

# Guidance on Purchasing Care and Services Under Wis. Stat. § 46.036

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This document is intended to provide guidance to Wisconsin county and tribal financial managers related to best practices for creating purchase of care and services contracts as required under Wis. Stat. § 46.036.

Guidance on  
Purchasing  
Care and  
Services  
Under Wis.  
Stat. § 46.036



**WISCONSIN DEPARTMENT**  
*of* **HEALTH SERVICES**

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Department of Health Services  
Purchase of Care and Services (POS) Guide

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## Foreword

Wisconsin Stat. § 46.036 requires the Department of Health Services (DHS) to establish standards and requirements for the contractual relationship between purchasers and providers related to the purchase of care and services. This document is a guide for meeting the requirements of the statute.

The following guidance on purchasing care and services represents a collaborative effort from stakeholders throughout DHS and is provided in the spirit of fostering excellence in contracting statewide. Going forward, DHS is committed to reviewing this document annually so that it remains up to date, and in the hopes that it will become the primary resource for our county and tribal partners. If you have questions related to this document or the guidance contained herein, please contact your region's [Area Administration office](#) for prompt attention and resolution.

## Introduction

### Statutory Requirement for Contracts

The requirements for contracts are contained in [Wis. Stat. § 46.036](#). All care and services purchased by DHS or by a county department under Wis. Stat. §§ [46.215](#), [46.22](#), [46.23](#), [51.42](#), and [51.437](#), except as provided under [sub. III of Wis. Stat. ch. 49](#) and [Wis. Stat. § 301.08\(2\)](#), shall be authorized and contracted for under the standards established under this section.

For purchases of \$10,000 or less in a calendar year, the requirement for a written contract may be waived by DHS. DHS' regional offices grant a blanket waiver for purchases of \$10,000 or less in a calendar year in the annual [Purchase of Services Memo](#). Contracts are required for all other purchases of care and services.

In addition to specifying that contracts are generally required, Wis. Stat. § 46.036 also specifies requirements for the business relationship between purchasers and providers. This document offers guidance on developing a purchase of services contract meeting the requirements of the statute. Purchasers and providers should consult their legal counsel when developing their purchase of services contracts.

## Definitions

**Care and services:** a term used, but not defined, in Wis. Stat. § 46.036. Our working definition is “Units of service or outcomes purchased by the purchaser or DHS for the benefit of a client or group of clients in accordance with the purchaser's service plan for the client(s).” This definition does not include purchases of goods or administrative or technical services for the benefit of the purchaser.

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**Client:** The end recipient of care and services provided by a provider. Certain DHS programs may use synonyms such as “consumer”, “member”, or “participant.”

**Code of Federal Regulations (CFR):** The codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

**Community Aids Reporting System (CARS):** A system for financial entry of executed contracts and reimbursement of allowable expenditures to local agencies.

**Contractor:** An entity that receives funds in exchange for providing goods or services in the normal course of business.

**County department:** May mean any of the following related to Wis. Stat. § 46.036:

- Wisconsin Stat. § 46.215 refers to a department of social services in a county with a population of 750,000 or more.
- Wisconsin Stat. § 46.22 refers to a department of social services in a county with a population less than 500,000.
- Wisconsin Stat. § 46.23 refers to a department of human services.
- Wisconsin Stat. § 51.42 refers to community mental health, developmental disabilities and alcoholism and other drug abuse services.
- Wisconsin Stat. § 51.437 refers to developmental disabilities services.

**DHS:** The Wisconsin Department of Health Services.

**Pass-through Entity:** A non-federal entity such as the State of Wisconsin that receives a federal grant award and provides a subaward to a subrecipient to carry out part of the federal program associated to that grant award.

**Provider:** an agency which receives purchaser or DHS funding for the provision of care and services to clients.

**Purchaser:** A county department under Wis. Stat §§ 46.215, 46.22, 46.23, 51.42 or 51.437.

**Subaward:** An award provided by a pass-through entity to a subrecipient for the subrecipient to carry out part of a federal award received by the pass-through entity.

**Subrecipient:** A non-federal entity such as a county human services department that receives a subaward from a pass-through entity to carry out part of a federal program.

**Uniform Guidance:** Guidance issued by the federal Office of Management and Budget (OMB) that sets uniform guidelines for administration, cost principles and audit requirements for federal awards.

## Contract Components

### Contract Summary Cover Page

DHS has recently embarked upon a multi-year project to modernize its contract documents. Among the most prominent changes was the development of a contract summary cover page that provides a concise summary of the most pertinent information about the contract. Wis. Stat. § 46.036 does not specify the form that a contract must take, however, DHS considers a contract

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summary cover page to be a best practice. An effective contract summary cover page may include information related to the following four areas:

- Purchaser and provider identifying information,
- Summary of the services to be provided, contract term, contract maximum, etc.,
- Contract identifying information, including the funding source(s),
- Purchaser and provider signatures.

### **Additional Disclosures Pertaining to Grant Agreements**

Relating to grant agreements, uniform guidance, 2 CFR Part 200, requires the purchaser to disclose the following:

- Federal award identification,
- Federal award identification number (FAIN),
- Federal award date to the recipient by the federal agency,
- Subaward period of performance start and end dates,
- Amount of federal funds obligated by this action by the pass-through entity to the subrecipient,
- Total amount of federal funds obligated to the subrecipient by the pass-through entity including the current obligation,
- Total amount of the federal award committed to the subrecipient by the pass-through entity,
- Federal award project description, as required to be responsive to the federal Funding Accountability and Transparency Act (FFATA),
- Name of federal awarding agency, pass-through entity, and contact information for awarding official of the pass-through entity,
- Catalog of federal Domestic Assistance (CFDA) number and name,
- Identification of whether the award is research and development,
- Indirect cost rate for the federal award,
- Percentages of federal, state, and local funds constituting the grant.

The funding information is included in the contract submitted to the provider. Additional resources on funding information are available to the provider and the provider's auditor on DHS' Community Aids Reporting System (CARS) webpage, which is found online at <https://www.dhs.wisconsin.gov/cars/index.htm>.

Detailed funding amounts arranged by provider, CARS Profile ID and CFDA may be found within the appendices associated to the contract. Additional information regarding the State and County Grant Award Contract for Social Services and Community Programs can be found online at <https://www.dhs.wisconsin.gov/sca/index.htm>.

