IRIS PROVIDER AGREEMENT

between

WISCONSIN DEPARTMENT OF HEALTH SERVICES DIVISION OF MEDICAID SERVICES

and

<<NAME OF ICA OR FEA>>

Issued January 1, 2023

Effective 1/1/2023 – 12/31/2024

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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 IRIS consultant agencies (ICAs) and 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 long-term care 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 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); and
- IRIS Service Definition Manual (P-00708B).

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

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

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 employment.

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

This Contract describes the contractual relationship between the contracted agency 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: One West Wilson Street, P.O. Box 309, Madison, Wisconsin, 53707-0309, and <<Generic>> an IRIS Consultant Agency or a Fiscal Employer Agency, hereafter ICA or 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. Stats § 46.90(1)(a), means any of the following:
   a) Physical abuse: intention or reckless infliction of physical pain or injury, illness, or any impairment of physical condition.
   b) Emotional abuse: language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.
   c) Sexual abuse: a violation of criminal assault law, Wis. Stats. §§ 940.225 (1), (2), (3), or (3m).
   d) Treatment without consent: the administration of medication to an individual who has not provided informed consent, or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has no provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.
   e) Unreasonable confinement or restraint: the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his/her living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of methods or devices in entities regulated by the Department if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint.

2. **Activities of Daily Living** or **ADLs**: bathing, dressing, eating, mobility, transferring from one surface to another such as bed to chair and using the toilet.

3. **Acute Care**: treatment, including all supplies and services, for an abrupt onset as in reference to a disease. Acute connotes an illness that is of short duration, rapidly progressive, and in need of urgent care.

4. **Adult at Risk**: as defined in Wis. Stat. § 55.01(1e), means any adult who has a physical or mental condition that substantially impairs his/her ability to care for his/her needs and who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation.

5. **Adult Protective Services** or **APS**: as defined by Wis. Stat. § 55.01(6r), includes any of the following: (a) outreach, (b) identification of individuals in need of services, (c) counseling and referral for services, (d), coordination of services for individuals, (e) tracking and follow-up, (f) social services, (g) care management, (h) legal counseling or

referral, (i) guardianship referral, (j) diagnostic evaluation, and (k) any services that, when provided to an individual with developmental disabilities, degenerative brain disorder, service and persistent mental illness, or other like incapacity, keep the individual safe from abuse, financial exploitation, neglect, or self-neglect or prevent the individual from experiencing deterioration or from inflicting harm on himself or herself, or another person.

6. **Advance Directive**: a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated.

7. **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.

8. **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.

9. **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.

10. **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.

11. **Assistance**: cueing, supervision or partial or complete hands-on assistance from another person.

12. **Behavior Modifying Medication**: a psychotropic medication (i.e., prescription medication within the classification of antipsychotic, mood stabilizing, anti-anxiety,

antidepressant, or stimulant and/or medication outside of these classifications utilizing off-label use as a means to regulate behaviors).

13. **Business Day**: Monday through Friday, except days which the office of the IRIS consultant agency or fiscal employer agent are closed.

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

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

16. **Community Supports**: supports and services that are not authorized or paid for by the participant's budget and that are readily available to the general population.

17. **Complex Medication Regime**: the participant takes eight (8) or more scheduled prescription medications for three (3) or more chronic conditions. Chronic conditions include, but are not limited to, dementia or other cognitive impairment (including intellectual and/or developmental disability), heart failure, diabetes, end-stage renal disease, dyslipidemia, respiratory disease, arthritis or other bone disease, and mental health disorders such as schizophrenia, bipolar disorder, depression or other chronic and disabling mental health conditions. Medication classes of particular concern are: anticoagulants, antimicrobials, bronchodilators, cardiac medications, central nervous system (CNS) medications, and hormones.

18. **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.

19. **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.

20. **Contract/the Contract**: the contractual agreement between the Wisconsin Department of Health Services and the IRIS consultant agency or fiscal employer agent

21. **Contractor**: for purposes of this contract, Contractor is used to refer to contractual obligations that are applicable to both IRIS consultant agencies and fiscal employer agents.

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

23. **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.

24. **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.

25. **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.

26. **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.

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

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

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

30. **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.

31. **DHS**: the Wisconsin Department of Health Services.

32. **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."

33. **Elder Adult at Risk**: as defined in Wis. Stat. § 46.90(br), means any person age 60 or older who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation.

34. **Emergency Medical Condition**: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

    a) Placing the health of the individual in serious jeopardy;

    b) Serious impairment to bodily functions; or

    c) Serious dysfunction of any bodily organ or part.

35. **Emergency Services**: covered fee-for-service inpatient and outpatient services that are:

    a) Furnished by a provider that is qualified to furnish these services under Title 19 of the Social Security Act; and

    b) Needed to evaluate or stabilize an emergency medical condition.

36. **Encounter**: An electronic record of a good, service, or support provided to a participant. The record includes, but is not limited to:

    a) The participant's Medicaid ID assigned by the Department.

    b) The provider's Medicaid ID assigned by the Department.

    c) The nature of the good, service, or support, described by established coding standards.

    d) The authorization under which the good, service, or support was provided.

    e) The date on which the good, service, or support was provided.

    f) The number of units of the good, service, or support provided, and its unit cost. For a service provided by a participant-hired worker, the unit cost is the wage per unit, plus any 7.65 percent employer FICA contribution for non-exempt employees.

    g) The total cost of the good, service, or support provided on that date. For a service provided by a participant-hired worker, the total cost is the amount of wages paid for that service on that date, plus any 7.65 percent employer FICA contribution for non-exempt employees.

    h) The date on which the good, service, or support was billed by the provider.

i) The date on which payment for the good, service, or support was remitted.

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

38. **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 ICA or FEA and advising on what factors to consider when choosing among these options.

39. **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.

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

41. **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 IRIS consultant agency or 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.

42. **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.

43. **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.

44. **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.

45. **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.

46. **Functional capacity**: the skill to perform activities in an acceptable manner.

47. **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.

48. **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.

49. **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.

50. **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.

51. **Home**: a place of abode and lands used or operated in connection with the place of abode.

52. **Hospital**: has the meaning specified in Wis. Stat. § 50.33(2).

53. **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.

54. **Indian**: an individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual:

    a) Is a participant of a Federally recognized Indian tribe; or

    b) Resides in an urban center and meets one or more of these four criteria:

    c) Is a participant of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such participant;

    d) Is an Eskimo or Aleut or other Alaska Native;

    e) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

    f) Is determined to be an Indian under regulations issued by the Secretary;

    g) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

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

56. **Individual Support and Service Plan (ISSP)**: A written plan developed by an IRIS participant and their legal decision maker (if applicable) that lists the IRIS waiver funded goods, supports, and services chosen by the participant to meet their long-term care needs and outcomes; the cost of services; their frequency; and the provider of each service.

Unpaid goods, services, and supports, as well as Medicaid-funded services received, are also listed on the ISSP and the participant's Long-Term Care Needs Plan.

57. **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.

58. **Ineligible Person**: a person is ineligible for enrollment in the IRIS program if the person fails to meet the eligibility requirements specified by the Department, the resource center or income maintenance agency prior to enrollment in the ICA, or if the person determined to be eligible prior to enrollment no longer meets eligibility requirements as determined by DHS, the resource center, or income maintenance agency.

59. **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.

60. **Instrumental Activities of Daily Living** or **IADLs**: management of medications and treatments, meal preparation and nutrition, money management, using the telephone, arranging and using transportation and the ability to function at a job site.

61. **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).

62. **IRIS Budget**: The money necessary to fund an IRIS participant's ongoing services, which excludes one-time and high-cost items. Each participant receives a budget estimate prior to their enrollment in IRIS and said budget is based upon an IRIS participant's needs and can be changed if needed.

63. **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.

64. **IRIS Long-Term Care Needs Panel (LTC Needs Panel)**: The Department's enterprise care management system user interface panel that the IRIS consultant uses to document

the methods by which all the participant's identified long-term care service, and support needs are met. The IRIS consultant documents all the participant's IRIS waiver funded service and support needs within the participant's Individual Support and Service Plan (ISSP). All other identified long-term care needs funded through a different source or natural supports should be documented within the LTC Needs Panel or the ISSP.

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

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

67. **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) appointed under Chapter 54 of the Wisconsin Statutes, a conservator appointed under Chapter 54 of the Wisconsin Statutes, a person designated power of attorney for health care under Chapter 155 of the Wisconsin Statutes or a person designated durable power of attorney under Chapter 244 of the Wisconsin Statutes. 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.

68. **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.

69. **Long-Term Care Facility**: a nursing home, adult family home, community-based residential facility, or residential care apartment complex.

70. **Long-Term Care Functional Screen or LTCFS**: a uniform screening tool administered by certified functional screeners to determine functional eligibility.

71. **Marketing/Outreach**: any communication, sponsorship of community events, or the production and dissemination of marketing/outreach materials from an ICA or 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 IRIS consultant agency, fiscal employer agent, or managed care organization or to disenroll from another IRIS consultant agency, fiscal employer agent, or managed care organization. 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.

72. **Marketing/Outreach Materials**: materials in all mediums, including but not limited to, internet websites, brochures and leaflets, newspapers, magazine, radio, television, billboards, yellow pages, advertisements, other printed media and presentation materials, used by or on behalf of an ICA or 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 ICA or FEA, as well as those materials that are intended to inform on the IRIS program, its policies, or a Contractor's role as an ICA or FEA. Marketing/Outreach Materials also refers to social media postings.

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

74. **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."

75. **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.

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

77. **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.

78. **Monthly Rate of Service (MROS)**: A contractually specified dollar amount paid to an~~d~~ IRIS consultant agency or fiscal employer agent 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 IRIS consultant agency or fiscal employer agent contracted services.

79. **Natural Supports**: individuals who are available to provide unpaid, voluntary assistance to the participant in lieu of paid supports and/or State Plan or home and community-based services (HCBS). They are typically individuals from the participant's social network (family, friends, neighbors, etc.).

80. **Neglect**: the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. "Neglect" does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual's previously executed declaration or do-not-resuscitate order under Wis. Stat. ch. 154, a power of attorney for health care under Wis. Stat. ch. 155, or as otherwise authorized by law.

81. **Outcome**: a desirable situation, condition, or circumstance in a participant's life that can be a result of the support and services provided through the IRIS program. Long-term care outcomes are situations, conditions, or circumstances that a participant and the legal decision maker identifies that maximizes the participant's highest level of independence. This outcome is based on the participant's identified clinical and functional outcomes, as well as their personal experiences. Clinical outcomes relate to an identified need, condition, or circumstance that relates to a participant's individual physical, mental, or emotional health, safety, or well-being, whereas functional outcomes relate to an identified need, condition, or circumstance that results in limitations on the participant's ability to perform certain functions, tasks, or activities and require additional support to help the participant maintain or achieve their highest level of independence, including, but not limited to, assistance with ADLs and IADLs. Participant outcomes should address a participant's ability to maintain and/or establish a living arrangement of their own; maintain and/or obtain community-integrated employment; maintain and/or establish community inclusion; ensure health and safety; building positive relationships; and have control of, and access to, transportation.

82. **Participant**: an individual enrolled in the IRIS program.

83. **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.

84. **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.

85. **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.

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

87. **Physical Disability**: a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, "major life activity" means self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking, and capacity for independent living.

88. **Potential Participant** or **Potential Enrollee**: a person who is or may be eligible to enroll in the IRIS program, but who is not yet a participant.

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

90. **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.

91. **Restrictive Measure**: any type of restraint, isolation, seclusion, protective equipment, or medical restraint.

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

93. **Self-neglect**: means a significant danger to an individual's physical or mental health because the individual is responsible for his/her own care but fails to obtain adequate

care, including food, shelter, clothing, or medical or dental care. See Wis. Stat. s. 46.90(1)(g).

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

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

96. **Subcontract**: means, as defined in 41 CFR § 60-1.3, Any agreement or arrangement between a contractor and any person (in which the parties do not stand in the relationship of an employer and an employee:

    a) For the purchase, sale or use of personal property or non-personal services which, in whole or in part, is necessary to the performance of any one or more contracts; or

    b) Under which any portion of the contractor's obligation under any one or more contracts is performed, undertaken, or assumed.

97. **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.

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

    a) Frail elderly.

    b) Adults with a physical disability.

    c) Adults with a developmental disability.

99. **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.

100. **Urgent Care**: medically necessary care that is required due to an illness or accidental injury that is not life-threatening and will not result in further disability but has the potential to develop such a threat if treatment is delayed longer than twenty-four (24) hours.

101. **Vulnerable/High Risk Participant**: a participant who is dependent on a single caregiver, or two or more caregivers all of whom are related to the participant or all of whom are related to one another, to provide or arrange for the provision of nutrition, fluids, or

medical treatment that is necessary to sustain life and to whom at least one of the following applies:

a) Is nonverbal and unable to communicate feelings or preferences; or

b) Is unable to make decisions independently; or

c) Is clinically complex, requiring a variety of skilled services or high utilization of medical equipment; or

d) Is medically frail.

