsibilities.

2. If Board membership changes or is expected to change by the end of the contract term, the Contractor must provide updated disclosure forms for each new board member, as well as completed Conflict of Interest Disclosure – Provider (F-01310) forms to the IRIS Contract Specialist.

3. The contractor must notify the Department if there are any changes in leadership of the contractor or their parent organization's Executive Director, Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, President, Controller, Certified Public Accountant, IT Security Officer, or Program Director.

4. The contractor must notify the Department at least 90 days prior to the proposed date of a merger, acquisition, or other change of ownership. Within 15 days of the date of completion of the merger, acquisition, or other change of ownership, the new business entity must file all the required forms and disclosures for a new business entity under this Contract and related IRIS program requirements.

L. Administrative Services Agreements and Subcontracts

Subcontracts and Administrative Service Agreements (ASA) include contracts to fulfill the requirements of this Agreement. Contracts to perform or fulfill the requirements under this Agreement require the Department's prior written approval.

1. Contractors who have or will have transactions with businesses through subcontracts or ASA, as reportable under 42 CFR 455.105, must provide to the IRIS Contract Specialist, the following information for each ASA or subcontract:

   a. Name, mailing address, phone number, and website of the business;
   b. Service(s) subcontracted and/or purchased along with the associated subcontract or ASA;
   c. Anticipated percentage of allocation to the IRIS program versus other line(s) of business;

d. Attestation that subcontractor(s) and ASA personnel will be held to the cultural competency standards set forth by the Contractor;
e. Whether service(s) are provided in-state or out-of-state; and
f. Description and examples of analytics used to evaluate and ensure accuracy of cost allocations and program-related charges related to the IRIS program.

M. Business Associate Agreement

Due to the Contractor using and/or disclosing protected health information subject to HIPAA, the Contractor shall review and execute a Business Associate Agreement (BAA): With Contract (F-00759) with the Department as a mandatory and critical exhibit to the contract. A BAA must be executed before the Contractor performs any work of any kind for DHS as a result of the contract.

N. Business Continuity

The Contractor shall have a Business Continuity Plan, available to the Department upon request. The Business Continuity Plan shall address, at a minimum, the following:

1. A description of the organization and the urgency with which activities and processes will need to be resumed in the event of a disruption.
2. Inclusion of a business impact analysis and risk assessment. This will address each continuity management strategy both at the corporate and key functional area separately and will identify, quantify and qualify areas that will be used to continue the organization's business impacts of a disruption to determine at what point in time the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.
3. Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.
4. A description of the steps that will be taken to document and ensure participant safety and wellbeing in the event of a disruption or disaster through supporting the mitigation of risks and to access community resources as needed.
5. Criteria for executing the business continuity plan, including escalation procedures.
6. A detailed communication plan with participants, employees, the Department, and other stakeholders.
7. Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event.

8. A description of the organization and the urgency with which activities and processes will need to be resumed in the event of a disruption. Recording and updating business events information, files, data updates once business processes have been restored.
9. Recovery time for each major business function, based on priority.
10. A description of an annual testing and evaluation plan.
11. Upon the Department's request, after a federal or state declared emergency or disaster expires, the Contractor shall submit an 'After Emergency Report' to the Department within a designated timeframe. The report will provide feedback regarding the operation of the Contractor's business continuity plan, including a discussion of successes and challenges, during the federal or state-declared emergency or disaster.

O. Commercial Leases

1. If the Contractor enters into leases of real property to support the administrative responsibilities of the Contractor, at the time the Contractor enters into a new lease or renews an existing lease the Contractor shall include a termination clause in that lease allowing the Contractor to terminate the lease on reasonable notice to the landlord, not to exceed 90 days, if the Contractor ceases to operate as an IRIS Contractor due to a discontinuation of this Contract with the Department. Such termination must not be considered a default of the lease, must occur without penalty, and must limit any future rent liability.
2. The Contractor is not required to negotiate such a clause into any existing lease until such time as the lease term expires and a new lease or renewal is required.
3. If after a good faith attempt to negotiate, the Contractor is unable to include such a clause in a lease of rental property but determines that such a lease is essential to the operation of the Contractor, the Contractor may apply to the Department for a waiver of this requirement. Any such waiver shall be at the discretion of the Department.
4. If the Contractor enters into leases of commercial property other than real property on a long-term basis, e.g., office equipment, the Contractor shall attempt to include a termination without penalty clause in those leases, to the extent practicable.

P. Electronic Visit Verification (EVV)

1. Please see the IRIS EVV policy for further information at https://www.dhs.wisconsin.gov/library/collection/p-03053.
2. The Contractors shall implement EVV for designated service codes. The FEA will use data collected from the EVV system to validate claims

pertaining to affected service codes against approved authorizations during the claim adjudication process. The Contractors shall also provide assistance and support to DHS and contracted EVV vendor for training, outreach, and utilization of the data collection system, as requested. For provider agencies that utilize the DHS-provided Sandata EVV system, DHS EVV Customer Care will be a resource for providing technical assistance.

3. FEA Responsibilities

   a. Enter participant-hired worker information into the ForwardHealth Portal.

   b. Verify live-in worker validation information.

   c. Provide the participant with EVV set-up information for their participant-hired workers.

   d. Communicate EVV compliance information to IRIS consultant agencies via biweekly reports.

   e. Clear exceptions to achieve verified visits.

   f. Create a document collection system for requested EVV corrections.

   g. Provide the participant and participant-hired worker with information on the process for EVV corrections.

   h. Link provider agency claims to verified visits and deny provider agency claims that are missing EVV information.

   i. Provide remittance to provider agencies regarding denial of payment due to insufficient EVV data.

   j. Link participant-hired worker timesheets to verified visits in EVV.

   k. Send DHS applicable EVV data with encounter details.

   l. Use the chosen EVV system to verify visits.

   m. FEAs and provider agencies that use the DHS-provided Sandata EVV system can find training resources online at https://www.dhs.wisconsin.gov/evv/training.htm.

   n. FEAs and provider agencies may choose to use an alternate EVV system. Alternate EVV systems must be certified. The alternate EVV certification process is detailed online at https://www.dhs.wisconsin.gov/evv/alternateevv.htm. FEAs and provider agencies that use an alternate EVV system are required to provide training and education to their users.

   o. Outline expectations for contracted providers regarding the use of EVV data collection system.

Q. Participant Records

The Contractor shall have a system for maintaining participant records and policies and procedures that ensure compliance with the following requirements.

1. Confidentiality of Records and HIPAA Requirements

   The Contractor shall implement specific procedures to assure the security and confidentiality of health and medical records and of other personal information about participants, in accordance with Wis. Stats. Chapter 49, Subchapter IV; Wis. Admin. Code § DHS 108.01; 42 C.F.R. Part 431, Subpart F; 42 C.F.R. Part 438; 45 C.F.R. Parts 160,162, and164; the Health Insurance Portability and Accountability Act (HIPAA); and any other confidentiality law to the extent applicable.

   a. Duty of Non-Disclosure and Security Precautions

      The Contractor shall protect and secure all confidential information and shall not use any confidential information for any purpose other than to meet its obligations under this contract. The Contractor shall hold all confidential information in confidence and not disclose such confidential information to any persons other than those directors, officers, employees, agents, subcontractors, and providers who require such confidential information to fulfill the Contractor's obligations under this contract. The Contractor shall institute and maintain procedures, including the use of any necessary technology, which are necessary to maintain the confidentiality of all confidential information. The Contractor shall be responsible for the breach of this contract and subsequent contract in the event any of the Contractor's directors, officers, employees, or agents fail to properly maintain any confidential information.

   b. Limitations on Obligations

      The Contractor's obligation to maintain the confidentiality of confidential information shall not apply to the extent that the Contractor can demonstrate that such information:

      i. Is required to be disclosed pursuant to a legal obligation in any administrative, regulatory, or judicial proceeding. In this event, the Contractor shall promptly notify the Department of its obligation to disclose the confidential information (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, the Contractor shall furnish only that portion of the confidential information that is legally required and shall disclose it in a manner designed to

preserve its confidential nature to the extent possible. Notification to the Department would not include routine subpoenas issued with record requests unless said subpoena extends beyond the standard documentation requested from said entity.

ii. Is part of the public domain without any breach of this contract by the Contractor;

iii. Is or becomes generally known on a non-confidential basis, through no wrongful act of the Contractor;

iv. Was known by the Contractor prior to disclosure hereunder without any obligation to keep it confidential;

v. Was disclosed to it by a third party which, to the best of the Contractor's knowledge, is not required to maintain its confidentiality;

vi. Was independently developed by the Contractor;

vii. Is the subject of a written agreement whereby the Department consents to the disclosure of such confidential information by the Contractor on a non-confidential basis; or

viii. Was a permitted use or disclosure, in accordance with Wis. Stat. Chapter 49, Subchapter IV; Wis. Admin. Code § DHS 108.01; 42 C.F.R. 431, Subpart F; 42 C.F.R. Part 438; 45 C.F.R. Part 160; 45 C.F.R. Part 162; and 45 C.F.R. Part 164 or other applicable confidentiality laws.

c. Unauthorized Use, Disclosure, or Loss

If the Contractor becomes aware of any threatened or actual use or disclosure of any confidential information that is not specifically authorized by this contract, or if any confidential information is lost or cannot be accounted for, the Contractor shall notify the Department and the Privacy Officer in the Department's Office of Legal Counsel within 24 hours of the Contractor becoming aware of such use, disclosure or loss. The notice shall include, to the best of the Contractor's understanding, the persons affected, their identities, and the confidential information that was disclosed.

The Contractor shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The Contractor shall reasonably cooperate with the Department's efforts, if any, to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its confidential

information, including complying with the following measures, which may be directed by the Department, at its sole discretion:

i. Notifying the affected individuals by mail or the method previously used by the Department to communicate with the individual. If the Contractor cannot with reasonable diligence determine the mailing address of the affected individual and the Department has not previously contacted that individual, the Contractor shall provide notice by a method reasonably calculated to provide actual notice;

ii. Notify consumer reporting agencies of the unauthorized release;

iii. Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the Department for one year from the date the individual enrolls in credit monitoring;

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.

d. Indemnification

In the event of unauthorized use, disclosure, or loss of confidential information, the Contractor shall indemnify and hold harmless the Department and any of its officers, employees, or agents from any claims arising from the acts or omissions of the Contractor, and its subcontractors, providers, employees, and agents, in violation of this section, including but not limited to costs of monitoring the credit of all persons whose confidential information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the Department in the enforcement of this section. In addition, notwithstanding anything to the contrary herein, the Contractor shall compensate the Department for its actual staff time and other costs associated with the Department's response to the unauthorized use, disclosure, or loss of confidential information.

e. Equitable Relief

The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of confidential information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the Department, which injury will not be compensable by money damages and for which there is not an adequate remedy at law. Accordingly, the Contractor agrees that

the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this contract or under applicable law.

f. Sanctions

In the event of an unauthorized use, disclosure, or loss of confidential information, the Department may impose sanctions, in the form of civil monetary penalties, pursuant to the terms described herein.

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.

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 all required IRIS background check process-related documents and forms, which are included in the IRIS Background Check policy (P-00708E) 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.

4. Participant Access and Disclosure

Participants shall have access to their records in accordance with applicable state or federal law. The Contractor shall use best efforts to assist a participant, his/her legal decision maker, and others designated by

the participant to obtain records within ten (10) business days of the request. The Contractor shall identify an individual who can assist the participant and his/her legal decision maker in obtaining records. Participants have the right to approve or refuse the release of confidential information, except when such release is authorized by law. If the records request is unable to be fulfilled due to lack of Contractor access to the reports requested, the request shall be immediately referred to the Department.

5. Provision of Records

   The Contractor must:

   a. Make participant's medical, claims, cost share, and/or long-term care records, as well as all pertinent and sufficient information relating to the management of each participant's records, available and readily accessible to the Department upon request. The Contractor shall provide this information to the Department at no charge.

   b. Have procedures to provide copies of records promptly to other providers for the management of the participant's medical, claims, cost share, and/or long-term care, and the appropriate exchange of information among the Contractors and other providers receiving referrals, as necessary.

   c. Allow access to participant records if the participant has a signed and effective Supported Decision-Making Agreement (F-02377) on file and permit the supporter to assist in accessing appropriate personal records, including protected health information under HIPAA and other records that may or may not require a release for specific decisions the participant makes.