## Audits

A financial audit is required by law for many providers that receive funding from purchasers. Wis. Stat. § 46.036(4)(c) requires any provider that receives in excess of \$100,000 in DHS funding to have an audit that meets departmental standards. Auditing standards are defined in the [DHS Audit Guide](#). In addition, federal requirements contained in [uniform guidance](#) require that both nonprofit and governmental agencies have audits when they receive \$750,000 or more in federal funds.

The \$100,000 audit threshold applies to the cumulative total of all DHS funding received by the provider, not per contract or per purchaser. In evaluating the audit requirement, purchasers should ask providers about contractual relationships with other purchasers to determine whether in total the provider receives greater than \$100,000 in DHS funding.

## Purchase of Service Audit Waivers

DHS' regional offices may waive audits on an individual provider basis. Audit waivers may be appropriate for low-risk providers where adequate fiscal and program monitoring exists. Audit waiver requests should be completed in conjunction with the contracting process and prior to signing the contract. Requests for audit waivers subsequent to contract signing are considered only in exceptional circumstances.

Purchasers may submit purchase of service audit waiver requests to the [regional office area administrator](#) by completing the Purchase of Service Audit Waiver Request form, [F-00945](#). This form provides information on the provider and includes a risk assessment. Instructions for completing the form and guidelines for determining the appropriate risk level can be found in the Purchase of Service Audit Waiver Request Instructions, [F-00945i](#).

Waiver of the DHS audit requirement is possible only if the provider is not required to have an audit in accordance with federal audit requirements. If the provider does not fall under the federal audit requirements, the regional office may then approve the purchase of service audit waiver request when:

- The purchaser has assessed the provider as having a low risk level, as documented by the "Risk Identification and Assessment Worksheet."
- The purchaser has increased other monitoring efforts to reduce the level of risk to low.
- The purchaser describes the alternate method of financial and program compliance monitoring implemented in lieu of an audit on the [Purchase of Service Audit Waiver Request](#) form.
- DHS' share of funding is a relatively small part of the provider's overall business.
- An audit would be a hardship on the provider.
- The audited information is not needed.

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DHS cannot waive audits that are required under the Single Audit Act Amendments of 1996. This law is implemented through 2 C.F.R., Part 200, “Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards,” and requires nonprofits and local governments that expend more than \$750,000 in federal funds to have audits in accordance with 2 C.F.R., Part 200, Subpart F.

**Audit Waivers That the County May Approve**

For contracts with small residential care providers, such as family group homes and adult family homes, the purchaser (rather than the state) has the authority to grant a waiver to the audit requirement. For contracts up to \$100,000, an audit is not required so no waiver is necessary. For contracts over \$100,000, the purchaser can provide a waiver by using the same audit waiver criteria that DHS uses, including the Risk Identification and Assessment Worksheet.

If the provider is determined to be a low risk by the Risk Identification and Assessment Worksheet, and the cost of an audit exceeds 5 percent of the total contract (as verified by written bid), an alternate year audit schedule that covers both years may be approved.

If it is determined that an audit would not be cost effective and may place an undue burden on the provider, the audit requirement may be waived. Specific circumstances that support granting the audit waiver and the alternate form of financial monitoring and program compliance in lieu of an audit, must be documented.

If an audit is required, the provider is to submit a copy to the purchaser. If the provider does not submit a copy, they may be deemed out of compliance with the conditions of the contract and corrective actions may be taken.

Purchasers have the option of requesting an audit whenever they wish, regardless of the audit threshold. If a provider is new, has had significant management changes, failed to meet program expectations, or has other factors that make them high-risk, an audit might be indicated. Keep in mind however that unless the audit is required by statute, the cost of that audit may not be allowable. Purchasers may contact DHS’ audit staff to seek advice in making this decision at [dhsauditors@dhs.wisconsin.gov](mailto:dhsauditors@dhs.wisconsin.gov). Purchasers should be aware that fiscal agents delivering financial management services are considered ancillary services and are not subject to audit requirements.

The contract should specify the purchaser’s remedies in the event of non-compliance with this section. If the provider fails to have an appropriate audit performed, or fails to provide a complete audit reporting package to the purchaser within the specified time period, the purchaser may:

- Arrange for an independent audit of the provider and charge the cost of such audit to the provider.
- Charge the provider for all loss of federal or state aid or for penalties assessed to the



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purchaser as a result of the provider's non-compliance.

- Disallow the cost of the audit that did not meet the applicable standards.
- Assess financial sanctions.
- Withhold payment, cancel the contract, or take other actions deemed by the purchaser to be necessary to protect the purchaser's interests.

### Caregiver Background Checks

[Wisconsin Admin. Code ch. DHS 12](#) was promulgated under the authority of Wis. Stat. §§ [48.685 \(1\) \(ag\) 1. a., \(2\) \(d\), \(4\), \(5\) \(a\), \(6\) \(b\) and \(c\)](#); [50.065 \(1\) \(ag\) 1. a., \(2\) \(d\), \(4\), \(5\), \(6\) \(b\) and \(c\)](#); and [227.11 \(2\)](#), to protect from harm clients served by DHS regulated programs, children placed in foster homes licensed by county departments of social or human services or private child placing agencies or children who are being adopted, and children served in day care programs contracted by local school boards under Wis. Stat. § [120.13 \(14\)](#), by requiring uniform background information screening of persons regulated and persons who are employees of or under contract to regulated entities or who are non-client residents of regulated entities.

The law applies to all individuals defined as caregivers, including nurse aides, who have access to clients in facilities or entities regulated by DHS' Division of Quality Assurance (DQA). Contracts for the services of caregivers who fall under the regulations must include a stipulation requiring that staff with access to clients successfully pass a background check prior to providing services to those clients. The following link is to DHS' caregiver program [webpage](#). Additional resources may be found in the DHS [caregiver background check manual](#).

The safety of our mutual clients is of the utmost importance. It is critical for contracts for direct care services to require the completion of background checks on all caregivers.

Wisconsin's Home and Community Based Services (HCBS) waiver programs, including the Children's Long-Term Support (CLTS) Waiver Program have also established requirements for providers whose services involve regular, direct access to clients to successfully pass a caregiver background check prior to executing a contract. Contracts must include a stipulation requiring employed or contracted staff with regular, direct access to clients or their funds to successfully pass a caregiver background check prior to authorization to deliver services to such clients.

### Civil Rights Compliance Plan and Affirmative Action

The federal funding which underpins many of DHS' grant awards brings with it requirements that pass-through entities, subrecipients, and contractors conduct their operations in a manner consistent with federal civil rights laws. Likewise, Wisconsin's contract compliance law, Wis. Stat. § 16.765, requires every contractor contracting with the state of Wisconsin to agree to equal employment and affirmative action policies and practices in its employment programs.