II. Functions and Duties of the Department

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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 IRIS consultant agency or fiscal employer agent 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, and the IRIS Service Definition Manual; 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, and is encouraged to provide documentation, and the accompanying narrative to explain the documentation. The Department will review the information and a final decision will be rendered within 30 days of receipt of the Contractor's request.

Once a reconsideration decision has been reached, the 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, agencies need to be certified by the Department.

E. Reporting Deadlines

It is expected that the Contractor will meet 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, to include the reason and the deadline they expect to provide the report. The Department will review and approve or deny the request for extension. This request should be submitted prior to the deadline.

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 designated representatives at the Contractor agency 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 plan of correction 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 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; and

d. Eliminate repeated deficient practices.

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. For a fiscal employer agency (FEA), untimely bank reconciliation, 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 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 under part b of this section.

Enhanced fiscal corrective action will include all of the components of fiscal corrective action under part b 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 as described herein, the Contractor may be subject to sanctions as described herein.

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 distribute directly or indirectly through any agent or independent contractor, materials that have not been approved by DHS or that contain false or materially misleading information.

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 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 IV).

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:

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 ICA, FEA, or MCO.

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.

b. 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, by providing a written notice to the other party at least 90 days in advance of the intended date of termination.

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 notify the other party in writing, at least ninety (90) days prior to the proposed date of termination, of its intent to terminate this contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the Contractor's reasonable and necessary costs to end operations and does not include ongoing expenses such as lease payments due after the date of termination.

iii. Changes in Reporting Requirements

If the Department proposes additional reporting requirements during the term of the contract, 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 written notice of termination at least ninety (90) days prior to the proposed date of termination and 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 Contractor will receive written notice of the Department's intent to decertify and terminate the contract 60 days prior to the effective date, to include the reason for termination.

b) The Contractor will have 30 calendar days from the date of receipt of notice to cure the failures or defects established within the notice sent by the Department.

c) If the failures or defects are not cured within 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. Termination for Insolvency, Dissolution, or Cessation of Operations

This Contract may be terminated if the Contractor becomes insolvent, dissolves, or otherwise ceases operations.

2. Contract Non-Renewal

The Contractor or the Department may decide to not renew this contract. In the case of a non-renewal of this contract, the party deciding to not renew this

contract must notify the other party in writing at least ninety (90) calendar days prior to the expiration date of this contract.

3. Transition Plan – Transfer of Participants

   a. After the Department notifies a Contractor that it intends to terminate the contract for failing to carry out substantive terms of this Contract, the Department may do the following:

      i. 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 ICA or FEA.

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

   b. 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 Contractor or MCO.

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

   d. 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.

4. Transition Plan

   In the case of this contract being terminated or there is a decision by either party not to renew this contract, the Contractor shall submit a written plan that receives the Department's approval, to ensure uninterrupted delivery of services to participants and their successful transition to applicable programs (e.g., Medicaid fee-for-service). The plan will include provisions for the transfer of all participant-related information held by the Contractor or its providers and not also held by the Department.

   a. Submission of the Transition Plan

      The Contractor shall submit the plan at one of the following times, depending on which applies: no less than ninety (90) calendar days prior to the contract's expiration when the Contractor decides to not renew the contract; within ten (10) business days of notification of termination by the Department; or along with the Contractor's notice of termination.

   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 ICA or 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.

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.

5. Obligations of Contracting Parties

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

a. 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;

b. Contractor Responsibilities - The Contractor shall be responsible for duplication, mailing, and postage expenses related to said notification;

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

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

6. 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.

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 any agents or employees of the Contractor, 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, said party may so 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), 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 provider 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 agrees to keep participant records and any records necessary to document the extent of services provided to recipients for a period of 7 years pursuant to Record Retention/Disposition Authorization (RDA) 297. If destroyed, records must be destroyed in a confidential manner. Upon request, the Contractor may be required to furnish to the Department, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the provider for furnishing services under the Wisconsin Medicaid Waiver program.
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 provider shall furnish to the Department in writing:
    a. The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers 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 provider;
    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 provider;

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 provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the provider 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 the consent from the Department.

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

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

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

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

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

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

B. FEA-Specific 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. Except personal vehicles driven by consultants and screeners that are used to carry out the requirements of this contract, motor vehicle insurance for all agency-owned vehicles that are used in carrying out this contract, must have a minimum coverage of one million dollars ($1,000,000) per occurrence combined single limit of automobile liability and property damage. It is the employee's responsibility to carry personal auto liability insurance. Recommended minimum limits of personal auto insurance coverage are $100,000 for bodily injury per person, $300,000 for bodily injury per accident when two or more people are injured, and $50,000 for property damage per accident.
4. Professional Liability (malpractice) with a minimum coverage of one million dollars ($1,000,000) per occurrence.
5. Director and Officers liability or equivalent coverage specific to the entity structure.
6. Umbrella coverage; and Employee Dishonesty or Fidelity Bond as a stand-alone policy or included under the entity's Commercial property coverage.
7. 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 (https://www.wdfi.org/) 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 the participants for whom they provide ICA or FEA services without the expressed prior 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 when it is informed by the Department that it has suspended fee-for-service Medicaid payments to the provider because of a credible allegation of fraud.

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

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

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

I. Expansion and Geographic Service Regions

1. The ICA must demonstrate the capacity to provide immediate services to the geographic service regions identified through initial certification and expansion requests. The ICA is required to serve all IRIS program target groups.

2. The ICA must be certified and receiving enrollments for a minimum of 6 months after their first enrollment, without any CAPs or sanctions, before applying for expansion to additional geographic service regions. If a CAP or sanction has been resolved, the ICA must wait 90 days from the date of the resolution letter to apply for expansion.

3. Existing ICAs must identify, in writing to the Department, in which service region it is looking to expand, including the proposed date of expansion. The proposed expansion date must be a minimum of 60 days from the date of the request and with the Department making the final determination on the start date.

    a. When an ICA is expanding, the Department will need to work with the Functional Screen team to ensure systems are adequately prepared and ADRCs to ensure workforce training has occurred prior to options counseling.

    b. The ICA must provide thorough and comprehensive responses to Department inquires as it relates to their agency's proposed expansion.

4. The ICA must demonstrate the fiscal capacity to expand to the proposed geographic service regions identified in the expansion request.

    a. The ICA must demonstrate fiscal stability over the most recent two quarterly financial reporting submissions.

    b. The ICA must demonstrate satisfaction of the working capital and restricted reserve requirements in the most recent two quarterly financial reporting submissions and the ability to satisfy the working capital and restricted reserve requirements in the proposed expansion area.

5. Between 2023 and 2028, the Department is changing the geographic services regions (GSR). Impacted ICAs will need to choose to expand to, or no longer provide services in, the newly configured regions. If an impacted ICA chooses not to expand to the new region affecting their current service area, they will be subject to the appropriate provisions herein, including sanctions, corrective action

for non-compliance, or even termination for cause. The proposed GSR reconfiguration timeline can be found at: https://www.dhs.wisconsin.gov/publications/p03225.pdf.

J. Physical and Localized Presence

1. The Contractor must maintain an office within Wisconsin. Signage must be present and visibly posted to indicate to participants or other visitors of the agency'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 agency's office(s).
   b. The signage must state the name of the IRIS agency.
2. ICA Expectations
   a. ICAs must have a localized presence in each region in which they will operate or provide services. This assures relative proximity to participants, as well as knowledge of the services and providers available in the region.

      Consultant agencies may be asked to supply the county of domicile and the county of assignment for consultant personnel as assurance of said localized presence.
   b. ICAs must identify a location(s) in each GSR and county within the region to conduct meetings with participants when it is not possible to do so in the participant's home.
   c. 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.
3. FEA Expectations
   a. FEAs are not expected to maintain a localized presence in each service region in which they operate but must have at least one office located in Wisconsin. This location must comply with the Americans with Disabilities Act. It must have nearby accessible parking space(s), be easily accessible for persons using assistive devices such as wheelchairs, scooters, or walkers, and have an accessible meeting room with a door to ensure privacy.
   b. FEAs must provide documentation to the Department indicating the number of FEA staff physically based in Wisconsin and the services they will be providing.

K. FEA Customer Service Standards

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

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

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

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

   a. Identifies the Contractor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Contractors must ensure staff answering customer service calls:

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

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

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

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

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

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

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

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

7. Contractors are expected to track calls and contacts received with basic identifying information, including, but not limited to:
    a. Time and date of call or contact
    b. Type of inquiry (e.g. ., phone, written, face-to-face, email)
    c. Caller name and identifying information (e.g. ., MCI ID)
        i. If the caller is not the participant but is seeking information about the participant, Contractors must determine and document the caller's relationship to the participant and verify that a valid, up to date Release of Information is on file for said caller, before any personally identifiable or personal health information is disclosed.
    d. Nature and details of the call or contact
    e. Name of the staff member that received and addressed the caller's concerns or questions
    f. Response given by the staff member
8. Contractors must be capable of producing, upon Department request, at minimum, files or reports that contain summary information on all calls and contacts received:
    a. Daily, weekly, monthly
    b. After hours calls and contacts
    c. Cumulative calls and contacts answered
    d. Total calls abandoned
    e. Abandoned or lost rate percent
    f. Average wait time
    g. Average hold time in queue
    h. Call topic
    i. Average length of calls
    j. Turnaround time to closure

L. 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.

1. 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.

2. 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.

3. 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.

M. Administrative Services Agreements and Subcontracts

Subcontracts and Administrative Service Agreements (ASA) include contracts to fulfil 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 administrative service agreements, as reportable under 42 CFR 455.105, must provide to 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 administrative service agreement;
   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.

N. 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) (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.

O. 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.

P. 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.

Q. 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. ICA Responsibilities

   a. Ensure the participant understands the following:

i. The EVV requirements and EVV's impact on the IRIS program.

ii. Where to find EVV information and resources.

b. Follow up with the participant during monthly contacts to ensure EVV compliance, create EVV risk agreement if needed, and initiate participant disenrollment for EVV non-compliance as outlined in the IRIS EVV Policy.

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

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

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

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

4. 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. Fiscal employer agencies 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. Fiscal employer agencies 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. Fiscal employer agencies 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.

R. 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. 438; 45 C.F.R. 160; 45 C.F.R. 162; and 45 C.F.R. 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 one day 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, 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 background check applications and results for not less than eight years following the end of this calendar year.

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

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

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 shall 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. The Contractor shall also 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.

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.

S. 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/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
1 West Wilson Street, Room 665
P.O. Box 7850
Madison, WI 53707

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: Attorney Laura Varriale
1 West Wilson Street, Room 651
P.O. Box 7850
Madison, WI 53707-7850

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
1 West Wilson Street, Room 672
P.O. Box 7850
Madison, WI 53707

-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 Agreement.

T. Cultural Competency

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.

U. Policy and Procedure Manual

The Contractor must maintain an internal policy and procedure manual consistent with DHS-communicated policy, 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 ICA Policy and Procedures Manual, at minimum, include:
   a. IRIS Consultant staff orientation and training requirements;
   b. Functional screener staff orientation and training requirements
   c. Ongoing training requirements for Consultants and Functional screeners;

d. Internal process for transition between IRIS contractors and adult programs such as Family Care, Family Care Partnership, and PACE;

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

f. Methodology for plan development and updates, to include but not be limited to identification and development of long-term care outcomes, strategies, service authorizations, and primary payer identification;

g. Process for identifying budget mismanagement and the fraud allegation review and assessment process (FARA);

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

i. Reporting and monitoring of participant cost share and financial eligibility;

j. Conflicts of Interest regarding personnel, participants, and service providers;

k. Incident reporting and immediate reportable protocols, including, but is not limited to, the ongoing evaluation of health and safety and identification of abuse, neglect, and/or misappropriation; the initial referral, follow-up, and ongoing actions when working with adult protective services and/or adults at risk;

l. Vulnerable High Risk protocol;

m. Issuance, tracking, and resolution of Notices of Action;

n. Process for preparation and representation at State Fair Hearings;

o. Record Review Remediation procedures;

p. Request for records from participants, legal decision makers, ombudsman, and other agencies;

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

r. IT Guidelines and Requirements;

s. Methodology for addressing, tracking, and resolving complaints and grievance;

t. Fiscal policies and procedures; and

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

v. Electronic Visit Verification, to include staff responsibilities, education to participants, and collaboration with FEAs and workers.

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

2. 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. Criminal and caregiver background check processing (before initial employment, at least every four-years after, and as needed), communication with participant-hired workers, participants, ICAs and/or

IRIS SDPC and have internal controls to prompt four-year background checks.