6. Participant-Employer Information Requests

   Acting as employer agent, the FEA must respond to all requests for information on behalf of the participant employer in an accurate and timely manner:

   a. The FEA will promptly handle all requests for information including participant-hired worker wages and workers compensation information (WCI).

   b. The FEA will assist the participant with WCI appeals, unemployment compensation-related requests, and inquiries as requested by the participant employer, the participant-hired worker, or by the State.

c. The FEA will work with the Department of Revenue and the Department of Workforce Development, as necessary, on wage-related or other questions.

R. Civil Rights Compliance and Affirmative Action Plan Requirements

All Contractors must comply with the Department's Affirmative Action/Civil Rights Compliance requirements at https://www.dhs.wisconsin.gov/publications/p0/p00164.docx.

1. Compliance Requirements

   All Contractors must comply with the Department's Affirmative Action/Civil Rights Compliance requirements at https://www.dhs.wisconsin.gov/publications/p0/p00164.docx and https://www.dhs.wisconsin.gov/civil-rights/index.htm.

2. Affirmative Action Plan

   As required by Wisconsin's Contract Compliance Law, Wis. Stat. § 16.765, the contractor must agree to equal employment and affirmative action policies and practices in its employment programs:

   The Contractor agrees to make every reasonable effort to develop a balance in either its total workforce or in the project-related workforce that is based on a ratio of work hours performed by handicapped persons, minorities, and women except that, if the department finds that the Contractor is allocating its workforce in a manner which circumvents the intent of this section, the Department may require the Contractor to attempt to create a balance in its total workforce. The balance shall be at least proportional to the percentage of minorities and women present in the relevant labor markets based on data prepared by the Department of Industry, Labor and Human Relations, the Office of Federal Contract Compliance Programs, or by another appropriate governmental entity. In the absence of any reliable data, the percentage for qualified handicapped persons shall be at least 2% for whom the Contractor must make a reasonable accommodation.

   The Contractor must submit an Affirmative Action Plan within fifteen (15) working days of the signed contract for certification. Exemptions exist, and are noted in the Instructions for Contractors posted on the following website: http://vendornet.state.wi.us/vendornet/contract/contcom.asp.

   The Contractor must submit its Affirmative Action Plan or request for exemption from filing an Affirmative Action Plan to:

   Department of Health Services
   Division of Enterprise Services
   Bureau of Strategic Sourcing

Affirmative Action Plan/CRC Coordinator
201 E Washington Ave
P.O. Box 7850
Madison, WI 53703
DHSContractCompliance@dhs.wisconsin.gov

3. Civil Rights Compliance (CRC)

As required by Wis. Stat. § 16.765, in connection with the performance of work under this contract and the accompanying contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training; including apprenticeship. The Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

In accordance with the provisions of Title VI of the Civil Rights Act of 1964 (nondiscrimination on the basis of race, color, national origin), Section 504 of the Rehabilitation Act of 1973 (nondiscrimination on the basis of disability), the Age Discrimination Act of 1975 (nondiscrimination on the basis of age), regulations of the U.S. Department of Health and Human Services issued pursuant to these three statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91, the Contractor shall not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, and in staff and employee assignments to participants, whether carried out by the Contractor directly or through a sub-contractor or any other entity with which the Contractor arranges to carry out its programs and activities.

Additionally in accordance with Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, and rules promulgated to implement Section 1557 (81 Fed. Reg. 31376 et. Seq. (May 18, 2016) (amending 45 C.F.R. Part 92 to implement Section 1557)), the Contractor shall not exclude, deny benefits to, or otherwise discriminate against any person on the basis of sex in admission to, participation in, or receipt of the services and benefits under any of its health programs and activities, and in staff and employee assignments, whether carried out by the

Contractor directly or through a subcontractor or any other entity with which the Contractor arranges to carry out its programs and activities.

The Contractor must file a Civil Rights Compliance Letter of Assurance (CRC LOA) within fifteen (15) working days of the effective date of the Contract. If the Contractor employs fifty (50) or more employees and receives at least $50,000 in funding, the Contractor must complete a Civil Rights Compliance Plan (CRC Plan). The current Civil Rights Compliance Requirements and all appendices for the current Civil Rights Compliance period, are hereby incorporated by reference into this Contract and are enforceable as if restated herein in their entirety. The Civil Rights Compliance Requirements, including the template and instructions for the CRC Plan, can be found at https://www.dhs.wisconsin.gov/civil-rights/requirements.htm or by contacting:

Department of Health Services
Civil Rights Compliance
Attn: Civil Rights Attorney
201 E Washington Ave
P.O. Box 7850
Madison, WI 53703

Telephone: (608) 266-1258 (Voice)
711 or 1-800-947-3529 (TTY)

Fax: (608) 267-1434

Email: DHSCRC@dhs.wisconsin.gov

The CRC Plan must be kept on file by the Contractor and made available upon request to any representative of DHS.

Civil Rights Compliance Letters of Assurances should be sent to:
Department of Health Services
Division of Enterprise Services
Bureau of Strategic Sourcing
Affirmative Action Plan/CRC Coordinator
201 E Washington Ave
P.O. Box 7850
Madison, WI 53703

-or-

DHSContractCompliance@dhs.wisconsin.gov

The Contractor agrees to cooperate with DHS in any complaint investigations, monitoring, or enforcement related to civil rights compliance of the Contractor or its Subcontractor under this contract.

S. Cultural Competency

1. Contactors shall include cultural diversity training, encourage, and foster cultural competency among staff. The Contractor shall incorporate in its policies, administration, and service practice the values of honoring participants' beliefs, being sensitive to cultural diversity including participants with limited English proficiency and diverse cultural and ethnic backgrounds, and fostering in staff attitudes and interpersonal communication styles which include participants' cultural backgrounds. Policy statements on these topics shall be communicated to any subcontractors.

2. During hours of operation, contractors must have staff and/or subcontractor(s) available for language translation, transliteration, and interpreter services in person, by phone, and/or virtually. Contractors must offer an interpreter, such as a primary non-English language or a sign language interpreter or a translator, in all crucial situations requiring language assistance as soon as it is determined that the participant is of limited English proficiency or needs other interpreter services. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act of 1964.

T. Policy and Procedure Manual

The Contractor must maintain an internal policy and procedure manual consistent with DHS-communicated policies, procedures, and work instructions.

DHS reserves the right to request a copy of a portion thereof, or the manual in its entirety for review and ongoing oversight. The Department further reserves the right to request other policies and procedures, as deemed necessary.

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

   a. FEA staff orientation and training requirements;

   b. FICA overpayments and refunds process, including remittance of refunds to the Department Deposit Account;

   c. Accounting procedures related to Medicaid cost share collection, including the procedures when payment involves checks returned for insufficient funds;

   d. Procedures related to worker wage payment exceptions, denial, or adjustment;

   e. Communication plans describing how and when the FEA will inform the ICA of the need to follow up with participant employers and participant-hired workers;

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

g. FEA internal monitoring controls;

h. Document retention and destruction policy;

i. Workers compensation policy and process;

j. Process describing how only participants and participant-hired workers that meet all minimum qualifications are compensated for services rendered;

k. FEA transfer policy and process;

l. Identification, notification, risk assessment, and monitoring of HIPAA Breaches, security incidents, and unauthorized disclosures of PII, PHI, and other confidential information;

m. Resolution of complaints and grievances;

n. Fiscal policies and procedures; and

o. Process for updating policies and procedures when federal, state, or program changes.

p. Electronic Visit Verification, to include staff responsibilities, education to participants, and collaboration with ICAs and workers;

q. Encounter reporting, to include data submission, certification, reconciliation, and auditing;

r. Conduct and manage the IRIS background check process for participant-hired worker applicants and established participant-hired workers in accordance with the IRIS Background Check (P-00708E) policy requirements.

U. Participant Materials

1. Participant materials are defined in Article I., Definitions. Participant materials shall be accurate, readily accessible, appropriate for, and easily understood by the Contractor's target population. All materials produced and/or used by the FEAs must be understandable and readable for the average participant and reflect sensitivity to the diverse cultures served. The Contractor must make all reasonable efforts to locate and use culturally appropriate material. Materials shall take into account individuals who are visually limited or who are limited English proficient.

   Participant materials shall be available to participants in paper form, unless electronic materials are available, the participant or the participant's

legal decision maker prefers electronic materials, and the electronic materials meet the requirements in section 2 below.

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

a. Use easily understood language and format.

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

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

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.

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

a) Participants must be able to opt out of receiving electronic communications upon request.
b) Participant contact information must be current, and materials are sent timely with important materials identified in a way that participants understand their importance.

b. Contractor must have a process for mailing of hard copies when electronic communications are undeliverable.

c. The format is readily accessible and fully available:

i. The information is placed in a location on the Contractor's website that is prominent;

ii. The information is provided in an electronic form, which can be electronically retained and printed;

iii. The participant is informed that the information is available in paper form without charge upon request, and the Contractor will provide it upon request within five (5) business days.

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, health-promotion, or wellness information that are 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 accessibility and 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.

V. Provider Enrollment

For vendor and individual provider enrollment with Medicaid through ForwardHealth:

1. Please see the Adult Long Term Care Update # 2024-01 at https://www.forwardhealth.wi.gov/kw/pdf/LTC_2024-01.pdf

2. The FEA will assist and support DHS with vendor and provider training and outreach, as necessary.

3. The FEA will provide reports containing vendors and/or individual providers who have not completed enrollment to DHS, as necessary.

W. 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 Article I., 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 Contractor, 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.

1. Marketing/Outreach

   If the Contractor engages in marketing/outreach activities, a plan describing those activities must be approved in writing by the Department before the plan is implemented.

2. Requirements and Approvals

   The Contractor shall submit to the Department for approval all marketing/outreach materials prior to printing, presenting, or disseminating the materials. Existing marketing/outreach materials that are being updated or reused for different audiences must also be resubmitted for approval.

   a. The Contractor must ensure that participants and potential participants receive accurate oral and written information sufficient to make informed choices.

   b. The Department will review all marketing/outreach plans materials in a manner which does not unduly restrict or inhibit the Contractor's marketing/outreach plans and materials, and which considers the entire content and use of the marketing/outreach materials and activities.

   c. Issues identified by the Department will be reviewed with the Contractor. The Contractor will be asked to make the appropriate revisions and resubmit the document for approval. The Department will not approve any materials it deems confusing, fraudulent, or misleading, or that do not accurately reflect the scope and philosophy of the program.

   d. Timeline for Department Review - The Department will review marketing materials within thirty (30) calendar days of receipt.

3. Contractor agreement to abide by marketing and distribution criteria:

   a. The Contractor agrees to engage only in marketing activities and distribute only those marketing materials that are pre-approved in writing.

b. All activities must not be intended to target or exclude a specific target population or subgroup of individuals.

4. Participant Usability

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.

5. Social Media Practices

Any social media postings referencing the IRIS program or the Contractor's role in said program must be pre-approved by the Department.

6. Prohibited Practices

The following marketing/outreach practices are prohibited:

a. Practices that are discriminatory;

b. Practices that seek to influence enrollment in conjunction with the sale or offering of any other service or product. The Contractor, through its employees, contractors, or agents, must not use or attempt to use its position as an employee, contractor, or agent of the Contractor to directly or indirectly influence an IRIS participant's enrollment options for the benefit of the Contractor, its parent company, corporate affiliates, subsidiaries, self-directed Medicaid benefits, or any other entity affiliated with the Contractor;

c. Direct and indirect cold calls, either door-to-door, email, telephone or text, or other cold-call marketing activity;

d. Offer of material or financial gain to potential participants as an inducement to enroll;

e. Practices that reveal PII or PHI of an IRIS participant without expressed written approval by the participant;

f. Activities and materials that could mislead, confuse, or defraud participants or potential participants, or otherwise misrepresent the Contractor, its marketing representatives, the Department, or CMS. Statements that would be considered inaccurate, false, or misleading include, but are not limited to any assertion or statement (whether written or oral) that:

i. The participant must choose the Contractor in order to obtain benefits or in order to not lose benefits;

ii. The Contractor is endorsed by CMS, the federal or state government, or other similar entity;

g. Practices that are reasonably expected to have the effect of denying or discouraging enrollment;

h. Practices to influence the recipient to either choose their Contractor or not choose another Contractor including referencing and using ratings or other info on scorecards in marketing or participant materials; and

i. Marketing/outreach activities that have not received written approval from the Department.