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The requirements of both the federal civil rights laws and the state's contract compliance law may be applicable to both purchaser and provider. Contracts for the purchase of care and services should contain a clause or clauses requiring compliance with these laws.

Civil rights compliance requirements arise based upon the presence of federal funding in the contract. Additionally, certain compliance requirements are based upon the dollar value of the contract, the type of services being purchased, and the number of employees the provider employs. Generally speaking, all providers of care services should be required to complete and submit to the purchaser a civil rights compliance letter of assurance, regardless of the dollar amount of the contract or number of employees. The civil rights compliance letter of assurance is due to the purchaser within 30 days of contract execution. Additionally, providers with 50 or more employees who receive an aggregate of \$50,000 or more in federal funds, must complete a civil rights compliance plan. The template and instructions for the [civil rights compliance plan](#) are available online. The provider is required to have the civil rights compliance plan available for inspection by the purchaser, but they are not required to submit the plan to the purchaser.

Wisconsin's contract compliance law Wis. Stat. §16.765, and Wis. Admin. Code § ADM 50.04 requires every contractor contracting with the state of Wisconsin to agree to equal employment and affirmative action policies and practices in its employment programs. Similarly, it is a best practice to require providers of care and services to comply with these provisions. Generally speaking, the purchaser should require the provider to submit an affirmative action plan if the contract amount exceeds \$50,000 per year. There are exceptions to this rule for providers with fewer than fifty (50) employees; those with a balanced workforce as defined under the statute; and those who have undergone an audit by the U.S. Office of Federal Contract Compliance Programs within the past year. The Wisconsin Department of Administration publishes excellent guidance on affirmative action compliance in their [Instructions for Contractors Affirmative Action Requirements](#). Please reference this information to inform your purchase of care and services contracts.

### **Client Funds**

Many clients served by human service programs need help handling their funds, and either the purchaser or provider may be assigned responsibility for providing this assistance. Purchasers may decide that the inherent conflict of interest involved in providing direct client services and handling the client's funds warrants a separation of these functions. Conversely, the purchaser may determine that the provider has sufficient safeguards in place to allow the provider to fulfill this role. The purchaser is responsible for making this determination. If the purchaser determines that the provider does not have sufficient safeguards in place, or lacks the experience necessary

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to manage the client's funds, the purchaser is responsible for either managing the funds internally, or arranging for a representative payee for the client.

A contract for the provision of care and services must clearly state which party is responsible for managing the client's funds, and who will bear the costs.

Regardless of who manages the client's funds, the following safeguards must be in place:

1. Unless otherwise authorized by the purchaser, the client must be allowed to use their funds as they wish, without undue obstacles to access.
2. Client funds must be maintained in a separate, interest-bearing account. Any earnings attributable to the funds accrue to the client.
3. The entity managing the client's funds must have written policies and procedures which clearly spell out how funds are to be managed.
4. Clients must be informed of the cost of care within a reasonable time either prior to or at the time of admission.
5. A budget should be developed for each client and agreed to by the client or their authorized representative.
6. There must be adequate segregation of duties between staff who authorize expenditures and those who reconcile accounts.
7. Records of client funds must be in writing, in good form, and must be reconciled monthly. All records of transactions involving client funds must be kept for a minimum of three (3) years. Clients must be provided a monthly accounting of their funds, with a copy provided to the purchaser by the end of the following month.
8. All staff handling client funds must be bonded and must pass a background check.

[Wis. Stat. § 51.61\(1\)\(v\)](#) discusses client funds and the rights and responsibilities thereof. DHS' Division of Care and Treatment Services publishes this guide related to [client funds](#). Finally, the Social Security Administration publishes a guide related to [representative payee](#) services.

## **Client Rights and Grievances**

Contractually, it is of critical importance that the requirements for client rights and grievances is clearly spelled out. Providers of direct care services must have a formal written grievance procedure that is approved by the licensing or certifying authority (if applicable), and the purchaser. The grievance procedure must follow the requirements specified in [Wis. Admin. Code ch. DHS 94, sub. III](#). The provider shall, prior to or at the time of client admission, provide oral and written notification to each client of their rights and the grievance procedure. Providers must post the written client rights and grievance procedures in an area readily available to clients and staff of the program, and make the contact information for the Provider's designated client rights specialist available to all clients.

[Wis. Stat. § 51.61](#) and [Wis. Admin. Code ch. DHS 94](#), Patient Rights, define rights and grievance procedures for clients with a mental illness, a developmental disability, alcohol abuse or dependency, or other drug abuse or dependency.

Additional considerations for this section of the contract might be the inclusion of a requirement on the part of the provider to report to the purchaser either monthly or annually on the grievances filed and their disposition. The frequency of such reporting is determined by the purchaser based on their history with the provider. At a minimum, such reports should contain client identifying information, the nature of the grievance, the date the grievance was filed, the disposition of the grievance, and the disposition date. Alternatively, a purchaser may require a provider to report each grievance as it is received.

The contract should clearly state the method by which grievances or reports thereof are to be delivered by the provider, as well as the level of involvement that the purchaser expects to maintain related to grievances.

### **Conditions of the Parties Obligations**

This section chiefly covers the four crucial aspects of: jurisdiction and legal venue of the contract; the impact of material changes in governing laws and/or available funding; the understanding that no provision of the contract supersedes the lawful duties of either party; entirety of the contract, and the agreement that the contract itself supersedes any oral negotiations, or representations that may have occurred between the parties.

Additional conditions or provisions often seen in this section relate to the topics of warranty, breach of contract, damages, enforceability, and timing. Work closely with your agency's legal counsel to evaluate the need for language pertaining to any or all of these potential additional provisions.

### **Confidential, Proprietary, and Personally Identifiable Information**

In connection with the performance of the work described in the contract, it may be necessary for the purchaser to disclose to the provider certain information that is considered to be confidential, proprietary, or containing personally identifiable information (confidential information). The contract must specify that the provider shall not use such confidential information for any purpose other than the limited purposes set forth in the contract, and all related and necessary actions taken in fulfillment of the obligations therein. The contract should stress that the provider must hold all confidential information in confidence, and shall not disclose such confidential information to any persons other than those directors, officers, employees, and agents who have a business related need to have access to such confidential information in furtherance of the limited purposes of the contract and who have been apprised of, and agree to maintain, the confidential nature of such information in accordance with the terms of the contract.