V. ICA-Specific Staff Expectations

1. The ICA should at a minimum have the following roles:
   a. IRIS Consultant(s),
   b. Long Term Care Functional Screener, and
   c. Long Term Care Functional Screen Liaison.
2. The ICA shall designate one member of their staff to act as the Tribal Liaison to address any tribal-specific questions that may arise. The Tribal Liaison will serve as the main point of contact between the ICA and the Department and the ICA and each tribe for all tribal issues. The ICA must provide contact information for the Tribal Liaison to the Department and to each tribe in Wisconsin
3. IRIS Consultant Expectations

   IRIS Consultants must meet the following criteria:

   a. Option 1:
      i. Possess a minimum of a Bachelor's degree in social work, psychology, human services, counseling, nursing, special education, or a closely related field.
      ii. Have one year of supervised experience working with seniors and/or people living with disabilities.
      iii. Complete all required IRIS orientation and training courses with the ICA.
      iv. Pass a nationwide caregiver criminal history screening pursuant to DHS's policy (http://www.dhs.wisconsin.gov/caregiver/).

   OR

   b. Option 2:
      i. Have a minimum of four years of direct experience related to the delivery of social services to seniors and/or people living with disabilities and long-term care needs in community settings.
      ii. Complete all required IRIS orientation and training courses with the ICA.
      iii. Pass a nationwide caregiver criminal history screening pursuant to DHS's policy (http://www.dhs.wisconsin.gov/caregiver/).
4. IRIS Consultant-specific Training

   The IRIS consultant agency is responsible for developing all training material content;

The IRIS consultant-training curriculum must include, but should not be limited to:

a. An overview of the IRIS program, including the history of the IRIS program, the structure of the program, budget and employer authority, the relationship between IRIS partners, processes of enrollment, processes of program participation, and processes of disenrollment.

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

c. Critical incident reporting

d. Person-centered plan development, including the development of outcomes and supports according to the DHS IRIS Policy Manual (P-00708) and IRIS Work Instructions (P-00708A).

e. Plan Approval

f. Annual financial eligibility requirements and how medical remedial is factored into financial eligibility.

g. Documentation requirements.

h. Conflict of interest, fraud, and other program integrity concerns.

i. IRIS Self-Directed Personal Care (SDPC).

j. Long-Term Care Functional Screen (LTCFS)

k. Record review remediation.

l. The Department's enterprise care management system.

m. Participant-hired worker onboarding, paperwork, authorizations, and participant responsibilities thereof.

n. Approved waiver services and supports, including supports paid for using IRIS funds and the limitations regarding who can provide those supports and services

o. Risk assessment and management, including identifying and helping the participant mitigate risks, including challenging behaviors, medical treatment, falls, environmental hazards, egress issues, and others

p. Needs assessments, including how to assist the participant in identifying their strengths and areas where they need assistance from natural supports, supports from other funding sources, and supports funded by IRIS

q. Complaints, appeals, and grievances, including supporting a participant to file a grievance or an appeal, the existing processes, the roles of IRIS partners, and how to complete the appropriate paperwork

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

s. Other training as requested by DHS

5. Long-term Care Functional Screener Expectations

ICAs must be able to provide participants with ongoing and annual redetermination Long-Term Care Functional Screens (LTCFS). The LTCFS determines functional eligibility for Medicaid waiver programs. Screeners must meet qualifications that ensure knowledge of long-term care needs to ensure reliable and consistent administration of LTCFS.

ICAs must become certified screening agencies by registering with DHS.

a. Long Term Care Functional screeners shall:

i. Be a representative of an ICA with an official function in determining functional eligibility.

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

iii. Successfully complete the online screener certification training course(s) and become certified as a functional screener by the Department. Information on the online web class can be found at: https://wss.ccdet.uwosh.edu/stc/dhsfunctscreen.

iv. Successfully complete all other training requirements, as required by DHS.

b. Certified Screener Documentation

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

c. Administration of the Screening Program

i. Listing of Screeners

Each ICA shall maintain an accurate, complete, and up-to-date list of staff that perform functional screens, as well as certificates documenting that each LTCFS screener has passed the required certification course.

ii. Communications

Each ICA that administers functional screens shall ensure that each screener is able to receive communications from the Department's functional screen listserv(s) (https://public.govdelivery.com/accounts/WIDHS/subscriber/new?topic_id=WIDHS_45).

iii. The ICA's functional screeners may also be IRIS consultants.

6. Long Term Care Functional Screen Liaison Expectations

Each ICA shall designate at least one staff person as "Screen Liaison" to work with the Department in respect to issues involving the screens done by the ICA. This person must be a certified functional screener and, at Department determined intervals, successfully pass the required continuing skills testing. This person's current contact information must be provided to the Department. Screeners shall be instructed to contact the Screen Liaison with questions when they need guidance or clarification on the screen instructions, and shall contact the Screen Liaison whenever a completed screen leads to an unexpected outcome in terms of eligibility or level of care;

The duties of the Screen Liaison are to:

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

b. Contact the Department's LTCFS staff on all screens that continue to have an unexpected outcome after consultation with the screener or that are especially difficult to complete accurately;

c. Oversee new screener mentoring program and train new screeners as listed in 8.a.;

d. Following the Department's quality review of functional screens, the screen liaison will meet with the screener to discuss the results. Subsequently, the screener will make any needed corrections/changes to the screen using established DHS procedures.

e. In regular staff meetings or in individual meetings with the screeners, to discuss/resolve any individual, specific, or agency-wide screening problems identified as a result of continued skills testing (CST) or quality reviews. The screener(s) will follow any recommendations related to improving knowledge or skills in the problem area(s).

f. Review and respond to any quality assurance issues detected by the Department's LTCFS staff and implement any improvement projects or correction plans required by the Department's LTCFS staff to ensure the accuracy and thoroughness of the screens performed by the ICA.

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

h. Ensure that all local screeners have received listserv communications and updates from the Department;

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

j. Act as the contact person for technical issues such as screen security and screener access;

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

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

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

   ii. Meet all other training requirements as specified by the Department.

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

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

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

7. Long-term Care Functional Screener & Liaison Training

   a. New Screener Mentoring and Training

Each ICA that employs newly certified screeners shall have a formal process for mentoring new screeners (that is providing them with close supervision, on-the-job training, and feedback) for at least six months. This shall be described in the ICA's internal policy and procedures documents and shall be made available to DHS upon request. The Department has resources available to supplement ICA training for screeners at: https://www.dhs.wisconsin.gov/functionalscreen/index.htm

i. Screeners shall receive and review copies of the most recent functional screen clinical instructions and functional screen form, diagnosis cue sheet, and other pertinent material.

ii. Screeners must pass the online certification course.

iii. Once certification is received, screeners shall work with the ICA screen liaison to obtain a Wisconsin Web Access Management System (WAMS) ID and obtain access to Functional Screen Information Access (FSIA).

iv. Newly hired screeners shall receive the following training from the screen liaison or an experienced screener:
   a) Observe an experienced screener administer a screen;
   b) Complete practice screens using either the electronic or paper version of the Wisconsin Adult Long Term Care Functional Screen (F-00366):
   c) Be observed by an experienced screener while completing first screens and have their screens reviewed by an experienced screener;
   d) Have the opportunity for discussion and feedback as a result of those observations or reviews;
   e) Instruction on procedures for obtaining verification of diagnoses and health related service;
   f) Getting a completed screen entered in FSIA;
   g) Making changes/corrections on a functional screen.

v. Ongoing and as needed, the screener shall consult with the screen liaison regarding questions related to the proper completion of the functional screen, interpretation of instructions, and any other LTCFS related questions.

b. Screen Quality Management

The ICA shall adopt written standards and procedures to govern quality management for its functional screening activities and will upon request submit those that describe. Activities documented in these policies and procedures shall include:

i. Monitoring Screeners

The methods by which the ICA and Screen Liaison monitor the performance of individual screeners and provide each screener with prompt guidance and feedback. Minimum monitoring methods include:

a) Consultation with the screen liaison on any questions related to how to properly complete the functional screen, interpret instructions, and any other screen related questions.
b) The screener will use a registered nurse (RN) through the IRIS SDPC nurse consultation service for questions regarding health-related services, medications, and diagnosis.
c) Participate in regular staff meetings where information about the functional screen received from DHS, the Functional Screen GovDelivery messages, DHS memos, Q&A documents, and other sources is shared and discussed.
d) Identification of how the accuracy, completeness, and timeliness of annual and change-in-condition screens submitted by screeners will be monitored;
e) Identification of how changes of condition are communicated to screeners;
f) Identification of how changes of condition are communicated between screener, participant, and IRIS Consultant (IC) if the screener when screens are completed by ICA staff other than the IC;
g) Identification of the methods that will be employed to improve screener competency given the findings of the monitoring

ii. Annual Review

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

iii. Monitoring Screens at Agency Level

The methods by which the ICA and Screen Liaison(s) monitor quality of screens at an agency level including the most recent results of the quality management monitoring of functional screen activities.

iv. Remediation

Review and respond to all quality assurance issues detected by the Department's LTCFS staff. The ICA shall correct errors in

evaluating level of care within 10 days of notification by the Department LTCFS staff.

v. Quality Improvement

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

c. Continued Skills Testing (CST)

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

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

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

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

W. 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 target population. All materials produced and/or used by the ICAs and 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. Letters sent to participants from ICAs cannot be provided using electronic media.

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

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;

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

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

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

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

X. Marketing/Outreach Plans and Materials

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

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

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, philosophy of the program.

d. Timeline for Department approval - 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.

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

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

e. 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;

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

iv. 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

f. 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 2.0 (WCAG 2.0).

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 442.302(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);

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

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; and

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

c. Temporary Living Arrangements

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

The IC is responsible for evaluating health and safety, as well as monitoring the participant's progress towards permanent residence.

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 until such time as they are released or disenrolled, as detailed herein. If a participant is incarcerated in a jail, prison, or other correctional facility 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, ensuring that the information is up-to-date and accurate.
2. The ICA must ensure that cost share information assessed by Income Maintenance is entered accurately in the Department's enterprise care management system.
3. The ICA is responsible for assisting a participant with the determination of medical/remedial expenses, as necessary. Reporting changes to the income maintenance agency is the responsibility of the participant.
4. The FEA is responsible for collecting participant's monthly cost share payments, subject to the following Department policies and procedures:
    a. The ICA will send the initial notice to any participant who has a cost share using their agency's designated letter for this purpose.

b. Statements are sent after payments are received, and no later than the 10th of each month.

c. 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.

D. Room and Board

Residential settings where waiver services are furnished to the participant, other than the personal home of the participant, are required to break out the participant's obligation for room and board from the cost of allowable waiver services using the following methodology prescribed by the Department. The participant uses his or her own resources to pay for their room and board obligation.

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

The participant's room and board obligation is the lesser of:

a. The prior calendar year's HUD FMR rental amounts, based on residential type by county, plus the prior calendar year's maximum Supplemental Nutrition Assistance Allocation for one person; or

i. HUD FMR amounts: HUD FMR rents are set at the 40% percentile of surveyed rental costs reflecting modest but reasonable housing, include utilities, vary by county and apartment size, and are updated yearly: https://www.huduser.gov/portal/datasets/fmr.html

ii. SNAP allocation: https://www.dhs.wisconsin.gov/foodshare/fpl.htm

b. The participant's available income for room and board using procedures specified by the Department.

Round HUD FMR, SNAP allocation, and participant's available income down to the nearest dollar. Use the prior calendar year's efficiency rent for owner-occupied Adult Family Homes, the one bedroom rent for corporate-operated Adult Family Homes and Licensed Community-Based Residential Facilities, and the two-bedroom rent for Residential Care Apartment Complexes. Use the HUD FMR amount for the county where the member lives. For a participant residing in a shared room, divide the HUD FMR by two and add the maximum SNAP allocation.

c. To calculate the amount of income the participant has available for room and board, the following calculations must be used:

Deduct from the participant's gross monthly income:

i. Health insurance premiums, defined in MEH 28.6.4.4;

ii. Discretionary income allowance of $100 for basic living expenses;

iii. Spousal income allocation, defined in MEH 18.6;

iv. Income used for supporting others, defined in MEH 15.7.2.1;

v. Expenses associated with establishing and maintaining a guardianship, defined in MEH 15.7.2.3;

vi. Court ordered fees and payments, defined in MEH 15.7.2.3;

vii. Garnishments;

viii. Deductions from unearned income, including IRS and SSA paybacks;

ix. Medical and remedial expenses, defined in MEH 15.7.3; and State and federal income taxes.

2. *Determining the Participant's Available Income*

The available income the participant has to pay for room and board, is determined using procedures specified by the Department. The room and board obligation calculation is not pro-rated for partial months.

3. *Sharing Information with Income Maintenance*

The ICA shall inform the income maintenance agency of the room portion of the participant's room and board obligation. The room portion is always the participant's obligation minus the maximum SNAP allocation (which is the board portion). That information may be used by income maintenance to determine any allowable excess housing costs that may reduce the participant's cost-share.