7. Sanctions

The Contractor that fails to abide by these marketing/outreach requirements may be subject to any and all sanctions identified herein. In determining any sanctions, the Department will take into consideration any past unfair marketing/outreach practices, the nature of the current problem and the specific implications on the health and well-being of the enrolled participant(s).

8. Websites

a. The Contractor shall maintain an up-to-date website(s) providing information regarding their agency. The website(s) shall be compliant with accessibility standards in Section 508 of the Rehabilitation Act, including but not limited to adherence with Web Content Accessibility Guidelines (WCAG) minimum standards.

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

i. All web content must be approved by the Department prior to deployment.

ii. The Contractor should aim for the written content on their websites to be at a 4th - 6th grade reading level, with a best practice that alternate formats be available (e.g. large print, languages other than English).

c. If the Contractor's IRIS-specific website is embedded within their parent organization's website, accessible plain language information and resources about IRIS must be present and available from that parent organization's home page. The Contractor is expected to provide a link on their agency website to the Department of Health Service's IRIS Program website: https://www.dhs.wisconsin.gov/iris/index.htm.

d. The Contractor is expected to provide a link on their agency website to the IRIS Self-Directed Personal Care website

maintained by the Department:
https://www.dhs.wisconsin.gov/iris/sdpc.htm.

V. Eligibility

A. Individual Eligibility Requirements

Per 42 CFR 441.302(b-c), all participants must meet and continue to maintain functional, financial, and non-financial eligibility requirements. Policies on eligibility requirements for individuals seeking participation in IRIS are summarized below.

1. Age and Target Group

   An individual must be at least 18 years of age and fall within one of the following target groups: frail elder, physical disability, or intellectual/developmental disability.

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.

3. Functional Eligibility

   Functional eligibility for IRIS and all adult long-term care programs is determined using the Long-Term Care Functional Screen. Individuals must have a level of care assignment that would allow admission to a nursing home or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The long-term care eligibility condition must be expected to last more than 12 months.

4. Need for Services

   Persons who have been determined to meet the financial and functional eligibility criteria for waiver participants, but who do not have an assessed need for waiver services, are not eligible for Medicaid using the special IRIS program eligibility criteria (42 CFR § 435.217(c)). The Centers for Medicare and Medicaid Services defines "reasonable need" as follows:

   "In order for an individual to be determined to need waiver [IRIS] services, an individual must require (a) the provision of at least one HCBS waiver service, as documented in the service plan, and (b) the provision of HCBS waiver services occurs at least monthly or, if the need for services

is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan."

5. Residency and Eligible Living Arrangements

An individual must be a resident of the State of Wisconsin and reside in an eligible living setting. While the arrangements below are generally permitted, there are some restrictions. For example, IRIS program funds may not be used to pay for community-based residential facilities (CBRFs), and many residential care apartment complexes (RCACs) may not admit persons who have a legal decision maker. Individuals seeking enrollment in the IRIS program may be residing in one of the ineligible settings listed below at the time of application. However, final eligibility cannot be established and services through the IRIS program may not begin until the person lives in an eligible setting.

a. Eligible living arrangements include:

i. A house, apartment, condominium, or other private residence;

ii. A rooming/boarding house;

iii. A certified Adult Family Home (1-2 bed AFH);

iv. A licensed Adult Family Home (3-4 bed AFH);

v. A certified RCAC.

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);

ii. An ICF-IDD or any of the state centers for people with developmental disabilities;

iii. A jail, prison, or other correctional facility;

iv. A community-based residential facility (CBRF); and

v. A registered RCAC, as this is a private pay-only facility.

c. Temporary Living Arrangements

i. In transitional situations, a participant may reside in a hotel, motel, homeless shelter, or other type of transitional housing. All other eligibility requirements continue to apply including Wisconsin residency.

ii. Participants residing in transitional housing without an established permanent housing plan in place, shall be referred to the Department for disenrollment after 90 days.

iii. The Department may approve an extension if the participant and ICA can provide a plan, with a completion date, to address the participant's long-term housing concerns.

d. Short Term Institutional Stays

IRIS participants admitted to a nursing home or hospital on a short-term basis for acute care or rehabilitation will not disrupt eligibility for enrollment in IRIS. IRIS funded services must be suspended while the person is in this short-term setting. The participant is required to report any institutional stay to the ICA. Providers cannot bill for services to the participant while they are in suspended status.

If the stay becomes permanent, it will result in a voluntary disenrollment. Any institutional stay that exceeds 90 days will result in disenrollment.

e. Incarceration

IRIS services must be suspended while the participant is incarcerated or admitted to an IMD. If a participant is incarcerated in a jail, prison, other correctional facility, or admitted to an IMD for 30 days or more, the ICA will initiate disenrollment from the IRIS program, since this is not an eligible living arrangement.

f. Re-enrollment

Individuals who are disenrolled may re-enroll into the IRIS program, if found eligible for the program, unless they were disenrolled for substantiated fraud or have failed to pay cost share arrearages (so long as they remain unpaid).

B. Separation from Eligibility Determination

1. Under the conflict of interest policy, the Contractor must ensure that there is separation from the initial eligibility determination and enrollment counseling functions.

2. IRIS is competitive for Contractors; no contractor is automatically afforded any number of participants in a specific region.

C. Cost Share Collection, Monitoring, and Reporting

Participants may be required to pay a monthly cost share in order to be eligible for Medicaid. Cost share could apply to participants in any IRIS-allowable living setting. The participant's local/county income maintenance agency is responsible for determining the participant's cost share. Information regarding cost share can be found in ForwardHealth interChange and the CARES system. Cost share is imposed on participants in accordance with 42 C.F.R. § 435.726 and is not prorated for partial months.

1. The FEA is responsible for the ongoing monitoring of the cost share payments of its participants and must enter the payment information into the Department's enterprise care management system within 10 business days of receipt, ensuring that the information is up-to-date and accurate.
2. The FEA is responsible for collecting participant's monthly cost share payments, subject to the following Department policies and procedures:
    a. Statements are sent after payments are received, and no later than the 10th of each month.
    b. The FEA will send a statement each month to participants reflecting the current status and at least three months of their cost share payment history, with a clear indication of whether they are in arrears or overpaid.
        i. Cost share overpayments shall be remit from the FEA's private funds and repaid to the FEA using the Reimbursement file.
        ii. Cost share overpayments should be repaid in full to participants within 30 days of identifying the need for repayment.

VI. Program Enrollment and Transfers

A. General Requirements

Enrollment in the IRIS program is a voluntary decision on the part of the applicant who is determined to be eligible. Individuals must make the choice to enroll in IRIS; the choice to enroll is verified by the signature of the participant (or their legal decision maker) on an enrollment form provided by the Department.

Program enrollments, program transfers, contractor transfers, and disenrollments are subject to IRIS program policy. Contractors are required to assist participants, other Contractors, the Department, and/or other agencies, with efficient, accurate, and unbiased enrollments, transfers, and disenrollments. Contractors must adhere to documented IRIS Program Policies and Work Instructions as well as the supplemental resource of the Enrollment and Disenrollment Process Desk Aid for Publicly Funded Long-Term Care Programs (P-02915) incorporated by reference herein.

If an MAPC provider reaches out to an IRIS contractor with enrollment, policy, or billing questions related to HMO and IRIS enrollment overlaps, they should be directed to contact the ForwardHealth Provider Service Call Center: 1-800-947-9627.

B. Program and Contractor Transfers

Participants may request a transfer to or from the IRIS program, to a different ICA or FEA, or to a new IRIS consultant at any time. Each transfer is subject to the requirements detailed in this agreement, within program policy, and any documents referenced herein.

1. FEA Transfers

    a. FEA transfers take effect pursuant to the FEA transfer calendar (F-02239).

    b. If an IRIS participant or their legal decision maker wants to change FEAs, the ICA/FEA is responsible for directing the participant or their legal decision maker to their local ADRC to initiate that change. When an ICA is notified by an ADRC that a participant is transferring to another FEA, the ICA, sending FEA, and receiving FEA follow the applicable program policies and processes related to FEA enrollments and transfers.

C. Disenrollment

Contractors shall comply with the following requirements and use Department-issued forms related to disenrollment.

1. Processing Disenrollments

   The Contractor shall adhere to the state 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 ensure:

   a. That the ICA shall provide information relating to eligibility to the income maintenance agency;

   b. That enrollments and disenrollments are accurately entered into the Department's enterprise care management system and ForwardHealth interChange so that correct monthly rate of service payments are made to the FEA;

   c. That timely processing occurs, in order to ensure that participants who disenroll have timely access to any Medicaid fee-for-service benefits for which they may be eligible, and to reduce administrative costs to the FEA and other service providers for claims processing.

2. Contractor Influence Prohibited

   The FEA will not 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

   a. Participant Requested Disenrollment

      All participants have the right to disenroll from the ICA, FEA, and the IRIS program without cause at any time.

      If a participant expresses a desire to disenroll from IRIS, the ICA shall provide the participant with contact information for their local ADRC; and with the participant's approval, may make a referral to the ADRC for options counseling. If the participant chooses to disenroll, the participant will indicate a preferred date for disenrollment. The date of disenrollment cannot be earlier than the date the individual last received services authorized by the ICA. The ADRC will notify the ICA that the participant is no longer requesting services and the participant's preferred date for disenrollment.

   b. Program Requested Disenrollment

      The participant will be disenrolled if they fail to meet program requirements, fail to perform responsibilities of self-direction, or as result of general program noncompliance. The ICA is required to

notify the ADRC and income maintenance agency when it becomes aware of a change in a participant's program eligibility.

Participants will be disenrolled in accordance with the program policy if any of the following causes for disenrollment occur:

i. Failure to utilize IRIS funding;

ii. No contact;

iii. Health and safety;

iv. Moved to ineligible setting;

v. Misappropriation of IRIS funds;

vi. Mismanagement of employer authority;

vii. Noncompliance with EVV requirements;

viii. Failure to pay cost share; or

ix. Program noncompliance.

c. Eligibility-Related Disenrollments

The participant will be disenrolled if they are determined to be no longer functionally or financially eligible. The ICA is required to notify the ADRC and income maintenance agency when it becomes aware of a change in a participant's program eligibility.

Participants will be disenrolled in accordance with program policy if any of the following causes for disenrollment occur:

i. Loss of functional eligibility, which includes no longer meeting functional eligibility requirements and not completing an annual screen, as required.

ii. Loss of financial eligibility, which includes no longer meeting criteria for Medicaid eligibility and not completing an annual Medicaid renewal, as required

VII. Fiscal Employer Agent Services

A. General Expectations

FEAs are responsible for all financial transactions on the participant's behalf, including but not limited to paying for goods and services, processing payroll for hired workers and processing agency provider (non-participant hired worker) invoices.

In general, FEAs must:

1. Document the participant-provider relationship;
2. File all required reports with the Internal Revenue Service (IRS) and Wisconsin Department of Revenue (DOR) according to standard deadlines; and
3. Utilize the Department's enterprise care management system.

B. Payroll and Claim System Requirements

The FEA must have a system that can process payroll and vendor claims. This system must:

1. Maintain a record of every payment made to every service provider per participant;
    a. Records must be delineated and capable of identifying all payments paid to a single provider, regardless of participant.
2. Utilize the conventional rounding method of to the nearest penny (two decimal points);
3. Extract authorization data daily; and
4. Automatically detect duplicate payments.

C. Bank Accounts

1. The FEA will have access to two bank accounts, a deposit and disbursement account. The FEA is responsible for adhering to the following expectations for both accounts:
    a. Monthly reconciliation of bank accounts and bank statements;
    b. Notify the Department and US Bank of any employee who had access to the account that is no longer employed by the FEA by close of business on the employee's last day;
    c. Issue positive pay exception (i.e., manual checks) reports, authorized by two staff, daily to US Bank and DHS designee, as needed;
    d. The maximum dollar threshold of a single transaction will be $25,000; and

e. Daily monitoring of account activity.