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The contract should specify that the provider must institute and maintain such security procedures as are commercially reasonable to maintain the confidentiality of the confidential information while in its possession or control including transportation, whether physically or electronically. Specify in the contract that the purchaser may conduct a compliance review of the provider's security procedures to protect confidential information. Also specify that the provider shall ensure that all indications of confidentiality contained on or included in any item of confidential information shall be reproduced by the provider on any reproduction, modification, or translation of such confidential information. Optionally, include a provision that the provider shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain confidential information of the purchaser.

Specify that the provider or its employees and subcontractors will not reuse, sell, make available, or make use in any format the data researched or compiled for the contract for any venture, profitable or not, outside the contract. Specify that the restrictions in this regard shall survive the termination of the contract and shall continue in full force and effect and shall be binding upon the provider or its agents, employees, successors, assigns, subcontractors, or any party claiming an interest in the contract on behalf of or under the rights of the purchaser following any termination. Be sure to specify that the provider shall advise all of their agents, employees, successors, assigns and subcontractors which are engaged by the purchaser of the restrictions, present and continuing, set forth in the contract. Also specifically state that the provider shall defend and incur all costs, if any, for actions that arise as a result of noncompliance of this section by provider, its agents, employees, successors, assigns and subcontractors regarding these restrictions.

While the above provisions spell out the ground rules for confidentiality, they do not specify the reporting requirements and or remedies in the event of a breach of confidentiality, nor the requirement under the Health Insurance Portability and Accountability Act (HIPAA). Be sure to include such provisions in the contract. An example of a reporting requirement might be that the provider shall report within five (5) business days to the purchaser any use or disclosure of confidential information of which it becomes aware. Specify also that the provider shall cooperate with purchaser's investigation, analysis, notification and mitigation activities, and that the provider shall be responsible for all costs incurred by purchaser for those activities.

Consider a clause related to indemnification in the event of a breach of confidentiality. Typical indemnification clauses contain wording prescribing that in the event of a breach of this section by the provider, the provider shall indemnify and hold harmless the purchaser and any of its officers, employees, or agents from any claims arising from the acts or omissions of the provider, its subcontractors, employees and agents, in violation of the section, including but not limited to, costs of credit monitoring and identity theft restoration coverage for one (1) year of coverage from the date the individual enrolls, of all persons whose confidential information was disclosed,

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disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the purchaser in the enforcement of this section.

It is also reasonable to include a provision related to liquidated damages whose purpose is to make the purchaser whole in the event of a breach or disclosure of confidential information. Such a section should include the specific assessment of damages, and how such amounts will be recouped. Consider language that acknowledges that an unauthorized use or disclosure of confidential information may result in damage to the purchaser's reputation and ability to serve the public interest in its administration of programs affected by the contract. Given that the amount of such damages may not be calculable with any degree of certainty, be sure to specify them in the contract. Be sure to note that assessment under this provision is in addition to other remedies under the contract and as provided in law or equity. Reserve the right to assess reasonable damages as appropriate and notify the provider in writing of the assessment. Specify that the provider shall automatically deduct any assessed damages from the next appropriate monthly invoice, itemizing the assessment deductions on the invoice. Be sure to specify the dollar amount of liquidated damages for each affected individual, as well as an amount for each day that the provider fails to substantially comply with any corrective action plan.

Provisions related to business associate agreements are standard in contracts for care and treatment services. Be sure to specify that the provider is a “business associate” pursuant to the definition under HIPAA and the regulations promulgated thereunder, specifically 45 CFR Part 160.103. In contracts for the provision of services, activities, or functions covered by HIPAA, the provider as a business associate must complete a business associate agreement. This document must be fully executed before contract performance begins.

Be sure to specify that the provider must agree to comply with the business associate agreement, HIPAA, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. Ensure that subcontractors meet the same standards. Be sure to define business associate to include the provider, subcontractors, and agents of the provider that receive, use or have access to protected health information under the contract and “Covered Entity” shall mean the purchaser.

Be sure the business associate agreement includes all required business associate agreement provisions per 45 CFR §164.502(e)(2).

- Identify what uses and disclosures are permitted or make reference to the contract that outlines services requiring the use or disclosure of protected health information. Indicate no other uses or disclosures unless specifically allowed.
- Implement appropriate safeguards.
- Report breaches and security incidents. Require business associates, at their own cost, to

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- respond to any potential HIPAA violation and provide any notice of privacy breaches or security incidents as mandated by the privacy, security or breach notification rules.
- Ensure contractors that create, receive, maintain, or transmit PHI on behalf of the business associate agree to the same restrictions that apply to the business associate with respect to such information.
- Assist covered entity with granting individuals' access, amendment, and accounting of disclosures of PHI.
- Include language that the Business Associate shall not, and shall ensure that employees, subcontractors, and agents do not, use or disclose PHI in any manner that is not permitted by the business associate agreement or that would violate Subpart E of 45 CFR 164 ("Privacy Rule") if done by covered entity. Business associate is not authorized to create de-identified information from PHI unless approved by the covered entity. All uses and disclosures of, and requests by, business associate for PHI are subject to the minimum necessary rule of the Privacy Rule and consistent with covered entity's minimum necessary policies and procedures.
- Make available books and records to HHS.
- Include appropriate termination provisions. Authorize termination if the business associate breaches the business associate agreement. At termination, return or destroy all information.

## **42 CFR Part 2 Patient Information**

42 CFR part 2 is a regulation that implements statutory provisions (42 USC §290 dd-2) enacted in the 1970s at a time when individuals seeking treatment for substance use disorders faced significant consequences, even legal problems, because they sought help.

A "Part 2 program" is:

1. An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment.
2. An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment.
3. Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers

A "lawful holder" is an individual or entity that is in lawful possession of patient identifying information, meaning the individual or entity received information as a result of a Part 2-compliant patient consent (including a prohibition on re-disclosure notice). Examples of a lawful holder include the patient's treating provider, insurance company, individual or entity performing an audit or evaluation or conducting scientific research.

A qualified service organization means a person or organization that provides services to a Part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting or other professional services or individual and group therapy, and has

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entered into a written agreement with the program, provided that the disclosure allows the qualified service organization to provide services to the Part 2 program.

A qualified service organization agreement is needed when Part 2 information is used or disclosed for services provided. In the agreement (which could be incorporated into your business associate agreement or could be a separate agreement), the qualified service organization acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by the Part 2 regulations; and if necessary, will resist in judicial proceedings any efforts to obtain access to patient records, except as permitted by these regulations.