VI. Program Enrollment

A. Referral Process

1. When a participant chooses IRIS, the ADRC representative will provide the participant with the program information. This material is provided to the ADRCs by DHS to ensure consistency across all ADRCs.
2. Once the participant chooses an ICA and FEA, the ADRC representative facilitates the referral process by submitting a referral packet to the ICA the participant has chosen. Immediately upon creating the participant's record in the Department's enterprise care management system, the ICA must notify the FEA of the referral.
3. ICA and FEA transfers are subject to IRIS Program Policy.
4. Contractors are required to assist participants, other Contractors, the Department, and/or other agencies, with efficient, accurate, and unbiased transfers between agencies.
5. Contractors must adhere to documented IRIS Program Policies and Work Instructions regarding transfers as well as the supplemental resources of the Enrollment and Disenrollment Process Desk Aid for Publicly Funded Long-Term Care Programs (P-02915) and the Adult Long-Term Care Programs: Enrollment and Disenrollment Resource Guide (P-02997), incorporated by reference herein
6. ICA Transfers
    a. If an IRIS participant or their legal decision maker wants to change ICAs, the ICA is responsible for directing the participant or their legal decision maker to their local ADRC to initiate that change.
    b. After a participant transfers to a new IRIS consultant within the same ICA, reassignment of the participant in the Department's enterprise care management system to the new IRIS consultant should be completed within one business day of the change.
    c. When an ICA is notified by an ADRC that a participant is transferring to another long-term care program, the ICA needs to enter the IRIS disenrollment date within two business days of receiving the disenrollment or transfer form.
7. FEA Transfers
    a. The initial FEA will provide the new FEA with all necessary information regarding the participant and will ensure the participant's successful transfer between FEAs.
    b. Participants may request to transfer FEAs at any time, transfers will take effect pursuant to the FEA transfer calendar (F-02239).

8. 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:

   ForwardHealth Provider Service Call Center:
   1-800-947-9627

B. Voluntary Enrollment

Enrollment in the IRIS program is a voluntary decision on the part of the applicant who is determined to be eligible. The Department does not guarantee any minimum enrollment level. Individuals must make the choice to enroll in IRIS, over other adult long-term care programs; 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.

C. Service Timeline Expectations

The Enrollment and Orientation period is intended to take place 1-60 days from the referral date, to include the following required actions and deadlines:

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

D. Enrollment and Orientation Services

ICAs are responsible for enrolling participants in the program as well as providing orientation services. Orientation includes an introduction to the participant's role and responsibility in the IRIS program and development of the Individualized Support and Services Plan (ISSP).

1. Welcome Call & IRIS Consultant Selection

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

   b. The ICA will contact the individual within three business days after receiving the participant's referral packet to assist the participant in choosing a consultant.

i. The ICA should obtain information from the participant about special needs or preferences and, in turn, provide the participant with at least three available consultants who are most suited to meet the participant's specified needs and provide IRIS consultant biographies, in the DHS required format.

ii. If the participant prefers to have a consultant chosen on his or her behalf, then the participant is assigned an IRIS consultant during this welcome call based on information provided by the participant to the ICA.

iii. If the participant does not identify a preferred consultant within three business days of the welcome call, then on the fourth business day, the ICA will notify the participant of the agency-selected consultant and notify the participant they can change consultants at any time, and for any reason. The ICA will advise the participant of the procedure to change consultants at this time.

iv. In addition to IRIS consultant selection, the welcome call will include a brief overview of the immediate next steps and the steps of the enrollment and orientation phase. After the welcome call, the appropriate ICA representative will schedule the initial enrollment and orientation meeting between the IRIS consultant and the participant.

2. Enrollment and Orientation Meeting

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

During this meeting, the consultant shall, at minimum:

a. Provide a review of the annual functional and financial eligibility requirements, and the role of the participant in maintaining their eligibility for Medicaid and IRIS.

b. Provide the participant with the amount of their IRIS individual budget allocation.

c. Provide a printed copy of the IRIS Participant Handbook (P-01008) to the participant.

d. Discuss the required ICA service levels, including the reasons for and the process by which DHS may require an increase in ICA services, such as with a vulnerable high-risk designation.

e. Provide information related to the ISSP, including allowable goods and services, planning tools, and available community resources.

f. Ensure the participant understands that they must be available to speak with and/or meet with their IRIS consultant.

g. Discuss the benefits, responsibilities, and alternatives to serving as the employer of record (e.g., hiring a vendor).

h. Review the IRIS consultant's contact information, contact information for the participant's chosen ICA and FEA, and contact information for the IRIS Call Center.

i. This information should be documented in front of the Participant Education Manual, and updated throughout the year, as needed when there are changes in consultant or Contractor.

ii. The contact information for the IRIS Call Center shall be pointed out in the IRIS Participant Handbook.

i. A review of additional required documentation for enrollment and obtain requisite participant signatures, as required by IRIS Policy.

E. Individual Support and Service Plan Development

1. IRIS consultants are required to provide the tools, resources, and information to assist the participant in making informed planning decisions about long-term care services and supports. The participant-identified outcomes lead to the development of an Individual Support and Service Plan (ISSP), based on the participant's assessed long-term care needs.

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

   Plan development is done in accordance with the IRIS participant's identified long-term care needs and outcomes. Based on this, the ICA selected by the person must:

   a. Assist the participant in completing all required and/or applicable assessments, including but not limited to, risk, behavior, and needs assessments.

   b. Utilize discussion with the participant regarding long-term care needs and life goals, all assessments, LTCFS, available medical records, and other available pertinent information to assist the participant in identifying participant-centered outcomes.

   c. Assist the participant to identify natural supports and other resources outside the IRIS program that may assist in meeting his or her needs.

d. Assist in the identification of long-term care strategies to accomplish their desired outcomes.

e. The ICA is responsible for the review and approval of the ISSP in accordance with IRIS Program Policy (P-00708) and IRIS Work Instructions (P-00708A).

f. The IC is responsible for completing the ISSP within 30 days of the enrollment and orientation meeting. If delays arise, the ICA shall notify and work with the Department towards a timely resolution, as necessary.

g. The IC is responsible for monitoring the plan.

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

i. The participant's person-centered outcomes, and the method by which progress towards meeting this outcome will be measured.

ii. The services and supports, covered by natural supports, other funding sources, and the IRIS program.

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

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

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

vi. Mitigation of any issues of conflict of interest.

vii. Any required cost share or medical remedial costs.

i. The IRIS consultant must complete the participant's Long-Term Care Needs Panel (LTC Needs Panel) during the completion of the ISSP. The LTC Needs Panel is accessible to IRIS consultants within the Department's enterprise care management system. The IRIS consultant documents all the participant's IRIS waiver funded service and support needs within the participant's ISSP. All other identified long-term care needs funded through a different source or natural supports should be documented within the LTC Needs Panel or ISSP.

3. Service Authorizations

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

b. Each service authorization must include:

i. Participant name

ii. Provider/employee name
iii. Start date
iv. End date
v. Unit of measure for the service or support
vi. Frequency of the service or support
vii. Cost per unit of service or support

F. Orientation Service Level Expectations

1. All new or re-enrolled IRIS participants are required to receive the orientation service level for the initial 90 days after plan implementation. The orientation service level requires the ICA to maintain contact with the participant to ensure that the participant builds a basic foundation and understanding of:
   a. Policy and procedures of the IRIS program
   b. The participant's role and responsibilities within the IRIS program;
   c. The process to get help, as needed; and
   d. A clear understanding of the ICA's role and responsibilities.
2. An Orientation and Enrollment Checklist is available for IRIS consultants to utilize during the first 90 days of enrollment to ensure that all required topics of discussion are addressed.
3. Participants are welcome to contact the orientation consultant or IRIS consultant as often as needed and the consultant will address their concerns and questions.
4. The minimum requirements for the ICA, during the orientation service level phase, include:
   a. A biweekly phone conversation with the IRIS participant to discuss any questions, concerns, and experiences with the IRIS program.
   b. Monthly, in-person conversations with the IRIS participant to discuss any questions, concerns, and experiences with the IRIS program.
   c. At least one in-person conversation with the participant, in the IRIS participant's residence.
   d. Provide a printed copy of the IRIS Participant Handbook (P-01008) to the participant.
   e. Participant Education Manual
      i. Review of all chapters and content in the IRIS Participant Education Manual (P-01704) and requisite completion of IRIS Participant Education Manual – Acknowledgement (F-01947).

ii. All topics included in the manual must be reviewed with the participant during orientation.

iii. Completion of the Budget Amendment Education Participant Education form (if applicable) (F-01205B).

iv. Completion of the One-Time Expense Participant Education form (if applicable) (F-01205C).

f. A review of the processes and paperwork for hiring and terminating participant-hired workers and vendors. This should include an explanation of requirements related to completion and submission of timesheets.

g. A review of the processes and paperwork for hiring guardians and other legal representatives as participant-hired workers.

h. A discussion regarding compliance with IRIS Program policy and possible disenrollment consequences.

i. Provision of participant training to include an understanding of requirements to act as an employer for participant-hired workers, including the obligation to train, supervise, and/or terminate workers.

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

G. Disenrollment

The ICA shall comply with the following requirements and use Department issued forms related to disenrollment.

1. Processing Disenrollments

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

a. That the ICA is not directly involved in processing disenrollments although the ICA shall provide information relating to eligibility to the income maintenance agency;

b. That enrollments and disenrollments are accurately entered in ForwardHealth interChange so that correct monthly rate of service payments are made to the ICA and 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 ICA, FEA, and other service providers for claims processing; and

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

2. Contractor Influence Prohibited

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

3. Types of Disenrollment

a. Participant-Requested/Voluntary 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 voluntary 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 as soon as possible, but this notification will be no later than one (1) business day following the participant's decision to disenroll. The ADRC will process the disenrollment.

b. Disenrollment Due to Loss of Eligibility

The participant will be disenrolled if he/she loses eligibility. The ICA is required to notify the income maintenance agency when it becomes aware of a change in a participant's situation or condition that might result in loss of eligibility.

Participants lose eligibility when the participant:

i. Fails to meet functional eligibility requirements;

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

iii. Fails to meet financial eligibility requirements;

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

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

vi. If the participant moves into a geographic service region not served by the ICA, the ICA must inform the participant that they will need to contact the ADRC, or Tribal ADRS if applicable, in the new

county of residence to enroll with another ICA or another long-term care program. The ICA must communicate the move to the new geographic service region to the participant's current ADRC, or Tribal ADRS if applicable, according to program policy. If the participant does not choose a new ICA, the ICA must disenroll the participant from the program according to program policy.

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

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

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

x. Dies.

c. Program-Requested Disenrollment for Cause

When requested by the ICA, a participant may be disenrolled in accordance with the IRIS Policy Manual and Work Instructions, if:

i. The ICA is unable to assure the participant's health and safety.

ii. The participant failed to complete a functional screen or sign their ISSP.

iii. The participant is no longer accepting services.

iv. The participant has been found to have mismanaged or abused their employer authority or budget authority.

v. The participant is out of compliance with IRIS Policy.

vi. The ICA may not request a disenrollment if the participant exhibits uncooperative or disruptive behavior that results from his/her special needs with the following exception:

a) Due to the participant's uncooperative or disruptive behavior, the participant's continued enrollment in the IRIS program seriously impairs the ICA's ability to verify health and safety of the participant or others.

VII. Consulting Services

A. Service Levels

1. DHS requires cost-neutral consulting models. The Contractor agency will already have provided clear descriptions of the roles of each type of consultant in the certification application.
2. All ICAs will collaborate with the IRIS participant throughout their participation in the program, to resolve any issues that may arise in which the participant needs assistance, such as changes in service plan, change in living environment, and provider or employee conflicts.
3. ICAs have the option of utilizing IRIS consultants and/or orientation consultants in the orientation phase, when familiarizing the participant with program responsibilities and requirements.
4. Regardless of the model under which the ICA operates, the ICA must ensure participants receive the correct level of consulting services.
5. Only an IRIS consultant or IRIS consultant supervisor can perform and complete monthly, quarterly, or annual visits.
6. After the orientation phase, the participant and the IRIS consultant must have a conversation discussing the participant's level of confidence, comprehension, and security in self-directing their long-term care support needs within the IRIS program.
    a. The orientation consultant or IRIS consultant may offer their assessment of the participant's orientation to the program.
    b. If, after this conversation, the participant requests, or it is mutually agreed upon, that the orientation level continue as they become familiar with the IRIS program, then the ICA is required to extend this service level an additional 90 days.
7. ICAs should note that participant life events including, but not limited to, a change in condition, seeking employment, moving, plan updates and amendments, and new or changing employees, are all considered naturally occurring life events and part of the standard ICA service delivery model required of all ICAs.
8. The ICA must uniquely adjust the level of service required for each participant.

B. Competency Standards for IRIS Consultants

The ICA shall utilize the competency standards cited below when hiring and training their consultants. The ICA shall provide or arrange for training to assure that ICA employees meet competency standards in the following areas:

1. Knowledge of long-term care services and supports, IRIS program governing documents (e.g., policy and work instructions), and available IRIS-funded services and supports.