D. Deposit Account

1. The FEA deposits funds owed to the Department into the deposit account.
2. No participant or provider shall deposit funds directly into the account.
3. The FEA will not withdraw from the deposit account.
4. A universal payment identification code (UPIC) will be assigned to the FEA's deposit account to be used when funds are deposited (direct deposit/AC) into the account, and the FEA must provide the UPIC or US Bank will reject the deposit.

E. Disbursement Account

1. The Department makes funds available to the FEA to pay service providers in the disbursement account.
2. The FEA will not make a deposit into the disbursement account.

F. Account Reconciliation

The FEA will reconcile both accounts. The FEA must:

1. Reconcile the previous month's transactions of each account.
2. Use the DHS-approved IRIS Bank Reconciliation spreadsheets. Separate spreadsheets are available for each account.
3. Submit the reconciled statements and all related documentation according to the 'Instructions' tab on the spreadsheet.

G. Provider Enrollment Third-Party Delegate

Upon request by the vendor or individual provider, in extenuating provider circumstances, the FEA must act as a third-party delegate as defined in Article I., Definitions. The vendor or individual provider may request assistance from the FEA to complete initial enrollment, re-enrollment, revalidation, demographic maintenance or make changes to programs or services on the ForwardHealth Portal to establish and/or to maintain Medicaid provider enrollment. The FEA must complete the data entry and upload supporting documentation signed by the vendor or individual provider authorizing the action to the ForwardHealth Portal. It is the responsibility of the vendor or individual provider to supply enrollment information to the FEA and to ensure information entered by the FEA is accurate.

H. 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 provider(s) specified in each service authorization; 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:

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.

I. 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. After the initial payment, providers are expected to provide their FEIN number to the FEA, which can be verified through the Internal Revenue Service verification line.

J. Workers' Compensation Payments

1. In this section, "required workers' compensation coverage" means workers' compensation insurance that fully covers all participant-hired workers employed by the FEA's enrolled participants in the IRIS program, as required by law.

2. The FEA, acting as agent on behalf of its enrolled participants in the IRIS program, shall provide required workers' compensation coverage.

3. The Department will reimburse the FEA for the actual costs of premiums billed by its insurance carrier for required workers' compensation coverage. Reimbursements will be made through the Department's ForwardHealth system. The Department will not reimburse premiums for other insurance coverage included in the same policy (such as workers' compensation for FEA's own employees or those of other programs, or other types of insurance such as terrorism or catastrophe coverage) or any costs that may be related to the provision of workers' compensation insurance or insurance in general.

4. The FEA shall submit to the Department a monthly invoice for required workers' compensation coverage. The invoice submission shall include

billing documentation from the insurance carrier and supporting detail in Excel or compatible format identifying the FEA's IRIS covered payroll for that period, the date range, the rate applied to the payroll, and the basis of the rate applied. The Department will verify the submission before reimbursement is made.

5. If the FEA identifies needed adjustments or corrections to prior invoices for required workers' compensation coverage, it shall include those with its next monthly invoice along with an explanation and documentation to support the adjustments or corrections submitted. The Department will verify the adjustments or corrections submitted before applying them to a reimbursement.

6. Within 30 days of issuance or renewal of the FEA's insurance policy that includes required workers' compensation coverage, the FEA shall submit the Department documentation that identifies the workers' compensation insurance and all other coverages provided and billed under that policy.

7. Annually, the FEA shall submit the following:

    a. The results of its insurance carrier's annual workers' compensation insurance audit, including any resulting premium adjustments. The audit report must provide sufficient detail to distinguish the actual costs and premium adjustments for required workers' compensation coverage from other costs and premium adjustments, or the FEA must provide supporting documentation for the Department to distinguish the actual costs and premium adjustments for required workers' compensation coverage.

    b. A reconciliation between the monthly invoices submitted and the premiums billed by the carrier during the period of its annual workers' compensation insurance audit. The reconciliation must distinguish the portions of those premiums for required workers' compensation coverage from the remainders of those premiums.

8. Following receipt of the annual submission required by the previous section, the Department will recoup the excess amount refunded or pay the additional amount due for the portion of the FEA's carrier's premium adjustment specific to its required workers' compensation coverage, as an adjustment to its subsequent workers' compensation and/or MROS payment(s). The amount of the adjustment will be determined by the Department's review, verification, and analysis of the annual submission, and the Department will notify the FEA of its determination before any adjustment is made.

VIII. Service Providers

A. Service Provider Setup

1. The participant must choose a service provider who is willing and qualified to provide IRIS-funded services. Qualification requirements vary based on type of service provider. See the IRIS Service Definition Manual for service provider-specific requirements.
2. The Department requires all providers and vendors of home and community-based services under an adult long-term care waiver program to enroll with Wisconsin Medicaid through the ForwardHealth Portal.
    a. Community Transportation providers that meet the definition of mass transit system, which is defined within Wis. Stat. § 85.20(1), do not enroll in Wisconsin Medicaid through the Department-centralized provider enrollment system unless this same provider acts as a community provider outside of their mass transit system contract.
        i. The FEA will verify that Community Transportation providers acting within their mass transit system contract meet the provider standards defined in the approved IRIS §1915(c) Home and Community-Based Services Waiver and ensure that all required licensure and/or certification standards applicable to the service being provided are met.
        ii. If the same provider acts as a community provider outside of their mass transit system contract, the provider is required to enroll as a Home and Community-Based Community Transportation provider through the ForwardHealth portal.
3. The Department will notify the FEA of an onset date in which FEAs can only reimburse service providers who have completed required enrollment as a Medicaid provider through the ForwardHealth Portal and been issued a Medicaid ID.
    a. Beginning upon the onset date received from the Department, the FEA will only reimburse service providers who are enrolled as a Medicaid provider through the ForwardHealth Portal and been issued a Medicaid ID.
4. The FEA must maintain records that meet or exceed the following criteria:
    a. All storage and disposal of paper and electronic employee and employer records must meet or exceed state and federal confidentiality laws and HIPAA compliance standards.

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

B. Onboarding Packets

1. The FEA is responsible for creating an onboarding packet with the information required to be a service provider for the program.
   a. This must include forms under Section 3504 of the Department of Treasury's Internal Revenue Service Code.
   b. All forms necessary for each packet are included in Appendix III.
2. Different onboarding packets shall be developed for each type of service provider: participant-employers, participant-hired workers, individual providers, and provider agencies. The packets for each group must be identical and contain the same Department, Internal Revenue Service, and/or agency-specific documents.

   Changes to the contents of the packet must be approved by the Department prior to distribution. This is referred to as the FEA's DHS-approved onboarding packet, which consists of the program-required forms and any FEA-specific forms.
3. The FEA shall provide to each vendor or participant-hired worker the DHS-approved onboarding packets in a printable electronic form.
4. The FEA is permitted and encouraged to provide the packet on their IRIS-specific website.
5. The FEA is responsible for collecting completed onboarding packets from the vendor.
   a. The participant, participant-hired worker, or vendor can submit the completed onboarding packet directly to the FEA.
   b. In the event that the completed onboarding packet is submitted to the ICA, the ICA will forward the completed onboarding packet to the correct recipient, which is the FEA.
6. The FEA must receive, verify, and archive documentation and records. The capabilities must include at a minimum:
   a. Electronic acceptance of all relevant paperwork; and
   b. Submission of all necessary documentation to the appropriate taxing or government authority in a manner that is accurate and timely.
7. For participant-hired workers, the FEA must create a new service provider record within the enterprise care management system and upload the

onboarding packet in its entirety, which must include the WI Medicaid Provider Agreement, to the newly created service provider record.

8. A service provider is approved when all of the applicable paperwork is completed, uploaded, and filed and the service provider's credentials have been verified, if required. The FEA must notify the participant, service provider, and the ICA when the service provider is approved.

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:

   a. The period of time for which services are authorized, including beginning and ending dates;

   b. Whether the authorization is new or changed;

   c. The service(s) the provider is authorized to provide;

   d. The unit of measure and billing for each authorized service; and

   e. The cost per unit for each authorized service.

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.

   a. The FEA may only pay vendors and workers via pay card or direct deposit. Payments may not be made with paper checks without Department approval.

   b. If the FEA is given approval to pay via paper check, the paper check must be made on the FEA's business check stock. No checks may be issued on State of Wisconsin or other Department check stock.

   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 FEA with only limited exceptions. The only limited exception reasons to the 365-day timely filing deadline are permitted, as follows:

      i. In accordance with a court order.

      ii. DHS-initiated corrective action taken to resolve a dispute.

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:

a. Pend payment of the invoice, timesheet, or other claim for payment until the error is corrected;

b. Document the error and ensure the documentation is available for the Participant's ICA;

c. Track and resolve the error;

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.

3. The FEA must ensure payments are compliant with:

a. The Fair Labor Standards Act (including exemption criteria, and payment of overtime) as well as any other state, federal, and local wage and hour rules.

b. The Wisconsin revised uniform unclaimed property act (Wis. Stats. Ch. 177) and other states' unclaimed property laws as applicable, and

c. Other applicable state and federal laws and regulations regarding payments to vendors and workers.

4. The FEA must indicate on a direct deposit payment advice or paper check the service(s) and participant(s) for which payment is being made. If it is not possible to include this information on a direct deposit payment advice or paper check, the FEA must provide a supplemental statement to the vendor or worker with this information.

5. Payment Funding

a. The Department will release Medicaid funds into the disbursement account for payments to vendors and workers. The FEA must use the Department-specified data template and process to submit payments for disbursement.

b. The Department will establish a weekly schedule and deadlines for submission of payment data to the Department by FEAs. The schedule will alternate between a "vendor" week, primarily used for payments to vendors, and a "payroll" week, primarily used for payments to workers; the schedule will also specify deadline adjustments for holidays. If necessary, the FEA may submit payments to workers in the "vendor" week or payments to vendors in the "payroll" week.

c. The FEA may not attempt to withdraw funds from the disbursement account in advance of the settlement date. The FEA is responsible for any fees charged for overdrafts caused by withdrawal of funds in advance or inaccurate submissions of payment data.

d. The FEA must receive Department approval prior to paying a single vendor or worker any amount over $120,000 in a pay cycle. Payments at or exceeding this amount may not be broken down into multiple payments by the FEA to circumvent this requirement.

D. Payments to Vendors

The FEA must be able to receive and process paper and electronic invoices and other claims for payment from vendors.

Invoices and other claims for payment must include for each service billed the participant's name, authorized service provided, authorized date(s) on which the service was provided, and the amount due. The FEA may not pay invoices or other claims for payment that are not documented as such.

FEAs should report payments exceeding the authorization to the ICA under established reporting procedures and standards.

E. Payments to Workers

1. The Department contracts with an agency for IRIS self-directed personal care (SDPC) oversight and nurse consultation services. The FEA is responsible for:

   a. Adhering to the IRIS Policy and Work Instructions dedicated to IRIS SDPC.

   b. Ensuring that all personal care services being paid to workers are only for those participants enrolled in IRIS SDPC.

   c. Assessing and reviewing the certification period and any holds in place to ensure that IRIS SDPC remains current and authorized.

   d. Paying only for those hours that are authorized.

i. SDPC is a service that requires physician orders and prior authorization, and the payment may not exceed the weekly authorized amount.

ii. The FEA may not use Medicaid funds to pay a worker providing self-directed personal care (SDPC) more than the weekly amount specified by the prior authorization.

e. Crosschecking to ensure there is a valid authorization prior to payment.

2. Timesheets

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

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

c. Timesheets for workers must be approved by the participant, their legal decision maker, or an appointed authorized representative. A signature is required for paper timesheets, while web-based or other electronic timesheets must record approval with an electronic signature or other type of authentication.

d. 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.

e. 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. Timesheet processing by FEAs must include verification of approval by the participant or legal decision maker, such as by

processing a paper timesheet only if signed, or by configuring payroll software to prevent unapproved timesheets from being processed for payment.

g. 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.