Here is an example of language that could be included in the business associate agreement if a qualified service organization:

*The “Qualified Service Organization Agreement” shall have the same meaning as defined in 42 CFR 2.12(c)(4). To the extent that in performing its services for or on behalf of Covered Entity, Business Associate uses, discloses, maintains, or transmits clients’ health information that is protected by 42 CFR Part 2, Business Associate acknowledges and agrees that it is a Qualified Service Organization for the purpose of such federal law; acknowledges and agrees that in receiving, storing, processing or otherwise dealing with any such client records, it is fully bound by the provisions of the Federal Regulations governing Confidentiality of Substance Use Disorder Client records, 42 CFR Part 2 regulations; and, if necessary will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by the Part 2 regulations.*

### **Conflict of Interest**

Specify that the provider must agree to enforce measures to avoid circumstances that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest. Specifically, require the provider to ensure the establishment of safeguards to prevent employees, consultants, or members of the board from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties.

### **Debarment, Suspension and Excluded Providers**

Many of the services under purchase of service contracts are paid with federal funds. The federal government maintains a list of “excluded parties” that are debarred, suspended, proposed for debarment, or declared ineligible by a federal agency from participating in federal assistance programs. The prohibition on making sub-awards to debarred and suspended parties is addressed in [2 CFR Part 180](#).

Providers and sub-providers must not make any award or permit any award (sub-grant or contract) at any tier to any party which is debarred or suspended, or is otherwise excluded from



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or ineligible for participation in federal assistance programs under [Executive Order 12549](#), “Debarment and Suspension”.

Debarment precludes individuals from participating in federal assistance programs. Suspension temporarily precludes individuals while debarment action is being processed. Causes for debarment include conviction of or a civil judgment for:

- Fraud or a criminal offense in connection with an agreement or transaction,
- Violation of a federal or state antitrust statute,
- Embezzlement, theft, forgery, bribery, falsification or destruction of records, false statements, receiving stolen property, false claims,
- Obstruction of justice,
- Any offense that shows a lack of business integrity or honesty that seriously and directly affects the individual’s responsibility,
- Violation of the terms of a public agreement or transaction,
- Doing business with a debarred, suspended, or ineligible person,
- Failure to pay certain substantial outstanding debts,
- Violation of a voluntary exclusion agreement,
- Any other cause so serious that it affects the individual’s responsibility.

Purchasers are required to check the [Excluded Parties Listing System](#) to find out whether their providers or the principals of their providers are on this list. However, purchasers should also require providers to certify that they and their principals have not been suspended or debarred. In addition, purchasers should require providers to notify the purchasers if their status changes during the contract.

If the federal government debars or suspends a provider during the period of the contract, the purchaser must revise or terminate the contract. Alternatively, the purchaser might be able to switch funding to other monies so that no federal funding is being used for the contract. Purchasers should consult with their legal counsel on actions to take upon learning the federal government has debarred or suspended a contracted provider. Additional resources include:

[Federal Acquisition Regulation, Subpart 9.4](#)  
[2 CFR Part 200](#)

### **U.S. DHHS Office of Inspector General Excluded List**

The U.S. Department of Health and Human Service’s Office of Inspector General (OIG) maintains a list of individuals and entities which are federally barred from receiving Medicare or Medicaid funds. Individuals and entities may be included on the list for a variety of reasons, including a conviction for Medicare or Medicaid fraud. OIG maintains a list of all currently excluded individuals and entities called the [List of Excluded Individuals/Entities](#) (LEIE). Anyone

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who hires an individual or entity on the LEIE may be subject to civil monetary penalties. The purchaser is required to conduct a search of the LEIE for all providers that are funded through Medicaid or Medicaid HCBS waiver programs prior to issuing a contract. In addition, the provider is required to conduct a search of the LEIE for each employed or contracted staff. Purchasers can conduct the search at no cost by accessing the LEIE data base at <https://exclusions.oig.hhs.gov/>

### **Eligibility**

A program may or may not have an eligibility requirement as one of the conditions associated with federal or state funding for whom the program is intended to serve. The contract should indicate whether the program has an eligibility requirement and who is responsible for determining such eligibility. The contract should also address responsibility for ensuring that clients are aware of their rights if they are determined ineligible.

If the program has eligibility requirements, please be specific in the contract as to what those requirements are and any related documentation and reporting requirements. If the eligibility requirements are complex or extensive, you may want to consider creating an appendix to contain them.

Also, be sure to specify the appeals process (if any) related to the eligibility determination. An individual may have a right to an administrative hearing concerning eligibility and the provider should provide clients with the information concerning both their rights and the appeals process.

## **Health Insurance Portability and Accountability Act of 1996 “HIPAA”**

### **Applicability**

The terms used in this section shall have the same meanings as used in the [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#), or the Health Information Technology for Economic and Clinical Health Act (HITECH), and any amendments or implementing regulations, (collectively HIPAA Rules).

### **Why is the section on HIPAA important?**

The federal Health Insurance Portability and Accountability Act (HIPAA) mandates the standardization of certain electronic health administration transactions and the safekeeping of protected health information (PHI). As covered entities under HIPAA or as business associates of covered entities, counties and tribes must comply with or are affected by HIPAA requirements. Some of these requirements are implemented through the contractual language of covered entities when purchasing services. HIPAA can impact contracts for human services delivery to clients, as well as contracts for administrative services. Contracts for human service delivery may be impacted if payment is through electronic claims. A covered entity’s contract or other written arrangement for administrative services with its business associate must contain the elements specified at 45 CFR Part 164.504(e).

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A covered health care provider, health plan, or health care clearinghouse can be a business associate of another covered entity. A business associate is a person or entity, other than a member of the workforce of a covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information. A business associate also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate.

The HIPAA Rules generally require that covered entities and business associates enter into contracts with their business associates or subcontractors to ensure that the business associates/contractors shall agree to be bound by the same restrictions, conditions, and requirements that apply to the business associate in respect with PHI. It is a best practice to require business associates to complete a business associate agreement. An [example of a business associate agreement can be found](#) on DHS' HIPAA webpage.

***How does HIPAA affect contracts for human service delivery?***

If the purchaser is acting as a health plan (or business associate of a health plan) in receiving and paying client-specific electronic claims from a provider for health care services, these transactions must be conducted according to HIPAA standards. One example is where the purchaser, as a DHS business associate, is conducting electronic claim or payment transactions with a provider in the Medicaid HCBS waiver programs. The contract should state this mandate and require the provider's compliance with payer-specific requirements which can be contained in an attached trading partner agreement and/or companion guide and referenced in the contract.