2. Knowledge of the principles of self-direction, self-determination, person-centered planning, budget authority, employer authority, and Medicaid eligibility;
3. Knowledge, experience, and understanding of working with IRIS target group populations and the customer service-driven role the consultant plays with regards to self-direction and empowerment;
4. Knowledge of IRIS fiscal employer agents' roles and responsibilities;
5. Monitor the health and safety of IRIS participants through the identification of risks and concerns, completion of critical incident reporting, and supporting participants after said incidents to ensure risks have been mitigated;
6. Capacity to create and maintain thorough, unbiased, accurate, well-written, and timely records and case notes related to each participant for whom the consultant is responsible;
7. Ability to educate participants on program responsibilities, as well as act as a resource on an ongoing basis regarding program policy and the completion of necessary forms;
8. Ability to work with agency peers, partner agencies, fiscal employer agents, and Department staff, as necessary, in a professional, collaborative, problem-solving driven atmosphere;
9. Possess interpersonal skills, display professionalism, and take accountability for the responsibilities of an IRIS consultant; and
10. Core professional competencies, such as the abilities to:
    a. Manage time effectively and multitask,
    b. Identify and gather key information through active listening and effective communication,
    c. Problem solve and assist with the implemented solution(s),
    d. Use proper grammar, spelling, proof reading, and other written communication skills in their interactions and recordkeeping,
    e. Utilize basic computer functions surrounding the internet and word processing, with the capacity to learn the Department's enterprise care management system, and
    f. Complete mathematical calculations, as necessary, with regard to participant budget and expenses.
11. Knowledge of how to identify, assist, and make referrals for vulnerable participants, abuse, neglect, and/or misappropriation.

C. Ongoing Service Level Requirements

The ICA service levels described herein are required for all IRIS participants to ensure proper orientation to the IRIS Program and ongoing consultant service level in the program. However, ongoing consultant services provide a level of service to a participant unique to their personal preferences and needs to maximize self-direction in the IRIS Program. The participant and the ICA develop an appropriate level of consultant services

to achieve the participant's long-term care outcomes. Regardless of the service level developed, the participant may initiate as many contacts as needed.

Activities occurring during ongoing consultant services include plan updates, annual recertification of functional eligibility by LTCFS screeners, annual completion of financial eligibility, completion of any change of condition assessments, resolving day-to-day issues, and supporting the participant's long-term care needs and outcomes be met through the IRIS Program.

1. Minimum Service Requirements

   The ongoing level of service is the minimum service level required for all program participants after completion of the orientation phase. The minimum ICA service requirements, during the ongoing service level, include:

   a. Monthly phone conversation with the participant, either telephonic or live video contact.

   b. A minimum of one in-person visit quarterly.

   c. Annually, a minimum of one in-person visit must take place in the participant's home.

   d. Respond to all inquiries and requests made by the participant in a timely manner, regardless of the participant's chosen level of IRIS consultant involvement.

   e. Completion of the annual plan review per IRIS Policy and Work Instructions.

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

   g. Ensuring that all services on the plan are being implemented to meet the participant's long-term care needs.

   h. Annual Participant Education Manual Review

      i. Review of all chapters and content in the IRIS Participant Education Manual (P-01704) and requisite completion of IRIS Participant Education Manual – Acknowledgement (F-01947).

      ii. Completion of the Budget Amendment Education Participant Education form (F-01205B), if applicable.

      iii. Completion of the One-Time Expense Participant Education form (F-01205C), if applicable.

   i. Completion of the Long-Term Care Functional Screen Level of Care Re-determinations.

      i. Functional Eligibility Redetermination

Once enrolled, the ICA is responsible to assure that all participants have a current and accurate level of care as determined by the Long-Term Care Functional Screen. The ICA shall develop procedures to assure that all participants have a current and accurate level of care as determined by the LTCFS. Level of care re-determinations may only be completed by an individual trained and certified to administer the LTCFS. This includes, at minimum, an annual re-determination of level of care. It may also include a post-enrollment redetermination shortly after enrollment or a redetermination necessitated by a change in the participant's condition.

ii. Post-Enrollment Re-Determination

The ICA may re-determine level of care for a new participant shortly after enrollment if the ICA believes that different or additional information has emerged as a result of the initial plan development.

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

iii. Annual Re-Determination

An annual re-determination of level of care shall be completed within 365 days of the most recent functional screen. If the level of care re-determination is not complete in the designed timeframe, the ICA is required to inform the income maintenance agency of the lack of functional eligibility determination. Participants will lose eligibility if the redetermination is not done timely.

iv. Change of Condition Re-Determination

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

2. Ongoing Service Level Requirements

In conjunction with the ICA service level requirements, IRIS consultants (ICs) are responsible for providing a unique level of ICA services to ensure participants effectively self-directed their services, based on their assessed needs, and that they understand their responsibilities. The services ICs must provide include, but are not limited to:

a. Discuss assessed needs and life goals, all assessments, functional screen results, available medical records, and other available pertinent information to support participants in the identification of participant-centered outcomes.

b. Assist in the development, implementation, and updating of the ISSP to ensure access to goods, services, supports, and to enhance success with self-direction.

c. Ensure ISSP for each participant includes the following:

   i. The participant's long-term care outcomes and purpose for requesting the good or service, as well as the method by which progress towards meeting this outcome will be measured.

   ii. The services and supports covered by natural supports, other funding sources, and the IRIS program to address the needs and outcomes of the participant as determined through an assessment and person-centered planning process.

   iii. The 24-hour backup plan for services that affect the health and safety of participants.

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

d. Signatures are required for any plan changes. Per Wis. Stat. § 137.11(8) an "electronic signature" means an "electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record."

e. Assist the participant with quality assurance activities.

f. Assist the participant in ensuring all services and supports are arranged, to include completion of all hire required paperwork, to begin in conjunction with the ISSP service authorization dates.

g. Ensure the participant's requirements for training of participant-hired worker(s)/service provider(s) are documented in the IRIS Participant Education Manual: Acknowledgement.

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

i. Assist the participant in managing the service plan budget by reviewing their budget statement.

j. Monitor, report, and address issues of budget mismanagement and/or abuse, conflict of interest, and health and safety issues.

k. Assist the participant and legal decision maker to develop and implement any behavior support plans and restrictive measures applications in accordance with DHS policy and the Wisconsin Restrictive Measures Guidelines and Standards.

l. Provide ongoing oversight of the participant's understanding of acting as an employer, the IC may also provide guidance, feedback, and act as a resource to the IRIS participant, as it relates to PHW-related functions. However, ICs are not a supervisor for participant-hired workers.

m. Assist the participant to arrange for participant-specific training of the participant-hired worker(s)/service provider(s) in circumstances where the participant is unable to provide the training.

n. Use provided Departmental reports and resources to ensure the participant understands and completes requirements for functional (LTCFS) and financial eligibility on an annual basis.

o. In the event of a change of condition, assist the participant in arranging to have an updated LTCFS.

p. Assist in the mitigation of any issues of conflict of interest.

q. Ensure participants understand their responsibility regarding cost share, if applicable.

r. Address and record all incidents and immediate reportables according to policy.

s. Make referrals to Adult Protective Services agencies, as needed, to address immediate or ongoing health and safety concerns.

t. Understand the role of the SDPC registered nurse(s) with regard to oversight, nurse consultation, and participant health and safety.

u. Assist DHS in implementing DHS's defined employment initiatives by assisting participants with employment needs and collecting data from participants as requested by DHS.

v. Refer participants who are seeking to transfer ICA or FEA to their local ADRC.

w. Regularly provide information on IRIS Program changes or updates.

x. The IC is responsible for routinely discussing multiple aspects of the participant's plan and ongoing enrollment in the IRIS Program.

y. It is the ICAs responsibility to inform participants about medical and remedial expenses (MRE), assist with the completion of the MRE Checklist, and submit the MRE total amount to income maintenance (IM). During program enrollment, annual review and any MRE reported change, discuss, review, and verify MRE documentation.

3. Monthly Contact Requirements

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

      The monthly contact with the participant must be either telephonically or by live video. Communications by email or text do not meet the monthly contact requirements.

      Topics of conversation for monthly contact shall include, but are not limited to:

      i. A review and documentation of progress on implementation of the ISSP.

      ii. Documentation of any usage and effectiveness of the 24-hour backup plan.

      iii. A review budget spending patterns, including an analysis of any over- and under-utilization of services.

      iv. Assessment of the quality of services, access to supports, and functionality of goods in accordance with the quality assurance section of the ISSP and any applicable IRIS service standards.

      v. A review of any incidents or events impacting the participant's health, welfare, or ability to fully access and utilize support as identified in the ISSP.

      vi. A review any conflict of interest issues and any health or safety issues.

      vii. The progress towards achieving outcomes, including employment if applicable.

      viii. If applicable, review EVV requirements and compliance.

   b. Other concerns or challenges as noted by the participant or legal decision maker.

4. Accuracy of Information

   The ICA shall not knowingly misrepresent or knowingly falsify any information in the participant's record, including but not limited to the LTCFS, the ISSP, or the case notes. The ICA shall also verify the information is obtained from or about the individual with the individual's medical, educational, and other records as appropriate to ensure its accuracy.

D. Increased Service Levels

1. Certain actions or activities involving the IRIS participant may demonstrate the need for an increased ICA service level. DHS has an obligation to ensure the

health and safety of IRIS participants, while ensuring the highest quality of service and integrity of the IRIS program. If any of the following circumstances occur, an increased level of consulting service from the ICA will be required:

a. Evidence of abuse or neglect,

b. Two or more related critical incidents in a rolling 12-month period,

c. Evidence of budget mismanagement or abuse,

d. Evidence of employer authority mismanagement or abuse,

e. Routine and consistent errors in timesheet reporting and submission,

f. 40-hour health and safety monitoring, as defined in IRIS Policy and IRIS Work Instructions,

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

i. The definition of vulnerable/high risk, as defined in Definitions, is a participant who is dependent on a single caregiver, or two or more caregivers all of whom are related to the participant or all of whom are related to one another, to provide or arrange for the provision of nutrition, fluids, or medical treatment that is necessary to sustain life and to whom at least one of the following applies:

a) Is nonverbal and unable to communicate feelings or preferences; or

b) Is unable to make decisions independently; or

c) Is clinically complex, requiring a variety of skilled services or high utilization of medical equipment; or

d) Is medically frail.

ii. If a participant meets the criteria as a vulnerable high-risk participant (VHRP), the ICA shall implement additional oversight including all of the following:

a) Every other month in-person visits with the participant.

b) In-person visits in the participant's home once every 6 months, which may be combined with every other month in-person visit.

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

Determination Form (F-02879) and upload it into the Department's enterprise care management system. The VHRP Determination Form (F02879) must be completed at a minimum once per year or when there is a change in condition of the participant.

2. Increase in Service Level

If one of the circumstances noted above occurs, then the ICA is responsible for explaining to the participant the reason for increased consulting services.

DHS will work with the ICA and the participant to develop a level of service appropriate to address and potentially resolve the situation. In certain circumstances, DHS may mandate an increased level of ICA services.

a. All increases in service level require the following information:

i. A description of the circumstances requiring the increased level of ICA services, including type, frequency, and severity of the identified circumstances.

ii. The number of monthly or weekly phone conversations to address the identified issue.

iii. The number of monthly or weekly face-to-face conversations to address the identified issue.

iv. The proposed duration of the recommended increased level of ICA services.

v. A description of the other solutions attempted to address and resolve the circumstances and a notation that those attempts were unsuccessful.

E. Participant Provider Service Agreement Language

The ICA must ensure participants have a participant provider service agreement with all required providers for all agency provided services. The participant provider service agreement shall be in writing; shall include the provisions of this subsection; shall only include approved waiver services and supports paid for using IRIS funds; and shall include and comply with any general requirements of this contract that are appropriate to the service. All amendments to the provider agreements shall be in writing and signed and dated by both the provider and the participant.

1. Requirements

Except for specific areas inapplicable in a specific participant provider service agreement, at a minimum, a participant provider service agreement shall include, but is not limited to, the following requirements:

a. Participant Provider Service Agreement

The participant and provider entering into the agreement are clearly defined.

b. Service(s)

The participant provider service agreement clearly delineates the scope of service(s) being provided, arranged, or coordinated by the provider.

c. Compensation

The participant provider service agreement specifies rate(s) for purchasing service(s) from the provider.

d. Term and Termination

The participant provider service agreement specifies the start date of the participant provider service agreement and the means to renew, terminate and renegotiate. The participant provider service agreement specifies the participant's ability to terminate and suspend the participant provider service agreement based on quality deficiencies.

Nothing herein shall impair the right of either party to terminate a service(s) contract as otherwise specified therein.

e. Participant Incidents

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

f. Notices

The participant provider service agreement specifies a means and a contact person for each party for purposes related to the participant provider service agreement (e.g., interpretations, provider agreement termination).

g. Certification and Licensure

The provider agrees to provide applicable licensure, certification and accreditation status upon request of the ICA and/or FEA and to comply with all applicable regulations.

h. Sanctions/Criminal Investigations

The provider must notify the participant of any sanctions imposed by a governmental regulatory agency and /or regarding any criminal investigations(s) involving the provider.

i. Cooperation with Investigations

To the extent permitted by law, the provider agreement shall require the provider to fully cooperate with any participant-related investigation conducted by APS, the Department, the Federal Department of Health and

Human Services, CMS, law enforcement, or any other legally authorized investigative entity.