3. Taxes and Withholdings

a. On behalf of participants, the FEA is responsible for fulfilling in aggregate and under their federal employer identification number (FEIN) the employer responsibilities of payroll withholding and employer taxes, including:

i. Verifying employment eligibility as required by law;

ii. Withholding income, payroll, or other taxes, as well as garnishments, liens, or other levies, from workers' wages;

iii. Determining payroll, unemployment, or other employer taxes due from workers' wages;

iv. Filing, reporting, and paying income, payroll, unemployment, or other taxes due to state, federal, or other governments as required by law;

v. Paying garnishments, liens, or other levies as specified by a court order and/or required by law; and

vi. Providing year-end tax forms and other required wage, tax, and other withholding disclosures to workers as required by law.

b. The FEA must report to the Department any receipts of tax refunds prior to depositing them into the Deposit Account.

c. The FEA must have written policies and procedures regarding how over-collected taxes are processed and documented, including how the employee and employer shares of over-collected FICA payments are refunded to the worker and Department, respectively.

F. Reimbursement File

1. The FEA may encounter a situation when it needs to issue a direct payment with its own monies.

2. To be reimbursed, the FEA is expected to submit this information via the Department reimbursement file spreadsheet with backup documentation for all transactions.

3. The Reimbursement file may be necessary for any of the following reasons:
    a. Payments to agency providers by paper check;
    b. Garnishment payments paid by paper check;
    c. Cost share reimbursement payments; or
    d. Refund payments.
4. The FEA must adhere to the 'Instructions' tab on the spreadsheet for data formatting requirements and submission deadlines.

G. Claims Adjudication

1. The FEA must provide prompt and accurate processing of claims from receipt to payment, or denial, and not accumulate an excessive claims inventory or aged claims.
2. Provider claims shall be processed at 98% financial accuracy.
3. The FEA shall measure and monitor the correctness of IRIS payments quarterly and make those reports available to the Department upon request.
4. There is an obligation to pay approved claims, and the FEA is responsible for compliance with the Department of Labor regulations.
5. When receiving a provider agency invoice or claim, the FEA must:
    a. Validate the service is on the authorization;
    b. Validate the provider is an approved provider and set up in the Department's enterprise care management system;
    c. Validate the unit frequency matches the authorization (i.e., daily, hourly, each, etc.);
    d. Validate the service was rendered during the authorized period;
    e. Validate the codes and applicable modifiers match the authorization;
    f. Validate the rate does not exceed the authorized amount;
    g. Validate the claim does not exceed the authorized amount;
    h. Pay only up to the authorized amount;
    i. Reject any claims that do not have a service authorization;
    j. Reject any claims that do not have an authorized provider; and
    k. Refer the claims that exceed the authorized amount to the ICA each payment cycle, and the IC will be responsible for working with the participant and the agency.

6. The FEA must make claim payments:
   a. Within 30 calendar days of receipt from a provider, or
   b. Within 14 calendar days of receipt of notice or validation that a claim has been corrected when there was a hold on processing the payment.
7. A vendor/agency should not be paid above that amount authorized.
8. A signed MA Provider Agreement is required for all vendors.

H. Home and Community-Based Settings Requirements Compliance

Participants shall use only a licensed or certified residential provider in which residential care services are provided or a non-residential setting in which adult day care, prevocational services, day services, or group 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).

I. IRIS Background Check

The FEA conducts and manages the IRIS background check process for participant-hired worker applicants and established participant-hired workers and must adhere to all IRIS Background Check (P-00708E) policy requirements and processes.

IX. Information Technology/System Requirements

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 contractor will reference the CMS standard acceptable risk safeguards and the standard for encryption of computing devices and information 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

1. General Security Provisions

   Contractor agrees that they will implement administrative, physical, and technical safeguards to protect all DHS data that are no less rigorous than accepted industry best practices, including but not limited to, National Institute of Standards and Technology (NIST), Federal Information Security Management Act (FISMA), Health Information Technology for Economic and Clinical Health (HITECH) Act, ISO/IEC 27001 Series, Information Technology Library (ITIL), Control Objectives for Information and related Technology (COBIT), Payment Card Industry Data Security Standard (PCI-DSS) or other applicable industry standards for information security.

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.

a. The Contractor must submit a completed WISITS– Request for User Setup (F-01578) form for each new user. DHS processes the account setup and will inform the agency's security officer of its completion.

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.

c. Contractor must submit a completed SharePoint – Request for User Setup (F-01578A) for each new user.

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 complete 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.

4. Governance

Contractors, and any subcontractors thereof, are expected to abide by all applicable policies, procedures, standards and guidelines (PPSG) set-forth by DHS. These PPSGs will be provided to the Contractor upon initial

certification, and any new PPSGs or changes will be communicated by DHS.

5. Data Security and Encryption

Contractor agrees to preserve the confidentiality, integrity, and availability of DHS data with administrative, physical, and technical measures to conform to industry best practices, as reiterated below. Maintenance of the environment the Contractor interfaces, manages or has access to, in addition to the Contractor's environment, must apply timely applications of patches, fixes and updates to operating systems and applications.

a. All data stored and/or transmitted by the vendor must be encrypted. All encryption, hashing and signing modules used must be certified by NIST to FIPS 140-2 standards or better.

b. All devices utilized by and issued to personnel, whether laptops, cell phones, iPads, or tablets, must be encrypted and password protected.

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. All training materials created by Contractors must use de-identified data or appropriately redact any personally identifiable data or protected health information.

e. Contracted agencies must have documentation of their internal data management plan and policy which must be made available at the request of DHS.

6. Infrastructure and Network Security

a. The vendor shall maintain network security at all times, and at a minimum perform the following actions;

i. Firewall provisioning

ii. Intrusion detection

iii. Regularly scheduled vulnerability scanning and assessments

iv. Additionally, the vendor agrees to maintain network security that conforms to industry best practices as mentioned herein.

7. Password Protection

a. Staff passwords should be a minimum of 8 characters, with at least one capitalized letter, one number, and one special symbol.

b. Staff shall be required to change passwords regularly, at least once every three to six months.

c. Staff must not share their passwords with others and they should not automatically save passwords on websites or browsers for their work computers.

d. Passwords should never be written down on paper, post it notes, or notebooks and/or hidden in or around a staff work computer.

e. Contractors may invest in encrypted password storage programs for staff, such as Password Safe, which can be installed on staff computers to safely retain passwords.

f. Controls must be implemented to protect sensitive information that is sent via email.

i. Email and any attachments that contain sensitive information when transmitted inside and outside of the Contractor's premises shall be encrypted when possible.

ii. Password protection of files is recommended to add an additional layer of data protection but shall not be used in lieu of encryption solutions.

iii. Encrypted emails may or may not encrypt documents attached to said emails. As such, attachments on encrypted emails should have an additional layer of security, such as password protection.

iv. Passwords and/or encryption keys shall not be included in the same email that contains sensitive information.

B. Governance and Privacy

The Contractor must, at minimum:

1. Appoint or hire personnel to be accountable for developing, implementing, and maintaining an organization-wide governance and privacy program to ensure compliance with all applicable laws and regulations regarding the collection, use, maintenance, sharing, and disposal of PII and PHI by programs and information systems.

2. Monitor federal privacy laws and policy for changes that affect the privacy program.

3. Develop a strategic operational privacy plan for implementing applicable privacy controls, policies, and procedures.

4. Develop and implement a Privacy Incident and Breach Response Plan; provide an organized and effective response to privacy incidents and breaches in accordance with the Business Associate Agreement.

5. Develop, disseminate, and implement operational privacy policies and procedures that govern the appropriate privacy and security controls for programs, information systems, or technologies involving PII and PHI; and

6. Update privacy plan, policies, and procedures, as required to address changing requirements, no less than every two years.

7. Document and implement a privacy risk management process that assesses privacy risk to individuals resulting from the collection, sharing, storing, transmitting, use, and disposal of PII and PHI. This assessment plan shall be conducted for information systems programs, electronic information collections, or other activities that pose a privacy risk.

8. Establish privacy roles, responsibilities, and access requirements for the Contractor, its staff, and service providers.

9. Keep an accurate accounting of disclosures of information held in each system of records under its control, specifically those provided in records requests, including:

    a. Date, nature, and purpose of each disclosure of a record; and

    b. Name and address of the person or agency to which the disclosure was made.

10. Provide means, where feasible and appropriate, for individuals to authorize the collection, use, maintaining, and sharing of PII and/or PHI prior to its collection.

11. Provide individuals with plain language education to ensure they understand the consequences of decisions to approve or decline the authorization of the collection, use, dissemination, and retention of PII and PHI.

12. Obtain consent, where feasible and appropriate, from individuals prior to any new uses or disclosure of previously collected PII or PHI.

13. Provide participants the ability to have access to their PII maintained in the information system.

14. Provide a process for individuals to have inaccurate, incomplete, or out-of-date PII maintained by the organization corrected or amended, as appropriate.

15. Implement a process for receiving and responding to complaints, grievances, concerns, or questions from individuals about the organizational privacy practices.

C. Disaster Recovery Plan

1. If the FEA owns and/or operates their own systems housing IRIS data, the FEA is required to have a disaster recovery plan to address, at a minimum, the following:
    a. Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.
    b. Communication plan for critical personnel, key stakeholders, and business partners.
    c. Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system operations, and user documentation (e.g. electronic, non-electronic, incremental, full).
    d. Full and complete backup copies of all data and software.
    e. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
    f. Policies and procedures for purging outdated backup data.
    g. Plan that supports the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.
    h. Identification of a back-up processing capability at a distant remote site(s) from the primary site(s) such that normal business processes and services can continue in the event of a disaster or major hardware problem at the primary site(s).
2. The FEA is required to have policies and procedures to ensure the preservation documentation of a participant's safety and wellbeing in the event of a disruption or disaster.
3. Disaster Recovery Plans must be reviewed and approved by the Department as a part of the annual site visit and/or recertification process.

D. Department's Enterprise Care Management System

The FEA 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, as well as their internal system, FEAs must be capable of meeting the core IT functions related to:
    a. Participant/consultant access requirements;
    b. Employer setup, records, and documentation requirements;
    c. Participant-hired worker records and documentation requirements;

d. Extraction and uploading of authorization and expenditure data;

e. Tax withholdings;

f. FEA payroll processing and wage payment requirements;

g. Provider claims adjudication requirements;

h. FEA reporting requirements.

2. 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.

3. The Department's enterprise care management system does not contain payroll or claims processing functionality, 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 in the Department's enterprise care management system and associate the provider to the correct serve type and when applicable, the correct participant.

E. ForwardHealth Secure Waiver Agency Portal and CARES

1. ForwardHealth Secure Waiver Agency Portal – Contractor Responsibilities

   a. Contractors must maintain a current, up-to-date list of users roles/permissions within the secure ForwardHealth Portal account to ensure only authorized users have access to data and functions provided.

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:

i. If the Contractor terminates the employment, the Contractor shall submit the deactivation request within one (1) business day of the staff participant's termination.

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.

2. Access to CARES Data

a. Contractors are authorized to have limited access to, and make use of, data found in the Client Assistance for Reemployment and Economic Support system (CARES) operated for the Department.

b. Each Contractor must identify an Authorizing Agent Security Officer specific to CARES Access requests. That individual must complete a security officer's form (F-00639) and submit it to their Contract Specialist for submission and approval. The only authority granted with this form is the authority of the designated Authorizing Agent Security Officer to submit requests for access to CWW/CARES on behalf of their agency.

i. Once approved, the designated Authorizing Agent Security Officer may submit a separate form (F-00476) to request access for them self or any other staff at their agency to use the CARES system. Only the designated Security Officer may submit requests for access to: dhscaresaccessandidentitymanagementservices@dhs.wisconsin.gov

ii. When staff leave and/or no longer have a need for access to CARES, the agency shall submit the deactivation request

within three (3) business days of the departure or reassignment. Contractors must maintain a current, up-to-date list of users' roles/permissions within the secure CARES account to ensure only authorized users have access to data and functions provided. The Department may limit the number of authorized Contractor staff with access to the CARES system. Contractors shall submit a completed CARES Access Request form (F-00476) to dhscaresaccessandidentitymanagementservices@dhs.wisconsin.gov, to have security access deactivated as follows:

If the Contractor terminates the employment, the Contractor shall submit the deactivation request within one (1) business day of the staff participant's termination.