***Can I simply attach the Business Associate Agreement to all contracts?***

This is not necessary and may not be advisable. The business associate agreement and related language in the contract should only be used when the provider is using PHI to provide relevant administrative services as a business associate, on behalf of the purchaser that is a covered entity under HIPAA.

If the contract is for the provision of human services, the provider is not a business associate as he/she is providing treatment activities. HIPAA allows the purchaser as a covered entity to share PHI with providers of health care services for treatment and payment purposes. HIPAA does not prohibit use of a business associate agreement for treatment providers, but it is not necessary.

In the vast majority of cases where PHI is exchanged with an outside entity on the covered entity's behalf, the covered entity is responsible to pay the entity for the service or product the outside entity provides. This is in contrast to the "Treatment" situation where the patients themselves or their insurer are typically financially responsible.

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An additional resource available to covered entities, business associates, and/or trading partners under HIPAA, as well as any other organization impacted by HIPAA regulations is the [Health Insurance Portability and Accountability Act Collaborative of Wisconsin \(HIPAA COW\)](#). Established in 2001, the mission of HIPAA COW is to “Assist HIPAA covered entities, business associates, and other interested parties in implementing HIPAA’s privacy, security, and EDI standard transaction provisions, as amended over time.”

### **Indemnity and Insurance**

Your agency’s corporation counsel, risk manager, and insurer must decide the type(s) and amount(s) of insurance coverage required in your contracts for care and services. The indemnity and insurance clause requires providers to agree that they will at all times during the existence of the contract indemnify the purchaser against any and all loss, damages, and costs or expenses which the purchaser may sustain, incur, or be required to pay as a result of participating in the contract. This includes those costs arising from death, personal injury, or property loss experienced by purchaser’s staff and/or clients of the provider resulting from services provided under the contract.

The contract should specify the acceptable minimum limits of the insurance coverage to be maintained by the provider for the duration of the contract. Certain insurances, such as that for professional liability, include both a minimum per occurrence, and a maximum for all occurrences experienced over the course of a year. It is best practice to periodically benchmark your agency’s insurance limits against those required by other human services agencies in your region. In this manner, your agency is less likely to find itself with insufficient indemnity coverage for your care and service contracts.

Indemnity and insurance provisions typically require that the insurance company be licensed by the State of Wisconsin. [The Office of the Commissioner of Insurance \(OCI\)](#) maintains records of agents and insurance companies licensed by the state. Verification of state licensure can be made by referencing OCI’s website.

The OCI [website](#) also includes a list of “unauthorized insurers”, which are insurers not licensed in Wisconsin, but nonetheless acceptable for offering “surplus lines” insurance. Surplus lines insurance must comply with prevailing insurance laws and is offered through insurance agents licensed as surplus lines agents, sometimes called brokers. Surplus lines insurance is allowed in Wisconsin and provides coverage for entities that cannot obtain insurance in the standard market. Surplus lines insurance will be specified through the insuring contract. It is important to read and understand the surplus lines contract and develop a level of business-comfort with the surplus lines agent.

Finally, be certain that your contracts for care and services require the provider to furnish a certificate of insurance verifying the existence of the required insurance(s) at their required amounts. Remember also to include a reporting provision in the indemnity and insurance clause requiring the provider to notify the purchaser of any event, suit, or proceedings related to any matter indemnified against. Require such notices to be delivered via registered mail, for example, within five (5) business days.

### **Independent Contractor**

Clearly spell out in this clause that the provider is acting as an independent contractor and is not controlled by the purchaser. The provider is at all times acting as an independent contractor and is not considered an employee, agent, or volunteer of the purchaser. Be sure to specify that nothing within the contract creates a partnership or joint venture between the purchaser and the provider.

### **License, Certification, and Staffing**

The purchaser must ensure that the provider meets the applicable license and certification standards. This clause should specify that the provider will meet state and federal service standards and applicable state licensure and certification requirements as expressed by state and federal rules and regulations applicable to the services covered by the contract. Included here should be a requirement that the provider furnish copies of such licensure or certification documents, and/or a report evidencing same upon execution of the contract. Contractually, it is important to specify that the provider must ensure that staff providing services are properly supervised and trained, and that they meet all of the applicable licensing and certification requirements. Finally, the contract should specify that during the contract period, the provider will provide copies of any report involving a licensing action or inspection within five (5) business days of receipt of such report(s). Be certain to specify the manner of delivery of such report(s).

### **Liquidated Damages**

Liquidated damages compensate the purchaser for losses incurred if the provider does not fulfill the terms of the contract. Liquidated damages are consistent with the intent of the contract in which two independent parties are mutually striving to achieve important, positive public goals. Properly constructed, liquidated damages are likely to be upheld in court. Alternatively, penalty provisions are viewed as punitive actions, and are unlikely to be upheld in court. Liquidated damages must be for a performance failure that would cause actual damages if it were to occur and must be in an amount that is a reasonable reflection of the potential damages caused by the nonperformance.

Specify liquidated damages in a contract if the actual damage would be difficult to measure, so the parties agree up front what the compensation would be. Liquidated damages are not needed

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for a nonperformance that creates easily measurable damages (e.g., walking off a job so that a replacement contractor is hired – the cost difference between the two contracts is obvious, so the needed compensation for harm is easily determinable). If liquidated damages are set too high for the likely actual damages, they may be considered a penalty and might therefore prove to be unenforceable.

Consult with your agency’s legal counsel about establishing liquidated damages through the contract and the procedures for collecting on these damages to provide a reasonable assurance that the liquidated damages provision will be upheld in court.

There are cases that hold the inconvenience to the public in delays or failure to perform is an actual damage that would justify the levying of liquidated damages. This could be a delay in providing contract services to the clients the program serves, a failure to correctly determine benefits for those clients, or a delay or failure to provide reports necessary for purchaser to obtain funds from its funding source.

The key points related to liquidated damages are that:

- Both parties agree to the amount of the liquidated damages up front when entering into the contract.
- The amount is a reasonable estimate of the actual damages that the purchaser would incur if the provider does not fulfill the terms of the contract.
- The amount is not so high as to be considered punitive.
- The amount is not so low that the purchaser decides it is more cost effective to pay the assessment than to perform the work required by the contract.