2. Required Providers

Participants shall have a written participant provider service agreement with all required providers for all agency provided services. Providers of the following IRIS waiver services are required providers:

a. Adult Day Care
b. Daily Living Skills Training
c. Day Services
d. Prevocational Services
e. Respite
f. Supported Employment - Individual
g. Nursing Services
h. Consultative Clinical and Therapeutic Services for Caregivers
i. Consumer Education and Training
j. Counseling and Therapeutic Services
k. Housing Counseling
l. Interpreter Services
m. Residential Services (1-2 Bed AFH)
n. Residential Services (Other)
o. Support Broker Services
p. Supported Employment - Group
q. Supportive Home Care
r. Training Services for Unpaid Caregivers
s. Vocational and Futures Planning

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

Contractors shall make reasonable efforts to ensure that their participants are free from abuse, neglect, self-neglect and exploitation.

1. Policies and Procedures

Contractors shall have policies, procedures, protocols, and training to ensure that staff:

a. Are able to recognize the signs of abuse, neglect, self-neglect, and exploitation as defined in Wis. Stats. §§ 46.90 and 55.01.

b. Identify participants who may be at risk of abuse, self-neglect and exploitation and in need of elder adult/adult-at-risk or adult protective services (EA/AAR/APS).

c. Report incidents involving participant abuse, neglect, self-neglect and exploitation as provided in Wis. Stats. § 46.90(4)(ar) and § 55.043(1m)(br).

d. Refer participants at risk or in need of services to the appropriate EA/AAR/APS agency.

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

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

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

2. Memorandum of Understanding (MOU)

The ICA is responsible for the following MOU requirement:

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

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

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

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

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

G. IRIS Consultant Capacity Expectations

1. ICAs shall ensure that the number of participants assigned to each IRIS consultant does not exceed the consultant's capacity to provide the highest quality of consulting services.

a. The ICA must ensure that all required consultant functions are met and adequate time exists to provide the necessary ICA services, unique to each participant.

b. The number of participants for each consultant shall be determined by the ICA based on the skill level of the consultant and the unique needs of the individual participant.

c. The ratio of consultant to participants must not exceed 1:50.

H. Service Authorization Accuracy

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

2. Service authorizations must be:

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

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

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

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

4. Effective April 1, 2024, for any individual support and services plan based upon a completed functional screen with eligibility determined on or after January 1, 2024, if an IRIS consultant creates service authorizations in excess of the total amount permitted for the duration of the participant's individual support and services plan or prior authorization for self-directed personal care, and payments are made under those authorizations in excess of the amount permitted, the Department may recoup some or all of the portion of those payments in excess as withholding(s) from the ICA's MROS payments, unless the portion was either:

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

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

5. The Department will provide the ICA with at least 45 days' notice of a recoupment under this section. The notice will include detail for each participant on the total amount permitted, excess amount authorized, and amount spent used to determine the recoupment. If the ICA believes part or all of the recoupment is inaccurate in total amount(s) permitted and/or excess amount(s) authorized, the ICA may submit a rebuttal within 30 days of the notice given. The rebuttal must include all supporting information the ICA believes will demonstrate the portion

of the recoupment included in the rebuttal is inaccurate. The Department will delay that portion of the recoupment until a determination is made on the rebuttal. The Department will determine whether or not the rebuttal is sustained based upon the supporting information provided by the ICA; if the rebuttal is sustained then that portion of the recoupment will not be made.

I. Self-Directed Personal Care

The Department contracts with an agency for IRIS self-directed personal care (SDPC) oversight and nurse consultation services. Contractors are responsible for adhering to the IRIS Policy and Work Instructions dedicated to IRIS SDPC, as well as the following specific expectations.

1. ICAs are responsible for:
    a. Training all new personnel initially and again annually on the IRIS SDPC option using the curriculum developed by the SDPC Oversight.
    b. Adding SDPC Prior Authorization to the Individual Support and Service Plan (ISSP) and stop any authorizations within 48 hours of disenrollment from IRIS SDPC services.
    c. Utilize the IRIS Self-Directed Personal Care Guide, provided by the oversight agency, to ensure participants qualify for IRIS SDPC prior to making a referral. A registered nurse at the oversight agency will complete the Personal Care Screening Tool to determine a participant's personal care hours if they are deemed eligible.
    d. Ensuring that the hours ordered by the physician and authorized by IRIS SDPC agency match the amount indicated on the plan.
    e. Informing the IRIS SDPC nurse consultant every time a long-term care functional screen results in skilled nursing care being added to the participant's ISSP.
    f. Making collateral contact with the IRIS SDPC registered nurse when completing the long-term care functional screen (LTCFS) for participants with IRIS SDPC (or MAPC) to verify changes to ADLS. This also ensures that the LTCFS is tied to the PCST if a change in personal care hours and cares may be impacted. If the ICA is contacted regarding a discrepancy between the PCST and the LTCFS, the ICA should work with the agency administering the PCST to resolve the issue.
    g. Informing the SDPC Registered Nurse (RN) when any of the following occur:
        i. Health-related critical incident report is completed;
        ii. Participant relocates;
        iii. A health-related risk agreement is identified or completed;
        iv. Health-related program integrity issues;

v. Skilled services in the home;

vi. Institutionalization (e.g., hospital, nursing home, prison, etc.);

vii. Participant is traveling out of state;

viii. Participant dies;

ix. Participant has experienced a change in guardian or legal representative;

x. Participant has been issued a Notice of Action for disenrollment;

xi. Participant has no workers;

xii. Adult Protective Services has been engaged/contacted;

xiii. Participant has disenrolled from the program; or

xiv. Any other health and safety issues that would impact services or care.

h. Completing the IRIS Self-Directed Personal Care Disclosure Statement (F-01258), when applicable per IRIS Policy.

2. FEAs are responsible for:

a. Ensuring that all personal care services being paid to workers are only for those participants enrolled in IRIS SDPC. FEAs should look at the certification period and any holds in place to ensure that IRIS SDPC remains current and authorized.

b. Paying only for those hours that are authorized.

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

d. Ensuring that no IRIS SDPC RNs or representatives are paid for providing IRIS SDPC services.

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

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

If a participant has SDPC, that RN may clarify needed information for cares or needed DME or other related services and obtain physician orders for personal

care services. IRIS Nurse Consultants should be involved when someone does not have an SDPC RN involved in their care when clarification is needed or required.

4. Discharge Planning

If a participant is being discharged from a hospital or other institution, that agency or institution's discharge planner needs to work directly with the participant or legal decision maker. Neither IRIS consultants, nor IRIS SDPC RNs are tasked with case coordination for participant discharge. Neither ICs, nor IRIS SDPC RNs should take on the duties of discharge planning, but rather are responsible for supporting the participant or their legal decision maker to supply needed information regarding resources as it relates to their plan. For example, if a person requires outpatient transportation, the IC may assist with identifying transportation resources to fit their needs; if IRIS SDPC workers needed to be trained on new cares after discharge, the IRIS SDPC RN will need to follow up for reassessment for personal cares.

Contractors with questions or seeking additional clarification are encouraged to contact the IRIS RN Nurse Consultant (irisnurseconsultant@wisconsin-iris.com).

5. Nurse Consultation

Nurse consultation is available to all ICAs regarding any participant in IRIS, not just those receiving IRIS SDPC services. In addition to providing consultation on individuals, nurse consultation may be used for trainings and other projects. Contact with the nurse consultant should be made by the IRIS consultant agency or their personnel, not by the participant, their guardian, family, or legal decision maker. Nurse consultation services can be accessed by emailing: irisnurseconsultant@wisconsin-iris.com.

a. Reasons for Individual Consultation

i. Individual consultation and discharge planning cares assessment when a person is being discharged from an institutional setting, such as a state operated facility, behavioral health unit, nursing home (SNF), hospital or other institution to a community setting and is deemed medically fragile or complex.

ii. All Private Duty Nursing Cases (nurses in independent practice or home health) are reviewed by the nurse consultant prior to putting any other waiver services on an ISSP.

iii. Before enrolling someone with complex medical concerns to best determine if all skilled cares are covered and the plan is safe. Examples would be anyone on a mechanical vent, receiving IV therapy, TPN, is in a semi-vegetative or vegetative state, or any other complex situation.

iv. Cases when individuals are asking for an adjustment to their IRIS budget related to medical staffing or specialized equipment that is not customary.

v. Request to add any nursing tasks/services to a plan (in the waiver the SDPC Agency Staff must prior authorize Nursing Services).

vi. Situations where a person is wanting to forgo medical care that is ordered by a physician. Those enrolled in IRIS SDPC are handled by the IRIS SDPC RN; those outside of IRIS SDPC should come to the nurse consultant for review.

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

viii. Ideas in care delivery that are needed "outside the box" in relation to provision of "medically necessary" cares. Examples may include consultation in obtaining a special lift, extra-large hospital bed, access to a clinic or provider, or complex care needs.

ix. Determining a "safe plan" as it relates to medical issues (e.g., refusing cares, wound issues, self-neglect, travel out of state, refusing to see a physician).

x. Interpretation of labs, medical tests, or medical orders.

xi. Assistance in finding MA services for home care, in home assessments, etc.

b. Examples of ICA Consultation for Trainings or Projects

i. ICA trainings on skilled care and HRS table.

ii. Standard Precautions, Communicable Diseases (for ICA staff, not participant caregivers).

iii. Medical Considerations within Target Groups.

iv. Dual Eligible, SSI Managed Care, Medicare Managed Care Projects.

v. Nurse delegation, skilled nursing, and scope of practice.

vi. Training on common medical issues (diabetes, hypertension, fall prevention, etc.)

vii. Training on various disabilities (spinal cord injuries, multiple sclerosis, dementia, etc.)

viii. Pre-qualification estimates for personal care.

c. Limitations in Consultation

i. Individual consultation where a RN or physician are already managing a case.

ii. Individual consultation where medical advice or diagnosis is being sought.

iii. Requests for nursing/health physical assessment (card service).

iv. Performing any hands-on nursing task or service (card service).

v. Supplying written order for a medical service (no prescriptive authority).

vi. Psychiatric-related consultations (card service).

vii. Wound care consultation (card service).

viii. One-on-one participant, guardian, or health care power of attorney consultation or education (covered by MAPC and SDPC or other FFS provider).

ix. Individual medication consultation.

VIII. 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. Each 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.
5. The code must be provided 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 is responsible for reconciling 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. Payment Accuracy

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

1. Payments must be:
    a. For authorized services under the participant's individual support and services plan;
    b. To authorized providers specified in the participant's individual support and services plan; and
    c. Within the units and rates authorized for the services.
2. If the FEA causes an error resulting in inaccurate, delayed, erroneously issued, or erroneously omitted payments, the FEA is responsible for resolving the error as soon as possible, but no more than 5 business days after a payment error is identified. The FEA must inform the Department after a payment error is identified no later than 3 p.m. on the next business day.
3. If an FEA issues payments to a vendor in excess of the amount authorized, the Department may recoup some or all of the portion of those payments in excess as

withholding(s) from the FEA's MROS payments, unless the portion of those payments in excess is required by law.

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

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

H. Federal Employee Identification Number (FEIN)

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

1. If the FEA has verified the information required to obtain a FEIN, and verifies that the information will be submitted to the Internal Revenue Service within fourteen calendar days; and
2. When the FEA has a protocol in place to retroactively correct all tax issues that may occur as a result of payroll being issued to participant-hired workers prior to the FEA receiving the provider's FEIN from the Internal Revenue Service (IRS).

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.

I. Workers' Compensation Payments

1. Workers Compensation Coverage

   a. The FEA is required to pay 100% Workers' Compensation coverage for all participant-hired workers in the IRIS program.

      Reimbursement for the costs of Workers' Compensation paid on behalf of the participants will be invoiced to DHS on a monthly basis by the FEA as a percentage of gross wages.

      i. The percentage invoiced by the FEA will be determined by written agreement between the FEA and DHS.

      ii. FEAs must submit documentation evidencing the existence of required coverage and the percentage of gross wage payment rate that the FEA's Workers' Compensation carrier provides to cover the population.

2. Workers' Compensation Coverage Invoicing and Reconciliation

   a. The FEA shall submit a monthly invoice to DHS with the amount of the actual Workers' Compensation coverage cost at the lesser of the actual carrier invoice or the percentage previously specified by the 10th of each month.

i. The invoice should include the actual carrier invoice or clear documentation to support the invoiced amount to DHS to demonstrate the number of workers, total payroll cost, and rate.

ii. The invoice should be submitted to the fiscal oversight mailbox at DHSLTCFiscalOversight@dhs.wisconsin.gov.

iii. Adjustments or corrections to a prior month amount should be included in the next monthly invoice with specific identification and calculation of the adjustment or correction.

b. DHS will perform validation and reconciliation against the payroll file submissions included in the FEA claim files, the actual carrier invoices, and the agreed upon reimbursement percentage.

c. FEAs must submit annual Workers' Compensation audit results from their carrier to support DHS reconciliation process.

i. Refunds resulting from the annual Workers' Compensation audit should be reflected as adjustments in the next monthly Workers' Compensation invoice submitted to DHS.

ii. The FEA is not permitted to profit from the Workers' Compensation provisions.