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

X. Hearings, Appeals, & Grievances

A. Background

1. Participants have the right to grieve or appeal any action or inaction of a Contractor that the participant perceives as negatively impacting them. The system for dealing with grievances and appeals has been designed to offer participants different options for attempting to resolve differences.
2. While multiple options are available to resolve grievances and appeals, participants are encouraged, and usually best served, to seek to directly resolve most concerns.
    a. If the grievance is related to a pended, voided, or delayed payment to a worker or a vendor, participants should directly communicate with the FEA about the issue.
    b. When a concern cannot be resolved through direct access with the FEA, participants should use the grievance and appeal process through the EQRO.
    c. The IRIS Ombudsmen are always available to assist IRIS participants with the resolution of grievances, appeals, and fair hearings: 1-800-928-8778.
    d. The State Fair Hearing process is the final decision-making process for the Department in resolving participant appeals.
        i. 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.

B. Definitions

As used in this section, the following terms have the indicated meanings:

1. An "action" is any of the following:
    a. The denial or limited authorization of a requested service that falls within IRIS services definitions, including the type or level of service.
    b. The reduction, suspension, or termination of a previously authorized service.
    c. The denial of functional eligibility as a result of administration of the Long Term Care Functional Screen, including a change from nursing home level of care to non-nursing home level of care.

d. A denial in IRIS fiscal employer agent transfer.

e. An involuntary disenrollment from the IRIS program.

f. Any other reason cited on Notice of Action – IRIS Program (F-01204).

2. Appeal

An "appeal" is a request for a review of an "action."

3. Grievance

"Grievance" is an expression of a participant's dissatisfaction about any matter other than an "action." The EQRO, as the independent third party mediator, assists participants with the referral and resolution of grievances. Ombudsman, Disability Rights Wisconsin (age 15-59) and the Board on Aging (age 60 and above) may work with participants to assist them with the grievance process.

4. Fair Hearing

A "fair hearing" means a de novo review under Ch. HA 3, Wis. Admin. Code, before an impartial administrative law judge, of an action by the Department, a county agency, a resource center, or an ICA.

5. Date of Adverse Action or Effective Date

The "Date of Adverse Action" or "Effective Date" when used in terms of establishing the time during which a participant has a right to file an appeal means ninety (90) calendar days from this date, which is included on notice of action communications.

C. Overall Policies and Procedures for Grievances and Appeals

Each Contractor is responsible for assuring that there is staff designated and responsible for addressing and resolving concerns raised by participants. The Contractor must dispose of each grievance and resolve each appeal. The policies and procedures used by the Contractor to dispose of grievances and to resolve appeals are subject to review and approval by the Department.

Contractors must attempt to resolve issues and concerns whenever possible. When a participant presents a grievance or appeal, the Contractors must attempt to resolve the issue or concern through internal review, negotiation, or mediation, whenever possible.

Functional and financial eligibility decisions and cost share calculations cannot be reviewed by the Contractor's internal grievance and appeal staff. The only means by which participants can contest those decisions is through the State Fair Hearing process.

1. Opportunity to Present Evidence

A participant shall have a reasonable opportunity to provide evidence, and allegations of fact or law in writing, as well as in person, in a grievance, independent review, or State Fair Hearing.

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.

3. Cooperation with Advocates, Mediators, and Ombudsman

Contractors must make reasonable efforts to cooperate with all advocates, mediators, and ombudsmen that a participant has chosen to assist him or her in a grievance or appeal.

a. As used here, "advocate" means any individual whom or organization that a participant has chosen to assist in articulating his or her preferences, needs, and decisions.

b. "Cooperate" means:

i. To provide any information related to the participant's eligibility, entitlement, cost sharing, budget, service plan, service authorizations, or service providers to the extent that the information is pertinent to matters in which the participant has requested the advocate's assistance.

ii. To assure that a participant who requests assistance from an advocate is not subject to any form of retribution for doing so.

c. Nothing in this section allows the unauthorized release of participant information or abridges a participant's right to confidentiality.

4. Confidentiality

Contractors shall assure the confidentiality of any participant who uses the grievance and appeal process.

5. Authority and Timing of Filing of Grievances

A participant or a participant's legal decision maker or anyone acting on the participant's behalf with the participant's written permission may file a grievance with the Contractor, the EQRO, the Ombudsmen, or the Department. Grievances can be filed at any time.

6. Remand/Reversed Appeal Decision

   If, following a State Fair Hearing, an Administrative Law Judge orders the reversal of an ICA's decision to deny, limit, reduce, or terminate services that were not furnished during the appeal, ICA must authorize services within the timeframe specified in the hearing decision.

   a. If a State Fair Hearing reverses a decision to deny authorization of services, and the participant received the disputed services during the appeal, the FEA must pay for those services using the participant's budget.

7. Continuation of Benefits During an Appeal

   a. Services shall be continued by the ICA throughout any local or State administrative appeals in relation to the initial action if the participant makes a timely request.

   b. Timely Request: A request for continuing benefits will be considered timely if it is submitted on or before the effective date in a Notice of Action.

   c. A participant does not have a right to continuation of benefits:

      i. Beyond any limit in a service authorization when the limit is reached during the course of an appeal.

      ii. When grieving adverse actions that are the result of a change in state or federal law; however, in such a situation, a participant does have the right to appeal whether he/she is a participant of the group impacted by the change.

      iii. After a State Fair Hearing decision upholding the ICA's denial, reduction, termination, or suspension of services is issued.

      iv. After electing to withdraw an appeal.

XI. Financial Provisions

The FEA will ensure continuity of care for enrolled participants through sound financial management systems and practices. Financial management systems shall be sufficient to track, reconcile, report, and project the operational and financial results of the Contractor, and support informed decision-making. Financial management practices shall ensure the overall financial health of the organization and support the maximization of quality services with the funds expended. All Contractors shall demonstrate the capacity for financial solvency and stability and the ability to assume the level of financial risk required under the contract and ensure continuity of care for enrolled participants.

A. Working Capital

1. The purpose of working capital is to provide ongoing liquid assets to manage routine fluctuations in revenues and expenses that will occur in the normal course of business operations.
2. Working capital is the difference between current assets and current liabilities.
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. Restricted Reserve

1. Purpose and Requirements
    a. The purpose of the restricted reserve is to provide continuity of services for enrolled participants, accountability to taxpayers, and effective program administration.
    b. The restricted reserve provides additional liquid assets to underwrite the risk of financial volatility due to extraordinary or unbudgeted program expenditures.
    c. The Contractor must maintain the required restrictive reserve in a segregated liquid account in a financial institution.

d. The title of the account must include the language "IRIS Restricted Reserves."

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).

2. Restricted reserve calculation for the Contractor will be based on a rolling basis against the most recent 12 months of actual IRIS revenues. The most recent IRIS revenues in year two will be the annualized revenues of the actual months under contract. The required minimum restricted reserve balance is calculated as follows:

a. 8% of the first $5 million;

b. 4% of the next $5 million;

c. 3% of the next $10 million;

d. 2% of the next $30 million; and

e. 1% of any additional.

3. Reporting

a. The Contractor shall evidence satisfaction of the restricted reserve account balance at least quarterly with the financial reporting (See Financial Reporting, C.7., below).

b. The Contractor may be required to report on the status more frequently if the Contractor is under heightened fiscal monitoring or under a corrective action plan.

c. Failure to maintain the restricted reserve requirement will result in heightened fiscal monitoring and/or fiscal corrective action as determined by DHS.

4. Withdrawal or Disbursement

a. Provided the minimum balance requirement will continue to be met, or when the Department allows, disbursements may be made from the restricted reserve account in order to fund operating expenses

b. Withdrawal or disbursement from the restricted reserve account requires prior written approval from DHS if the withdrawal or disbursement results in a balance below the required minimum balance. Additionally, withdrawals for a purpose other than

payment of operating expenses require prior written approval from the Department.

5. Disbursement Requests

   a. The Contractor must file a plan for accessing the restricted reserve funds with the Department at least twenty (20) calendar days prior to the proposed effective date.

   b. The Contractor must obtain affirmative approval for withdrawals or disbursements that result in a balance below the required minimum balance.

   c. Additionally, the Contractor must obtain approval for withdrawals for a purpose other than payment of operating expenses.

   d. The Department shall render decisions on requests within ten (10) business days only after consideration of all solvency protections available to the Contractor.

   e. Withdrawals or disbursements that result in an account balance below the required minimum balance will only be approved to fund working capital or operating expenses of the Contractor on a short-term basis.

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

6. Plans for Replenishment of Restricted Reserves When Below Minimum

   a. If the disbursement request results in the reserve account balance falling below the minimum requirements, the disbursement request plan must specify the methods and timetable the Contractor shall employ to replenish the restricted reserve account.

   b. If the Contractor fails to submit an acceptable replenishment plan, the Department may deny the request for disbursement. In approving or disapproving the plan, the Department will consider existing or additional solvency protections available to the Contractor.

7. Failure to Maintain Required Minimum Balance

   a. In the event the Contractor fails to meet the requirements of the replenishment plan, the Contractor will be placed under corrective action and shall submit a plan to the Department for approval that includes an analysis of the reasons for the shortfall and a plan for restoring the required restricted reserve balance.

b. If the Contractor continues to maintain an inadequate restricted reserve balance, the Department may decertify the Contractor and terminate this contract.

8. The Department reserves the right to request an updated submission of the completed IRIS Financial Projection Template (F-02046) at any point during the term of the contract. Factors include, but are not limited to:

   a. Actual IRIS participant enrollment;

   b. Projected IRIS participant enrollment;

   c. New or expanded lines of other business for the certified Vendor; and

   d. Termination or reduced lines of other business for the certified Vendor.

   e. Fiscal oversight review finding.

C. Financial Reporting

1. The Contractor will communicate the fiscal health of the organization and demonstrate the integrity of the financial operations consistent with the conditions of this contract.
2. All financial reporting will be presented in accordance with generally accepted accounting principles (GAAP).
3. Financial reporting for all entities is due to DHS within 30 calendar days of the close of the first three (3) calendar quarters, ending March 31, June 30, and September 30 respectively.
4. Calendar year-end preliminary financial reporting is due by February 28 of the following year.
5. The submission of financial reporting may be required on a more frequent basis, at the discretion of DHS.
6. Requests for an extension to the required reporting deadline(s) must be made prior to the due date and include the length of extension request and a reason for the extension request.
7. Quarterly Financial Reporting Document Submission Requirements:

   a. Year-to-date (YTD) financial reporting in the IRIS Financial Reporting Template (F-02047),

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

   c. Financial institution statement(s) evidencing the IRIS segregated Restricted Reserve balance for the period end reporting.

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.

   The Contractor and any subcontractors or providers shall make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the Contractor, subcontractors or providers which relate to the Contractor's capacity to bear the risk of potential financial loss, or to the services performed and amounts paid or payable under the contract.

D. Annual Financial Audit

The Contractor will demonstrate annually through a financial audit performed by an independent certified public accountant the reasonable assurance that the Contractor's financial statements are free from material misstatement in accordance with GAAP. The audit report should demonstrate to DHS that the internal controls and related reporting systems in operation by the Contractor are sufficient to ensure the integrity of the financial reporting systems.

1. Deadline for Submission of Financial Audit Report

   a. The financial audit report and related submissions are due to the Department by June 1 of each calendar year for the previous calendar year (See D.3. below).

   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.

   c. Requests for an extension must be made at least ten (10) calendar days prior to the audit submission due date and include the length of extension requested and provide a reason for the extension request.

2. Auditor Qualifications

   The accountant or accounting firm retained by a Contractor shall furnish to the Contractor, and the Contractor will obtain and include with the submission of the annual audited financial report to DHS annually a CPA Qualification Letter to attest that the accountant or accounting firm:

   a. Is in good standing with the American Institute of Certified Public Accountants and licensed to practice in the State of Wisconsin. Contractor may request a variance for this requirement if they originate from an out-of-state operation, but the auditor must be

licensed to practice in the State of your company's base of operations.

b. Has not, directly or indirectly, entered into an agreement of indemnification with respect to the audit.

c. Conforms to the standards of the accounting profession as contained in the code of professional ethics of the American Institute of Certified Public Accountants rules and regulations, code of ethics, and rules of professional conduct of the accounting examining board, or a similar code.

d. Has not been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations (RICO) Act, 18 USC 1961 to 1968, as revised, or any dishonest conduct or practices under federal or state law.

e. Has not been found to have violated the insurance laws or rules of this state.

f. Has not demonstrated a pattern or practice of failing to detect or disclose material information in financial reports.

g. Does not have a conflict of interest to complete the independent audit due to a direct role, relationship, or appearance of role or relationship, with the entity to be audited. This includes a related party relationship, previous employment relationship of the audit firm partner, manager, or audit fieldwork staff, or participation on the entity's Board of Directors or other management role, either paid or voluntary. A request for exception to this requirement may be made to DHS in the case of unusual circumstances.