Given that liquidated damages are an estimate of actual damages that may occur, not every violation of a contract term will result in the same level of damages. Therefore, the contract should be specific as to the failure or type of failure that will subject the provider to liquidated damages, and in what amount. Examples could be a delay in providing services to a client, the loss of key personnel, or an error in calculating a benefit. Depending upon the non-compliance, contracts may allow for a period to correct the violations before liquidated damages are assessed. Purchaser may allow for a correction period, if applicable, if the failure was delaying services, but the loss of the program manager may cause liquidated damages to be assessed as soon as the manager is not replaced.

If liquidated damages are to be assessed, the purchaser will issue a “Notice of Assessment of Liquidated Damages” to the provider (your agency’s legal staff can assist in developing the document). The purchaser will determine the amount and deduct the value of the liquidated damages from the next or the final payment to the provider or bill the provider for this amount.

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Liquidated damages are compensation for a damage that occurred to the purchaser or the public and should go to those who incurred the damage. For example, amounts related to additional work incurred by the purchaser to handle the problems resulting from the non-performance should be credited to that division within the purchaser's organization. Similarly, amounts collected for damages incurred by the program that the contract is being paid from would be a cost offset to that program.

### **Matching, Maintenance of Effort, and Earmarking**

Programs may or may not have matching, maintenance of effort, or earmarking requirements. A requirement for matching, maintenance of effort, or earmarking is more likely with a cost reimbursement payment method than it is with a unit-times-unit-price or other payment methods. Be sure to understand the program you are contracting for and if you have questions contact DHS for verification of these requirements.

*Matching or cost sharing* includes requirements to provide contributions (usually non-federal) of a specified amount or percentage to match federal awards. Matching may be in the form of allowable costs incurred or in-kind contributions, including third-party in-kind contributions.

*Maintenance of effort* includes requirements for three situations:

- A specified level of service is to be provided from period to period.
- A specified level of expenditures for specified activities is to be maintained from period to period.
- Funds are to supplement and not supplant other funding of services.

*Earmarking* includes requirements that specify the minimum and/or maximum amount or percentage of the program's funding that must or may, at the discretion of the purchaser, be used for specified activities, including funds provided to sub-recipients. Earmarking may also be specified in relation to the types of participants covered.

Matching, maintenance of effort and earmarking requirements must:

- Be verifiable from the purchaser's records.
- Not be included as contributions for any other federally-assisted project or program, unless specifically allowed by federal program laws and regulations.
- Be necessary and reasonable for proper and efficient accomplishment of project or program objectives.
- Be allowed under the applicable cost principles.
- Not be paid by the federal government under another award, except where authorized by federal statute to be allowable for cost sharing or matching.

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- Be provided for in the approved budget when required by the purchaser.
- Be in conformance with other applicable provisions of 2 CFR Part 200 Uniform Guidance and the laws, regulations, and provisions of contract or grant agreements applicable to the program.
  
- [Allowable Cost Policy Manual](#)
- [State Single Audit Guidelines](#)
- [2 CFR Part 200 Uniform Guidance](#)

## Payment and Allowable Costs

Most purchasers are using one of three payment methods when contracting with providers:

- Unit-times-unit-price, with limited profit or reserves (Cost Plus)
- Unit-times-unit-price (fee-for-service)
- Reimbursement of allowable costs

Guidance on establishing unit prices or rates for services is a complex issue that is beyond the scope of this document. The purchaser should have policies and procedures in place to provide reasonable assurance that the prices or rates agreed to in the contract are allowable and reasonable. If the factors and assumptions underlying those rates change substantially, the purchaser may seek to revise the rates or terminate the contract as outlined in the “Renegotiation or Termination of the Contract” section below.

**Cost Plus** is a variation of a cost-based contract under Wis. Stat. § 46.036(3)(b), which allows purchasers to make payments to providers on the basis of actual allowable costs up to the contract maximum. Payments throughout the period are made on a unit-times-unit-price basis, and final settlement brings the payment to an actual allowable cost basis plus limited profit or reserve. A cost plus basis can be high-risk if the purchaser does not have a method to ensure that the final settlement is based on allowable costs. In some cases, an audit will be needed to determine the final reimbursement to be earned under the contract. An audit provides assurances that the provider has not exceeded allowable profit or reserves.

**Fee-for-Service** is one of the methods of payment allowed by Wis. Stat. § 46.036(3)(b), which allows purchasers to make payment on the basis of a unit rate per client service multiplied by actual client units furnished each month, up to the contract maximum. Under a fee-for-service system, the provider and the purchaser decide on a per unit price for the service, the provider reports the number of units of service to the purchaser, and the purchaser pays the provider for the number of units times the price per unit. A fee-for-service method can have high-risk if the purchaser does not have a means of ensuring that the unit price is reasonable and that the number of units the provider claims to have supplied are accurate. However, if the purchaser is confident



that the price is reasonable and controls the units of service, the risk may be reduced substantially.

**Reimbursement of allowable costs** is one of the payment methods authorized under Wis. Stat. § 46.036(3)(b), which allows purchasers to make payments to providers on the basis of actual allowable costs, up to the contract maximum. In an allowable cost-based contract, the provider reports costs to the purchaser which is responsible for reimbursement of the costs. An allowable cost-based contract can have high-risk if the purchaser does not have the means of ensuring that the provider is claiming only allowable costs for reimbursement. Some of the risks of inappropriate payments for an allowable cost-based contract include unallowable costs resulting from conditions such as inaccurate cost reports, misallocation of costs or cost shifting, lack of approval for costs, inappropriate or unnecessary items and lack of documentation for costs. Wis. Stat. § 46.036(3)(c) allows profit for for-profit entities under an allowable cost reimbursement methodology. Wis. Stat. § 46.036(5m) limits reserves to non-profit providers who are paid on a prospectively set rate (i.e., unit-times-unit-price methodologies above).

#### **Profits and Reserves Under the Statute**

Wisconsin Stat. § 46.036 includes several sections related to profits and reserves allowed to providers of care and services. Agency financial managers must balance the need to keep contract costs under control with the need to avoid inflicting financial hardship upon their pool of care and service providers. Non-profit agencies may earn up to 5% of revenue as reserves, while for-profit agencies may earn between 7 ½% and 10% of allowable costs, depending on their investment in fixed assets. Lower profit percentages may be negotiated. Allowable profit is addressed in the [Allowable Cost Policy Manual](#) (ACPM). DHS has not promulgated a rule specifying a different, lower percentage, so the wording in the statute and the ACPM should be your guide as to what the maximum profit or reserve percentage might be.