IX. 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 FEA must approve a service provider's qualifications prior to the service provider rendering services and receiving payment and must maintain records reflecting those credentials.
3. Although it is the responsibility of the FEA to verify and approve qualifications of service providers, the ICA and participant play key roles in timely set up in the program.
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.R.4 of this Agreement.

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 can be found 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 ICA 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 ICA is responsible for submitting completed onboarding packets to the FEA, if involved in the process. Note: Participant, participant-hired worker, or vendor can submit documentation directly to 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. The FEA must upload the entire onboarding packet, which must include the WI Medicaid Provider Agreement, into the Department's enterprise care management system provider document console.

   This may require setting up the service provider as a new service provider in the system.

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

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 fiscal employer agent (FEA) with only limited exceptions. Effective 1/1/2023, the only limited exception reasons to the 365-day timely filing deadline are permitted, as follows:

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

2. 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.

3. Timesheets

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

b. Effective 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, activated financial power of attorney, guardian of the estate, 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.

4. 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. 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, 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. Ineligible Service Providers

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

2. Upon verification of an ineligible entity or individual, the FEA shall take immediate action to:

   a. Exclude from further remuneration and begin the process of collecting overpayments, if applicable.

   b. Notify the Department within ten (10) days of discovery the identity of each ineligible provider and other details enumerated under subsection 4. *Disclosure of Excluded Individuals or Entities*, below.

   Individuals or organizations may be found ineligible under one or more of the categories herein.

3. Ineligibility

   Entities which could be excluded under Section 1128 (b) (8) of the Social Security Act are entities in which a person: (1) who is an officer, director, agent or managing employee of the entity; (2) who has a direct or indirect ownership or controlling interest of five percent or more in the entity; (3) who has beneficial ownership or controlling interest of five percent or more in the entity; or (4) who was described in (2) or (3) but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the household (as defined in 1128(j)(1) and 1128(j)(2)) in anticipation of (or following) a conviction, assessment, or exclusion has:

   a. Been convicted of the following crimes:

      i. Program related crimes, such as, any criminal offense related to the delivery of an item or service under title XVIII or under any State health care program (see Section 1128 (a) (1) of the Act);
      ii. Patient abuse, such as, criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128 (a) (2) of the Act);
      iii. Fraud, such as, a state or federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government (see Section 1128 (b) (1) of the Social Security Act);
      iv. Obstruction of an investigation or audit, such as, conviction under state or federal law of interference or obstruction of any investigation or audit related to any criminal offense described directly above (see Section 1128 (b) (2) of the Act); or,
      v. Offenses relating to controlled substances, such as, conviction of a state or federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128 (b) (3) of the Act).

b. Been excluded from participation in Medicare or a state health care program.

A state health care program means a Medicaid program or any state program receiving funds under Title V or Title XX of the Act. (See Section 1128 (h) of the Act.) Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person described above from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

c. Been assessed a civil monetary penalty under Section 1128A or 1129 of the Act.

Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the federal Department of Health and Human Services Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128 (b) (8) (B) (ii) of the Act.)

4. Contractual Relations

Entities which have a direct or indirect substantial contractual relationship with an individual or entity listed above in Article H.1. Substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

a. The administration, management, or provision of medical or long-term care services;

b. The establishment of policies pertaining to the administration, management, or provision of medical or long-term care services; or

c. The provision of operational support for the administration, management, or provision of medical or long-term care services.

5. Excluded from Participation in Medicaid

Entities which employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A of the Act, for the provision (directly or indirectly) of health care, utilization review, medical social work or administrative services. For the services listed, the FEA shall exclude from contracting with any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

The FEA attests by signing this contract that it excludes from participation in the FEA all individuals and organizations which could be included in any of the above categories.

6. Disclosure of Excluded Individuals or Entities

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

The disclosure shall include the following information:

a. The name, address, phone number, Social Security number/Employer Identification number and operating status/ownership structure (sole proprietor, LLC, Inc., etc.) of the individual or organization;

b. The type of relationship and a description of the individual or entity's role (for example, provider and service type or employee and classification);

c. The initial date of the relationship, if existing;

d. The name of the database that was searched, the date on which the search was conducted and the findings of the search;

e. A description of the action(s) taken to exclude the individual or entity from participation in IRIS.

7. Foreign Entity Exclusion

Pursuant to 42 C.F.R. § 438.602(i), the State is prohibited from contracting with an ICA or FEA located outside of the United States. DHS contracts are rendered null and void in the event an ICA or FEA moves outside of the United States.

I. 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, 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).

J. Criminal History and Background Investigation

1. IRIS fiscal employer agents (FEA) shall ensure selected persons working as paid caregivers pass required criminal and caregiver background checks.

a. The FEA must conduct and ensure that all participant-hired workers or individual providers, applying to work as paid caregivers pass a criminal and caregiver background check before being allowed to provide services and/or supports to participants.

b. If a provider submits paperwork using a social security number (SSN) and not an employer identification number (EIN), they are considered an individual provider and are subject to criminal and caregiver background checks.

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

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

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

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

X. 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 CMS standard acceptable risk safeguards (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/CIO-Directives-and-Policies/CIO-IT-Policy-Library-Items/STANDARD-ARS-Acceptable-Risk-Safeguards.html) and the standard for encryption of computing devices and information (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Info-Security-Library-Items/HHS-Standard-for-Encryption-of-Computing-Devices-and-Information.html) documents are available online, with greater detail, for Contractor reference on increased safeguards.

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

A. General Requirements

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

3. Contractor Systems

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

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. Passwords should be changed regularly, at minimum once every three to six months.

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

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

f. 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.

g. 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.

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.

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

B. Governance and Privacy

Contractors 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 ICAs / FEAs 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 plain language education with individuals 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. Contractors that own and/or operate their own systems housing IRIS data, especially fiscal employer agents, are 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. All Contractors are 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

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

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

   a. Service level requirements;

   b. Enrollment, Disenrollment, Suspension, and Orientation requirements;

   c. Plan Development requirements;

   d. Service Authorization requirements;

   e. Ongoing consultant service requirements;

   f. Participant records and documentation requirements; and

   g. Agency program integrity and quality management requirements.

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

   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

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

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

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

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

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

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

1. Functional Screen Information Access (FSIA)

   ICAs are responsible to maintain an accurate, complete, and up-to-date list of all staff or contractors with approved access to the FSIA system. ICAs shall submit

to the Department requests to have a staff member or contractor's security access deactivated as follows by following the instructions outlined at Deleting Long Term Care Functional Screeners (Wisconsin.gov):

a. If the ICA terminates the employment of a staff member or contractor who has approved access to FSIA, the ICA shall submit the deactivation request within one (1) business day of the individual's termination.

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

2. 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.

3. 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.

XI. 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. The participant's ICA is usually the best option to deal with issues directly and expeditiously. The IRIS consultant within the ICA is the most direct source of information and assistance.
    b. If the grievance is related to a pended, voided, or delayed payment to a worker or a vendor, the FEA is the most direct source of information and assistance to deal with these issues directly and expeditiously.
    c. When a concern cannot be resolved through direct access with the ICA or FEA, the grievance and appeal process through the EQRO is the next most direct source for resolving grievances.
    d. Ombudsmen are also available to assist IRIS participants with the resolution of grievances and appeals.
    e. The State Fair Hearing process is the final decision-making process for the Department in resolving participant appeals.

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 consultant agency or 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.

D. Notice of Action

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

   a. Deny or limit a participant's request to add or change a good or service;

   b. Terminate, reduce, or suspend any currently authorized good or service;

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

   d. Involuntarily disenroll from the IRIS program.

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

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

4. Content of Notice of Action

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

      i. Notice of Action – Denial,

      ii. Notice of Action – Limit,

iii. Notice of Action – Reduction,

iv. Notice of Action – Termination,

v. Notice of Action – ICA Transfer Denial

vi. Notice of Action – FEA Transfer Denial.

b. The notice of action communication must also include, at minimum:

i. Notice of Action form (F-10204),

ii. Participant Appeal Rights (P-00679),

iii. Request for State Fair Hearing – IRIS (F-00236B), and

iv. Voluntary Withdrawal form (DHA-17).

c. The notice of action and/or the letter accompanying the notice must include:

i. The date the notice is mailed or hand-delivered.

ii. The action the ICA has taken or intends to take, including the effective date of the action.

iii. The reason for the action.

iv. Any law, policy, or work instructions that support the action.

E. State Fair Hearing Process

1. The State administrative fair hearing process is governed by Wis. Stat. Ch. 227.

2. All communication, both verbal and written, to the administrative law judge (ALJ) must also be sent to the participant, their legal decision maker, or attorney.

3. The ICA is required to represent DHS in the state fair hearing process. This requirement is applicable when the ICA issues the Notice of Action (NOA) on behalf of DHS or if the NOA is issued from DHS as a result of a budget amendment request, a one-time expense request, or other termination, denial, limitation, or reduction of service NOA.

a. All NOAs issued must reference the federal or state statute, Wis. Admin. Code, the Medicaid HCBS 1915(c) IRIS Waiver, or IRIS policy that resulted in the intended action.

b. DHS may assist the ICA during the preparation phase of the fair hearing process, at its discretion.

c. ICA must notify DHS if a hearing decision is received that could require further action on the part of the ICA or the IRIS program.

d. In the event of a remanded decision from the ALJ, ICA must internally document the steps taken to mitigate and resolve the case to the specifications set forth in the remand.

e. The Department reserves the right to attend fair hearings as part of ongoing quality oversight and compliance.

4. The ICA will assure that an adequately prepared representative from the ICA participates in State Fair Hearings, if:

   a. Any action issued by the ICA is being appealed; or

   b. The ICA has knowledge that the issue being appealed concerns participant's cost share and the ICA has relevant information likely to help the Administrative Law Judge reach a decision.

   c. The ICA representative must be trained and prepared to:

      i. Represent the ICA's position;

      ii. Explain the rationale and authority for the ICA action that is being appealed; and

      iii. Accurately reference and characterize any policies and procedures related to the action that is being appealed.

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

XII. Financial Provisions

IRIS consultant agencies and fiscal employer agents shall 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 7.c).

   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 take into account 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 (http://docs.legis.wisconsin.gov/document/usc/18%20USC%201961) to

1968 (http://docs.legis.wisconsin.gov/document/usc/18%20USC%201968), 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.

XIII. 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, Individual Support and Service Plan (ISSP) development, administrative authority and best practice.
   b. Compliance related to contractual requirements detailed in the IRIS Record Review Tool and IRIS Record Review Instructions. These documents are provided by the IRIS program's External Quality Review Organization, but are not published publicly.
3. Contractor Recertification Site Visit

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

   a. Review of contractor's pre-submitted documentation as requested by the Department; and
   b. Discussion regarding contractor's current practices, procedures, policies and methodologies related to the IRIS program.
4. IRIS Participant Satisfaction Survey

   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

Each 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. Quarterly Contractor Oversight Meetings

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

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).

c. Behavior Support Plans (BSP)/ Restrictive Measures Monitoring (RM).

Behavior Support Plan and Restrictive Measures Request and Monitoring can be located in the IRIS Policy Manual (P-00708). Business rules and how to manage the BSP/RM processes are located in the IRIS Policy Manual-Work Instructions (P-00708A). This responsibility is applicable to ICAs only.

XIV. Reporting Requirements

A. General ICA Reporting Expectations

1. Quarterly submission of updated IRIS Consultant Agency Assignments by Area of Responsibility (F-01555).
2. New staff completion of the IRIS Certification Acknowledgement (F-01209) and retention of document in employee record, of which a sample will be reviewed at an annual site visit.
3. Completion 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 are subject to review by the Department upon request.
4. Annual submission of updated Conflict of Interest – Provider (F-01310) forms for all new members of the agency's governing Board of Directors, if applicable.
5. Monthly IRIS Consultant Agency Staffing list, to include an indication of each consultant and screener's supervisor, geographic service area(s), email address, and phone number.
6. Annual submission of demographic data as it relates to IRIS consultant personnel, to include but not be limited to said consultants' race, ethnicity, language(s) spoken, and disability status.
7. At the Department's request, submission of staff turnover data to the Department.

B. General FEA Reporting Expectations

1. Quarterly submission of an updated Fiscal Employer Agent Assignments by Area of Responsibility (F-01555A).
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 to the IRIS SDPC Oversight Agency or allowing them access to the FEA systems to extract biweekly reports 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 individual budget allocation. All overspending and nonspending reports that the FEAs send to ICAs should also copy DHS IRIS Quality mailbox: DHSIRISQuality@dhs.wisconsin.gov.