3. Audit Report Submission

a. The full audit report will include the following:

i. Comparative financial statements other than audit schedules and reports required for the type of financial audit necessary for the Contractor and resulting audit report and opinion.

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

iii. A report on the Contractor internal control environment over financial reporting.

iv. A report describing the system of cost allocation for shared overhead and direct services between programs or lines of business as required.

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.

vi. Letter(s) to management as issued or written assurance that a management letter was not issued with the audit report.

vii. Management responses/corrective action plan for each audit issue identified in the audit report and/or management letter.

viii. The completed CPA audit checklist signed by the Contractor's designated financial officer.

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.

4. Access to Financial Auditor's Work Papers

When contracting with an audit firm, the Contractor shall authorize its auditor to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of DHS. Such access shall include the right to obtain the work papers and computer files, or other electronic media, upon which records/working papers are stored in an agreed upon format.

5. Failure to Comply with the Requirements of this Section.

a. In the event that the Contractor fails to have an appropriate financial audit performed or fails to provide a complete audit report to DHS within the specified timeframes, in addition to applying one or more of the remedies available under this contract, DHS may:

i. Conduct an audit or arrange for an independent audit of the entity and charge the cost of completing the audit to the entity; and/or

ii. Charge the entity for all loss of federal or state aid or for penalties assessed to DHS because the entity did not submit a complete financial audit report within the required timeframe.

b. Other Regulatory Reviews and Identified Irregularities

i. The Contractor will notify DHS within ten (10) business days of notice of any reviews, investigations, decisions, and requirements for corrective action from other state and federal regulatory agencies, including but not limited to, the Internal Revenue Service, Department of Workforce Development, State Department of Revenue, or Department of Labor.

ii. The Contractor will notify DHS within ten (10) business days of any identified irregularities involving financial fraud from internal or contracted operations.

c. Even if it is not an adverse action or audit, DHS should be made aware of all identified reviews and/or irregularities. This includes, but is not limited to reviews and/or irregularities identified by Wisconsin Department of Revenue, Workforce Development (regarding unemployment compensation), and any other regulatory authority.

E. Annual Financial Projections Submission

1. The Contractor will complete and submit the annual financial projections in the DHS financial projections template for the next calendar year by October 15, of each year to demonstrate the projected fiscal health of the organization and ability to support ongoing operations consistent with the conditions of this contract in the next calendar year.

2. Annual Financial Projections Document Submission Requirements:

a. Year-to-date (YTD) financial reporting in the IRIS Annual Financial Projections Template,

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.

XII. Quality Management (QM)

A. Department Oversight Activities

1. The Department provides program oversight through the following activities:

   a. Program Record Review

   b. Contractor Recertification Site Visit

   c. IRIS Participant Satisfaction Survey

   d. Critical Incident Review

2. Program Record Review process

   The Department contracts with an External Quality Review Organization (EQRO) to manage and work directly with the contractors to complete the Program Record Review process. The Program Record Review consists of performance indicators derived from the performance measures identified within the 1915(c) Home and Community Based Services (HCBS) waiver, as well as programmatic requirements identified within this document The Program Record Review is a review of the following:

   a. Participant records within the Department's enterprise care management system focusing on health and welfare, IRIS Service Plan 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

   The Department will administer an IRIS Participant Satisfaction Survey annually. The Department will survey a sample of each contractor's participants to identify their level of satisfaction with the contractor's services.

5. Critical Incident Review

   The contractor is responsible for completing participant incident reporting outlined in the updated Critical Incident and Immediate Reportable policy, https://www.dhs.wisconsin.gov/publications/p03131.pdf. This process includes a review of substantiated cases of abuse, neglect, misappropriation and exploitation to ensure participant immediate and ongoing health and safety.

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:

      i. Participant services;

      ii. Participant issues or concerns;

      iii. Participant wellness and safety, including critical incident prevention;

      iv. The Department may require specific topics for PIPs and may require specific performance measures.

   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.

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:

a. Performance indicator compliance percentages;

b. Contractor remediation activities for performance indicators below the CMS defined threshold;

c. Contractor Recertification Site Visit details;

d. Participant Satisfaction Survey results;

e. Substantiated cases of abuse, neglect, misappropriation and exploitation;

f. Contractor Performance Improvement Projects (PIP).

8. Monthly Contractor Oversight Meetings

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

9. Other Contractor Responsibilities

Contractors are responsible for the completion and engagement in other areas of the program. These areas include the following:

a. Critical Incident and Immediate Reporting.

Critical Incident and Immediate Reporting processes are outlined in the policy (P-03131).

b. Fraud Allegation and Review Assessment (FARA).

The FARA purpose is defined in the IRIS Policy Manual (P-00708). Business rules and the FARA process can be located in the IRIS Policy Manual-Work Instructions (P-00708A).

XIII. Reporting Requirements

A. General FEA Reporting Expectations

1. Quarterly submission of an updated Fiscal Employer Agent Assignments by Area of Responsibility.
2. Completion of the Conflict of Interest – Provider (F-01310) form for all new hires and all staff who experience changes in employment linked with Medicaid. Records must be retained within the employee's file and is subject to review by the Department upon request.
3. Annual submission of updated Conflict of Interest – Provider (F-01310) forms for all new participants of the agency's governing Board of Directors, if applicable.
4. FEAs are responsible for providing biweekly reports to the ICAs indicating IRIS SDPC workers that are submitting invoices exceeding the weekly authorized amount(s).
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 IRIS Budget. All overspending and nonspending reports that the FEAs send to ICAs should also copy the DHS IRIS Quality mailbox: DHSIRISQuality@dhs.wisconsin.gov.

B. 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. The 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.

C. 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.

2. Self-Directed Personal Care Reports

   On or around the 15th day of each month DHS will generate:

   a. An SDPC summary report of enrollment totals, broken down by month, for the previous twelve (12) months.

   b. The SDPC Monthly Rate of Service Detail report, broken down by SDPC status, with an IRIS SDPC enrollment breakdown by FEA.

D. Reports to the Department

1. Contractors agree to furnish information from its records to the Department, and to the Department's authorized agents and upon request to CMS, which may be required to administer the program.

2. The number and frequency of reports is subject to change based on CMS requirements and program policy. Changes to the methodology of the data submitted, must be sent to the Department and is subject to DHS approval.

3. Completed reports shall be emailed to the designated contract coordinator and DHSIRISQuality@dhs.wisconsin.gov, unless specified otherwise.

XIV. Payment to FEA

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, the FEA 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.
    a. The FEA will receive a standard MROS payment of $82.77 per participant.
2. An FEA that provides services to a participant for an entire calendar month will receive a full MROS payment. An 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 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).

B. Payment for Financial Closeout Responsibilities

1. For a 12-month duration that begins on the date that the final participant disenrolls from the FEA, the Department will pay a financial closeout amount per participant per month.
    a. The financial closeout amount per participant per month will be paid monthly for each participant in which the FEA paid claims and will be based on the claims that the FEA paid in the prior month.
    b. The financial closeout amount per participant per month will be the lesser of the following two amounts:
        i. Calendar Year (CY) MROS amount; or
        ii. CY 2026 MROS amount multiplied by the result of the following equation:

a) The number of claims per participant that the FEA paid in the prior month divided by the average number of claims that the FEA paid per participant per month from January 1, 2025 through June 30, 2025. Multiply the result of this equation by the CY 2026 MROS amount.

C. Suspension of Payment Based on Credible Allegation of Fraud

1. Requirement

The Department shall suspend the monthly rate of service (MROS) payments to the Contractor if it determines that there is a credible allegation of fraud by the Contractor, unless the Department determines there is good cause for not suspending payments or for only suspending them in part, pursuant to the requirements of 42 C.F.R. § 455.23.

2. Credible Allegation of Fraud

A credible allegation of fraud is, as defined in 42 C.F.R. § 455.2, one considered by the Department to have indicia of reliability based on a careful and judicious review by the Department of all assertions, facts, and evidence on a case-by-case basis.

3. Good Cause to Not Suspend Payments

The Department shall determine whether good cause exists to not suspend payments, to suspend them only in part, or to lift a payment suspension based on the criteria under 42 C.F.R. § 455.23 (e) or (f). Good Cause shall exist if any of the following apply:

a. Law enforcement officials request that a payment suspension not be imposed because of a possible negative effect on an investigation;

b. Other available remedies more effectively or quickly protect Medicaid funds;

c. The Department determines based on written evidence submitted by the Contractor that the suspension should be removed;

d. Law enforcement declines to certify that a matter continues to be under investigation; or

e. The Department determines that payment suspension is not in the best interests of the Medicaid program.

4. Notice Requirements

The Department shall send the Contractor written notice of any suspension of MROS payments:

a. Timeframes

i. Within five (5) business days after taking such action unless requested by a law enforcement agency to temporarily withhold such notice; or

ii. Within five (5) business days after taking such action if requested in writing by law enforcement to delay the notice, which request for delay may be renewed in writing up to twice but may not exceed ninety (90) days.

b. Content – The notice shall include the following:

i. A statement that payments are being suspended in accordance with 42 C.F.R. § 455.23.

ii. The general allegations as to the reason for the suspension.

iii. A statement that the suspension is temporary and the circumstances under which it will be ended.

iv. If the suspension is partial, the types of services or business units to which it applies.

v. The Contractor's right to submit written evidence for consideration by the Department. The authority for the Contractor to appeal the suspension and the procedures for doing so can be found at Wis. Stat. ch. 227.

5. Duration of Suspension

A suspension of payment will end when:

a. The Department or a prosecuting authority determines there is insufficient evidence of fraud;

b. Legal proceedings related to the alleged fraud are completed; or

c. The Department determines there is good cause to terminate the suspension.

D. Contractor Net Income

1. Net income under this Agreement shall be calculated using generally accepted accounting principles (GAAP) and shall apply appropriate cost drivers for all direct and indirect costs. The Contractor's net income margin for providing IRIS FEA services under this Agreement will be calculated as the Contractor's net IRIS income (total IRIS revenues minus total IRIS expenses) divided by the Contractor's total IRIS revenues, a negative margin indicating a loss. Profit distributions recorded as expenses and goodwill, will not be treated as IRIS expenses in calculation of the Contractor's net income. Prior period adjustments for periods ending on or before December 31, 2024, will not be treated as IRIS revenues or

expenses in calculation of the Contractor's net income. Recoupments, monetary sanctions, and damages will be treated as IRIS expenses in calculation of the Contractor's net income.

2. The Department will recover a portion of the Contractor's annual net income for providing IRIS FEA services under this Agreement in excess of a 2 percent margin. The amount recovered will be the sum of the following:

   a. 50 percent of the portion of Contractor's annual net income that constitutes more than 2 percent and less than or equal to 6 percent of the net income margin.

   b. 100 percent of the portion of Contractor's annual net income that constitutes more than 6 percent of the net income margin.

3. Each month during the calendar year, the Department will withhold from the Contractor's MROS payments one-twelfth of an estimated amount to be recovered for that calendar year. The amount will be estimated using the method described in paragraph 2 with data from the Contractor's most recent submitted, reviewed, and accepted annual financial projection or quarterly financial report. If the most recent submitted, reviewed, and accepted annual financial projection or quarterly financial report indicates that the Contractor's net income margin will be 2 percent or less, no amount will be withheld. Re-estimates will be made as each quarterly report is submitted, reviewed, and accepted during the calendar year.

4. After submission, review, and acceptance of the Contractor's annual financial report and audited financial statements for the calendar year, the Department will make a final determination of the amount to be recovered under this section for that calendar year, if any, and recover or pay the difference between the estimated amounts previously withheld during that calendar year and the final amount determined, within the recovery or payment made within 30 days of the Department's final determination as an adjustment to the Contractor's next MROS payment, or a payment to or recovery from the Contractor if it is no longer under contract at the time a final determination is made.