C. Encounter and Cost Share Reporting

1. The FEA is required to collect electronic data regarding participant encounters and cost share payments and submit those data to the Department, as described in Appendix IV. Data are used for required federal reporting, program evaluation and analysis, program integrity monitoring, and other purposes.
2. The FEA is required to maintain a system capable of generating accurate and timely submissions of encounter and cost share data in a format and using a system specified by the Department, as described in Appendix IV.
3. The FEA is required to submit all encounter and cost share data for a calendar month no later than the 30th day after the last day of the month, or the next business day if that 30th day is not a business day, as described in Appendix IV.
4. The FEA is required to ensure and maintain compliance with HIPAA and other laws governing the collection, storage, use, and submission of data regarding participant encounters and cost share payments.
5. The FEA is required to conduct all necessary internal checks, audits, and testing procedures to ensure that encounter and cost share data submissions are true, complete, and accurate; to verify that data submissions have been accepted by the Department's system; and to certify the accuracy of their data submissions as required by law and described in Appendix IV.
6. FEA is required to actively cooperate with Department staff in development and implementation of changes to the submission process for encounter and cost share data to improve the efficiency and quality of submissions or as required by law. Active cooperation includes participation in workgroups, meeting established testing and certification deadlines, and implementing changes to FEA systems in support.
7. The FEA is required to provide notice of system changes that will impact its processes and capabilities for collection, storage, and submission of encounter and cost share data to the Department at least 180 days in advance of implementation. Changes may include, but or not limited to, acquiring new software packages, major system upgrades, or contracting with a third party to fulfill data collection and submission requirements. As part of its notice, the FEA must include a testing plan that meets with Department standards and requirements to ensure no interruption in its fulfillment of data collection and submission and other contractual requirements. The testing plan must be completed successfully before the FEA implements the system changes.

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

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

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

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

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

D. Quarterly Employment Data Report

1. The ICA is required to report employment data for participants who have competitive integrated employment (CIE) on a quarterly basis using a prepopulated list of participants provided by DHS.

2. The ICA may choose to request employment service providers report employment data to them. However, the ICA will be responsible for the uploading and certification of the employment data sent to DHS.

3. The tool the ICA will use for employment data collection and submission of these reports will be the Informational Exchange System (IES) (https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html).

4. The IES spreadsheet will be available from the Department for ICAs on the 2nd Friday of the month after the quarter. ICAs are required to submit their information to the IES six weeks after receipt of said report.

E. Reports from the Department

1. Monthly Enrollment and Gross Enrollment Totals

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

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.

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

F. 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: IRISContractCompliance@dhs.wisconsin.gov and DHSIRISQuality@dhs.wisconsin.gov, unless specified otherwise.

XV. Payment to IRIS Contractors

A. Monthly Rate of Service (MROS)

1. As payment for performance of services in accordance with the terms and conditions of the IRIS Provider Agreement, ICAs, and FEAs will receive monthly rate of service (MROS) payments for Medicaid-eligible IRIS participants in enrolled status, or for participants in suspended status for no more than 90 days, on a calendar month basis as follows:

   a. ICAs will receive a standard MROS payment of $230.52 per participant.

   b. FEAs will receive a standard MROS payment of $65.56 per participant.

   c. FEAs will receive a supplemental MROS payment of $18.18 per participant receiving self-directed personal care (SDPC) services.

2. An ICA or FEA that provides services to a participant for an entire calendar month will receive a full MROS payment. An ICA or FEA that provides services for part of a calendar month will receive a prorated payment. Adjustments will be made for retroactive enrollment changes in prior months; a negative adjustment will be applied as a receivable against the next MROS payment.

3. Payments will be based upon enrollment and SDPC data recorded in the Department's Medicaid Management Information System (MMIS).

4. Payments will be determined and remitted electronically by MMIS. The ICA or FEA will be able to access remittance advices and MROS payment detail reports through the ForwardHealth Waiver Agency Portal.

5. Payments for the current month will be calculated on the first Friday of the month for deposit by the second Friday of the month (or next business day after the Friday if a holiday). Adjustments for participants incorrectly included or omitted in prior months will be calculated every Friday for deposit by the next Friday (or next business day after the Friday if a holiday).

B. 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 affect 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;

Legal proceedings related to the alleged fraud are completed; or

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

APPENDIX I. Contract Signatures

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

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

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

APPENDIX 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:

- Monthly IRIS Enrollment Snapshot
- 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 Consultant Agency Quality Management Plan, F-01208
- IRIS Consultant Agency Quality Management Plan Tracking, F-01208A
- IRIS Fiscal Employer Agent Quality Management Plan, F-01207
- IRIS Fiscal Employer Agent Quality Management Plan Tracking, F-01207A

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

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

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 Workers New Employee Packet

1. The employee packet shall 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. Stats. § 50.065 to ensure worker completes a criminal and caregiver background check.

DHS F-01246	Background Information Disclosure Addendum – IRIS. This form captures the worker's previous residences for consideration in the resulting background check.
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 shall 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 Form W-5	Earned Income Credit Advance Payment Certificate (upon request).
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 shall include, but shall not be limited to, the following:

Form Number	Form Title
DHS F-01312	IRIS Provider Application.
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.
DHS F-00180C	Wisconsin Medicaid Program Provider Agreement and Acknowledgement of Terms of Participant. This form

	must be signed and returned to the FEA before any payment can be issued.
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 shall be utilized, as needed:

DHS F-82064	Background Information Disclosure, as needed, for individual providers.
DHS F-01246	Background Information Disclosure Addendum, as needed, for individual providers.
Copy of Liability Insurance Certificate, if required for the profession.	
Copy of Professional License and/or 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 XIV.C. of this Provider Agreement.

1. The Department will transition encounter reporting from its Long-Term Care Information Exchange System (IES) to its Medicaid Management Information System (MMIS). The transition will take effect for dates of service on or after a Transition Date specified by the Department as follows:
    a. A Transition Date will be specified after all FEAs demonstrate the capability for encounter reporting in MMIS. Capability for encounter reporting in MMIS is demonstrated by completion of all testing and certification milestones and successful submission of encounters without errors to the Department's MMIS user acceptance testing (UAT) system.
    b. If all FEAs have demonstrated the capability for encounter reporting in MMIS by November 30, 2023, the Transition Date will be January 1, 2024.
    c. The Transition Date will be the first day of a calendar month.
    d. The Transition Date will be no fewer than 28 and no more than 59 days after the Department determines that all FEAs have demonstrated the capability for encounter reporting in MMIS.
    e. The Transition Date will be communicated to FEAs with at least 28 days' notice.
    f. Notwithstanding any other provision of this section, the Transition Date will be no later than January 1, 2025.
    g. An FEA that has not demonstrated the capability for encounter reporting in MMIS by January 1, 2024, will have its MROS payment reduced by $1.48 per participant until the first day of the month on or after which it has demonstrated the capability for encounter reporting in MMIS.
2. For all encounters with dates of service on the Transition Date or later, encounter and adjustment data must be submitted to MMIS. Submissions of encounters to MMIS with dates of service earlier than the Transition Date will be denied. All submissions must be in a HIPAA-compliant ASC X12 transaction format and include all data elements required for encounter submission. The FEA must:
    a. Follow the data specifications defined in The Adult Long Term Care Encounter User Guide and must submit encounters that conform to national standards as well as specific Departmental requirements;
    b. Enter itself as an “other payer” on the encounter; and
    c. Process all the FEA-specific files as defined in the report matrix on the ForwardHealth Waiver Agency Portal. All enrollment, encounter,

response, capitation, provider, error reports and special program files must be processed in a timely and accurate manner.

3. For all encounters with dates of service earlier than the Transition Date, including encounters or encounter adjustments submitted on or after the Transition Date with dates of service earlier than the Transition Date, encounter and adjustment data must be submitted to IES. All submissions must be in the XML format specified for IES and include all data elements required for encounter submission.
4. Cost share data must be submitted to IES. All submissions must be in the XML format specified for IES and include all data elements required for encounter submission.
5. The Department will provide user guides on data submission to MMIS and IES.
6. The FEA must certify each data submission, in the form prescribed by the Department in the system used for the data submission.

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 _____(ICA/FEA, Choose One), _____ (Name of ICA/FEA), hereafter referred to as the _____ (ICA/FEA, Choose One). The _____ (ICA/FEA, Choose One) 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 _____ (ICA/FEA, Choose One).

The _____ (ICA/FEA, Choose One) 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 _____ (ICA/FEA, Choose One) 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 _____ (ICA/FEA, Choose One) 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 _____ (ICA/FEA, Choose One) 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 _____ (ICA/FEA, Choose One). 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 – All Contractors

i. Materials with Specific Due Dates – All Contractors

Report	Reporting Period	Due Date	Submit To
1. Year to Date Financial Reporting (to include completed reporting template, signed Financial Statement Certification, investment/bank statement for segregated Restrictive Reserve account)	1/1/2024 – 3/31/2024	4/30/2024	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2024 – 6/30/2024	7/30/2024	
	1/1/2024 – 9/30/2024	10/30/2024	
2. Preliminary Year End Financial Reporting (to include completed reporting template, signed Financial Statement Certification, investment/bank statement for segregated Restrictive Reserve account)	1/1/2023 – 12/31/2023	3/1/2024	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2024 – 12/31/2024	3/1/2025	
3.1 Audited Year End Financial Reporting* (with the audit report, required schedules, letters, updated financial reporting template, financial statements, and signed Financial Statement Certification) **see contract for comprehensive list of required submission files.*	1/1/2023 – 12/31/2023	6/1/2024	DHSLTCFiscalOversight@dhs.wisconsin.gov
	1/1/2024 – 12/31/2024	6/1/2025	
3.2 Accountants Letter of Qualifications	Same as 3.1 above	Same as 3.1 above	Same as 3.1 above
3.3 CPA Checklist	Same as 3.1 above	Same as 3.1 above	Same as 3.1 above

4. Annual Financial Projections	1/1/2025 – 12/31/2025	10/15/2024	DHSLTCFiscalOversight@dhs.wisconsin.gov cc: DHSIRIS@dhs.wisconsin.gov

ii. 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.	12/1/2023 – 12/31/2023	1/30/2024	DHS LTC IES: https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html
	1/1/2024 – 1/31/2024	2/29/2024	
	2/1/2024 – 2/29/2024	4/1/2024	
	3/1/2024 – 3/31/2024	4/30/2024	
	4/1/2024 – 4/30/2024	5/30/2024	
	5/1/2024 – 5/31/2024	7/1/2024	
	6/1/2024 – 6/30/2024	7/30/2024	
	7/1/2024 – 7/31/2024	8/30/2024	
	8/1/2024 – 8/31/2024	9/30/2024	
	9/1/2024 – 9/30/2024	10/30/2024	
	10/1/2024 – 10/31/2024	12/2/2024	
	11/1/2024 – 11/30/2024	12/30/2024	
	12/1/2024 – 12/31/2024	1/30/2025	
2. Funding Files	Weekly Pay Cycles, pursuant to the Payroll and Vendor Schedule (P-01740)	See P-01740	DHSDMSIRISFiscal@dhs.wisconsin.gov
3. Deposit and Disbursement Accounts Bank Reconciliation	12/1/2023 – 12/31/2023	1/16/2024	IRIS Contract Specialist(s) and DHSDMSIRISFiscal@dhs.wisconsin.gov
	1/1/2024 – 1/31/2024	2/15/2024	
	2/1/2024 – 2/29/2024	3/15/2024	
	3/1/2024 – 3/31/2024	4/15/2024	
	4/1/2024 – 4/30/2024	5/15/2024	
	5/1/2024 – 5/31/2024	6/17/2024	
	6/1/2024 – 6/30/2024	7/15/2024	
	7/1/2024 – 7/31/2024	8/15/2024	
	8/1/2024 – 8/31/2024	9/16/2024	
	9/1/2024 – 9/30/2024	10/15/2024	
	10/1/2024 – 10/31/2024	11/15/2024	
	11/1/2024 – 11/30/2024	12/16/2024	
	12/1/2024 – 12/31/2024	1/15/2025	
4. Reimbursement Files	12/1/2023 – 12/31/2023	1/11/2024	DHSDMSIRISFiscal@dhs.wisconsin.gov
	1/1/2024 – 1/31/2024	2/8/2024	
	2/1/2024 – 2/29/2024	3/14/2024	
	3/1/2024 – 3/31/2024	4/11/2024	
	4/1/2024 – 4/30/2024	5/9/2024	
	5/1/2024 – 5/31/2024	6/13/2024	
	6/1/2024 – 6/30/2024	7/11/2024	

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

iii. Materials with Specific Due Dates – IRIS Consultant Agencies

	Contract Year	**Review Period**	**IES Spreadsheet from DHS available for ICAs** (2nd Friday after the quarter)	**ICA IES Info Due to DHS** (6 weeks after receiving spreadsheet)	**Submit To**
Employment Reporting	2023	Q1 Jan, Feb, Mar	Apr 14, 2023	May 26, 2023	DHS LTC IES: https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html
		Q2 Apr, May, June	July 14, 2023	Aug 25, 2023	
		Q3 July, Aug, Sept	Oct 13, 2023	Nov 24, 2023	
		Q4 Oct, Nov, Dec	Jan 12, 2024	Feb 23, 2024	

	2024	Q1 Jan, Feb, Mar	Apr 12, 2024	May 24, 2024	
		Q2 Apr, May, June	July 12, 2024	Aug 23, 2024	
		Q3 July, Aug, Sept	Oct 11, 2024	Nov 22, 2024	
		Q4 Oct, Nov, Dec	Jan 10, 2025	Feb 21, 2025	