APPENDIX I. Contract Signatures

Unless earlier terminated, as provided herein, this Contract shall remain in full force and effect until December 31, 2026.

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	William Hanna Medicaid Director
Date	Date

APPENDIX II. Key IRIS Program Publications and Forms

Waiver and Manuals:

- 1915(c) Home and Community-Based Services Waiver
- IRIS Policy Manual, P-00708
- IRIS Work Instructions, P-00708A
- IRIS Service Definition Manual, P-07008B
- IRIS Participant Education Manual, P-01704

Enrollment Reports and Maps:

- ICAs and FEAs by Geographic Service Region, P-02029
- Active IRIS Participants by County, P-01759
- Active SDPC Participants by County, P-01758

Financial and Fiscal:

- Payroll and Vendor Schedule, P-01740
- Financial Projections Template, F-02046
- Financial Reporting Template, F-02047
- IRIS CPA Audit Checklist, F-02021

Quality Management:

- IRIS Fiscal Employer Agent Quality Management Plan
- IRIS Fiscal Employer Agent Quality Management Plan Tracking

Department Resources:

- IRIS Program Website: https://www.dhs.wisconsin.gov/iris/index.htm

Department of Health Services Forms Library

- https://www.dhs.wisconsin.gov/forms/index.htm

Department of Health Services Publications Library:

- https://www.dhs.wisconsin.gov/publications/index.htm

APPENDIX III. Fiscal Employer Agent Paperwork Packet Expectations

A. Participant-Employer Packet

1. The participant-employer packet must include the following documents. All agency-specific forms must be approved by the Department prior to distribution and utilization.

Form Name/Number	Form Title/Purpose
Internal Revenue Service Form SS-4	Application for new or activation of existing FEIN. The FEA verifies that a 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 enterprise care management system record. The FEA will check the Department's enterprise care management system prior to requiring said documentation from the participant.

2. The following additional forms shall be utilized, as needed:

Form Name/Number	Form Title/Purpose
FEA-Specific Direct Deposit Authorization Form	This is optional for participants to complete. There may be circumstances whereby participants require payment or reimbursement.
Application for Wisconsin State Income Tax Withholding Account Number	The FEA submits necessary forms and obtains an individual state tax account for each participant employer.
Wisconsin State Unemployment Compensation related documents	
Workers Compensation Insurance	The FEA must arrange for Workers' Compensation insurance according to state rules and for each participant employer and must maintain and manage a policy covering all participant-hired workers employed by participants served.

B. Participant-Hired Worker New Employee Packet

1. The employee packet will include, at minimum, the following:

Form Number	Form Title
DHS F-00180C	Wisconsin Medicaid Program Provider Agreement and Acknowledgement of Terms of Participation. This form must be signed and returned to the FEA before any payment can be issued.
U.S. Citizenship and Immigration Services Form I-9	Employment Eligibility Verification (and copies of appropriate documents) necessary to validate citizenship or other work-related authorization.
Internal Revenue Service Form W-4	Employee's Federal Tax Withholding Certificate. This form determines how much tax the participant-employer will withhold from the worker's paycheck.
WI Department of Revenue Form WT-4	Wisconsin Income Tax Withholding Allowance Exemption Certificate/New Hire Reporting. This form is used to report the hiring and allowance exemptions to the Wisconsin Department of Workforce Development.
DHS F-01201	IRIS Participant-Hired Worker Set-Up. This form is intended to provide demographic information on the participant and their worker.
DHS F-01201A:	IRIS Participant-Hired Worker Relationship Identification. This form documents any relationship that the worker has with the participant, so as to ensure that the following tax obligations are managed correctly: Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), and State Unemployment Tax Exemptions (see Internal Revenue Publication 15, Circular E, Family Employees Section).
DHS F-01201C	IRIS Participant Employer/Participant-Hired Worker Agreement. This form provides demographic information for the worker, as well as an indication as to the services they will provide, their proposed work schedule, and the pay rate(s) thereof.
DHS F-82064	Background Information Disclosure (BID). Completion of this form is required under Wis. Stat. § 50.065 to ensure the participant-hired worker applicant and established participant-hired worker complete the IRIS background check.
DHS F-01246	Background Information Disclosure Addendum – IRIS. This form captures the participant-hired worker applicant's and established participant-hired worker's previous residences for consideration in the resulting IRIS background check.

Form Number	Form Title
FEA-Specific Payment Election Form	Each FEA shall generate and utilize a payment election form to ensure workers are offered the choice of pay card or direct deposit for receipt of wages.

2. The following additional forms will be utilized, as needed:

Form Number	Form Title
Internal Revenue Service Form W-9	IRS Request for Taxpayer Identification Number and Certification. Should the ICA incorrectly determine that the worker is not an individual employee; the FEA refers the worker back to the ICA for setup as an independent provider.
Internal Revenue Service Notice 797	Possible Federal Tax Refund Due to the Earned Income Credit (EIC).
Documentation necessary for workers under age 18 (minors)	Ensure state rules regarding employed minor workers are followed.
Worker benefit accounting and health insurance forms	Establish a tracking system for all workers earning vacation or other time off benefits as part of employment.
Verification and validation of Social Security number	
Local tax employee forms, as applicable	Completed using the Social Security Administration (SSA) number verification service.

C. Vendor and Individual Provider Packet

1. The packet for Vendors and Individual Providers will include, but will not be limited to, the following:

Form Number	Form Title
Internal Revenue Service Form W-9	Request for Taxpayer Identification Number and Certification. This form is required for all providers, as well as for any existing provider that changes their name.
FEA-Specific Direct Deposit Authorization Form	Vendors and individual providers must be strongly encouraged, if not required, to utilize direct deposit payments.

2. The following additional forms will be utilized, as needed:

Copy of Liability Insurance Certificate, if required for the profession.
Copy of Driver's license, if providing transportation.
Adult Family Home Information Form, if AFH provider with non-taxable income. This information is required only if the AFH income is qualified to be non-taxable. The AFH is exempt from taxes and 1099 reporting only if the AFH qualifies based on the information provided on the form.

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 XIII.B. 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.

Form should be created on Contractor letterhead

FINANCIAL STATEMENT CERTIFICATION

Pursuant to the IRIS Program contract between the State of Wisconsin, Department of Health Services, Division of Medicaid Services, and the Contractor, _____ (Name of Contractor), hereafter referred to as the FEA, the FEA certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as an FEA.

The FEA acknowledges that if payment is based on any information required by the State and contained in financial statements, the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The FEA hereby requests payment from the Wisconsin Medicaid program based on any information required by the State and contained in financial statements submitted and in so doing makes the following certification to the State of Wisconsin.

The FEA has reported to the State of Wisconsin for the period of _____ (indicate dates) all information required by the State and contained in financial statements. The FEA has reviewed the information submitted for the period listed above, and I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) acknowledge that the information described above may directly affect the calculation of payments to the FEA. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.

Signature of CFO, CEO, or delegate **Date signed**

Name and title of CFO, CEO, or delegate

APPENDIX V. Materials With Specific Due Dates

A. Materials with Specific Due Dates – Financial Reporting

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)*	1/1/2026 - 3/31/2026	4/30/2026	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2026 – 6/30/2026	7/30/2026	
	1/1/2026 – 9/30/2026	10/30/2026	
2. Preliminary Year End Financial Reporting *(to include completed reporting template, signed Financial Statement Certification, investment/bank statement for segregated Restrictive Reserve account)*	1/1/2025 – 12/31/2025	2/28/2026	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2026 – 12/31/2026	2/28/2027	
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.*	1/1/2025 – 12/31/2025	6/1/2026	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2026 – 12/31/2026	6/1/2027	
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	1/1/2027 – 12/31/2027	10/15/2026	DHSLTCFiscalOversight@dhs.wisconsin.gov

			cc: DHSIRIS@dhs.wisconsin.gov

B. Materials with Specific Due Dates - Fiscal Employer Agent

Report	Reporting Period	Due Date	Submit To
1. Encounter Reporting Submission and Data Certification form, as applicable.	12/1/2025 – 12/31/2025	1/30/2026	DHS LTC IES: https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html
	1/1/2026 – 1/31/2026	3/2/2026	
	2/1/2026 – 2/28/2026	3/30/2026	
	3/1/2026 – 3/31/2026	4/30/2026	
	4/1/2026 – 4/30/2026	5/30/2026	
	5/1/2026 – 5/31/2026	6/30/2026	
	6/1/2026 – 6/30/2026	7/30/2026	
	7/1/2026 – 7/31/2026	8/30/2026	
	8/1/2026 – 8/31/2026	9/30/2026	
	9/1/2026 – 9/30/2026	10/30/2026	
	10/1/2026 – 10/31/2026	11/30/2026	
	11/1/2026 – 11/30/2026	12/30/2026	
	12/1/2026 – 12/31/2026	1/30/2027	
2. Funding Files	Weekly Pay Cycles, pursuant to the Payroll and Vendor Schedule (P-01740)	See P-01740	DHSDMSIRISFiscal@dhs.wisconsin.gov
3. Deposit Account Bank Reconciliation	12/1/2025 – 12/31/2025	1/15/2026	IRIS Contract Specialist(s) and DHSDMSIRISFiscal@dhs.wisconsin.gov
	1/1/2026 – 1/31/2026	2/15/2026	
	2/1/2026 – 2/28/2026	3/15/2026	
	3/1/2026 – 3/31/2026	4/15/2026	
	4/1/2026 – 4/30/2026	5/15/2026	
	5/1/2026 – 5/31/2026	6/15/2026	
	6/1/2026 – 6/30/2026	7/15/2026	
	7/1/2026 – 7/31/2026	8/15/2026	
	8/1/2026 – 8/31/2026	9/15/2026	
	9/1/2026 – 9/30/2026	10/15/2026	
	10/1/2026 – 10/31/2026	11/15/2026	
	11/1/2026 – 11/30/2026	12/15/2026	
	12/1/2026 – 12/31/2026	1/15/2027	
4. Disbursement Account Bank Reconciliation	Same as 3 above	Same as 3 above	IRIS Contract Specialist(s) and DHSDMSIRISFiscal@dhs.wisconsin.gov
5. Reimbursement Files	12/1/2025 – 12/31/2025	1/15/2026	DHSDMSIRISFiscal@dhs.wisconsin.gov
	1/1/2026 – 1/31/2026	2/15/2026	

Report	Reporting Period	Due Date	Submit To
	2/1/2026 – 2/28/2026	3/15/2026	
	3/1/2026 – 3/31/2026	4/15/2026	
	4/1/2026 – 4/30/2026	5/15/2026	
	5/1/2026 – 5/31/2026	6/15/2026	
	6/1/2026 – 6/30/2026	7/15/2026	
	7/1/2026 – 7/31/2026	8/15/2026	
	8/1/2026 – 8/31/2026	9/15/2026	
	9/1/2026 – 9/30/2026	10/15/2026	
	10/1/2026 – 10/31/2026	11/15/2026	
	11/1/2026 – 11/30/2026	12/15/2026	
	12/1/2026 – 12/31/2026	1/15/2027	
6. Cost Share Arrearage Report	12/1/2025 – 12/31/2025	1/10/2026	
	1/1/2026 – 1/31/2026	2/10/2026	
	2/1/2026 – 2/28/2026	3/10/2026	
	3/1/2026 – 3/31/2026	4/10/2026	
	4/1/2026 – 4/30/2026	5/10/2026	
	5/1/2026 – 5/31/2026	6/10/2026	To each IRIS Consultant Agency with impacted participants.
	6/1/2026 – 6/30/2026	7/10/2026	
	7/1/2026 – 7/31/2026	8/10/2026	
	8/1/2026 – 8/31/2026	9/10/2026	
	9/1/2026 – 9/30/2026	10/10/2026	
	10/1/2026 – 10/31/2026	11/10/2026	
	11/1/2026 – 11/30/2026	12/10/2026	
	12/1/2026 – 12/31/2026	1/10/2027	
7. Cost Share Statement	Same as 6 above	Same as 6 above	To each IRIS participant with cost share obligation