All other discussion of a provider's revenues exceeding their allowable costs relates to rate based services, which the statute defines as "...a service or a group of services, as determined by the Department, that is reimbursed through a prospectively set rate..." Wis. Stat. § 46.036(5m)(2). These are the unit-times-unit-price reimbursement methodologies mentioned above. In this context, "provider" is defined as a "...nonstock corporation organized under ch. 181 that is a nonprofit corporation..." "...that contracts...to provide client services on the basis of a unit rate per client service...". In short, these are your agency's nonprofit providers of care and services.

Three allowable surplus scenarios arise in the language of the statute. The first, as found in Wis. Stat. § 46.036(5m)(2)(b) relates to the situation in which the provider receives revenues under the contract which exceed the allowable costs incurred in providing the service(s). In cost accounting parlance, this is known as a favorable cost variance. In such a circumstance, the statute allows the provider to retain as surplus the lesser of the excess of revenues over allowable

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costs -or- five percent of the revenue received during the contract period. The retained surplus is the property of the provider.

The second allowable surplus scenario exists when at December 31 of any year, across all of the provider's contracts for the rate-based service expiring within that year, revenue is received in excess of the allowable retention rate for all such contracts (Wis. Stat. § 46.036(5m)(3)). This is a situation in which the unit-times-unit-price rate prospectively agreed upon already includes a modest percentage for reserves. For these rate methodologies, the provider is responsible for reconciling revenues and allowable costs across all purchasers and notifying the purchasers as a group that the allowable retention rate was exceeded. Under the provisions of the statute, the provider must provide this notice. Upon receipt of such notice, the purchaser(s) must request a return of the excess revenues in writing. The purchaser, under statute, has six months to request the return of such excess revenues (Wis. Stat. § 46.036(5m)(3)).

The third allowable surplus scenario relates specifically to purchases of care and services from an inpatient alcohol and other drug abuse (AODA) program that is not affiliated with a hospital, and that is licensed as a community based residential facility (CBRF). Purchasers may allocate one hundred percent of the excess of revenues over allowable costs for the period of the contract without regard to the five percent maximum specified elsewhere in the statute (Wis. Stat. § 46.036(5m)(4)(e)).

#### **Payments, Fee Collections, and Advance Payments**

Wis. Stat. § 46.036(3)(a) requires all contracts for the purchase of care and services to include a contract maximum. Additionally, the statute requires the contract to specifically state the number of clients to be served, number of client service units, the unit rate per client service, and the total dollar amount for each service. With the exception of the contract maximum (which is specified on the cover page), these details may be specified in the body of the contract or a referenced exhibit. The contract should also specify the frequency of payments to be made to the provider, and the form that the provider's invoice must take to meet the purchaser's requirements.

Final settlement and payment on the contract may be based upon the results of an audit of the provider. Wis. Stat. § 46.036(4)(c) requires the provider to provide a certified financial and compliance audit report if the care and services purchased with DHS funding exceed \$100,000. Audits which follow standards prescribed by DHS invariably document revenues, allowable expenses, profits, reserves, and losses related to the service and should serve as the basis for final disposition of the contract. In circumstances where an audit is not required, work directly with the provider to reconcile contract payments to authorized units of service and allowable costs.

Be certain to emphasize contractually how excess payments, if any, will be recouped. Wis. Stat. § 46.036(5) emphasizes that the purchaser shall recover from the provider monies paid in excess

of the conditions of the contract from “subsequent” payments made to the provider. However, the contract must address eventualities in which there are no subsequent payments to a provider. A clear recoupment mechanism and timeframe, such as ninety days from the end of the contract period, should be included in the contract.

Certain programs require clients to pay co-pays and deductibles directly to the provider; likewise, payments made pursuant to a sliding fee scale may also offset the costs of providing the service. Be sure to specify these offsets in the contract unless they are collected directly by the purchaser from the client. Wis. Stat. § 46.036(4)(e) requires that a uniform schedule of fees shall be charged to clients but is silent as to which party to the contract will collect such fees. In order to properly manage these potential offsets, it is critical that the provider have a recordkeeping system that can properly capture these receipts and report them to the purchaser. The contract should stipulate these responsibilities in detail.

### [Allowable Cost Policy Manual](#)

### **Records and Retention**

The provider must maintain records supporting its financial and performance reporting and allow the purchaser to have access to those records.

At first glance, specifying a retention period for records appears to be straightforward: [2 CFR Part 200 Uniform Guidance](#), which details the administrative requirements for nonprofits that receive federal funding, stipulates that records must be kept for at least three years, or longer if litigation or audit is begun before the three years has expired. However, according to DHS’ records experts, there is no such thing as one single minimum record retention period that applies to all activities involving all governmental funding. Different activities are subject to different state and federal requirements, including different record retention requirements and the provider must honor whichever requirements are applicable. As an example, DHS reserves the right under statute to audit purchaser and provider records for up to six years following the end of a contract for the purchase of care and service. Addressing records retention contractually is accomplished by requiring the provider to meet state and federal laws, rules, and regulations for records. The purchaser may choose to state a minimum retention period when it knows the applicable retention period for records related to the funding and services covered by the contract.

Contractually, it is also important for the purchaser to specify that the provider shall permit the purchaser’s representatives reasonable access to records relating to the contract. The purchaser may need to periodically review records for purposes of quality assurance, or compliance with funding requirements or other requirements under the contract. Be sure to reserve the right to access the records based upon the foreseeable needs of the purchaser.

- [Financial Management Manual for Counties, Tribes and 51 Boards](#)

- [Wisconsin Statutes, Chapter 19](#)
- [Wisconsin Administrative Code ADM 12](#)

## Reporting

Contracts for the purchase of care and services should clearly specify the types and timing of reports due to the purchaser from the provider. The nature of the contract will have a bearing on the form, number, and complexity of the reports due, but be sure also to establish the frequency, due dates, and delivery methods of required reports. Establishing these expectations contractually provides the purchaser with leverage in the event that required reports are not forthcoming as expected. Wisconsin Stat. § 46.036(4)(a) requires providers to “...maintain a uniform double entry accounting system and a management information system which are compatible with cost accounting and control systems prescribed by the Department.” The inability of a provider to provide the purchaser with timely, meaningful reports may be indicative of shortcomings in the provider’s management information systems.

Certain programs sponsored by DHS have unique reporting requirements related to allegations of client abuse, neglect, and exploitation. Be sure to specify these requirements in your provider contracts.

## Dispute Resolution

Specify the process to be used for dispute resolution should disputes arise during the course of the contract. Wisconsin Stat. § 46.036(7) provides that the service provider may appeal decisions of the purchaser in accordance with the terms of the contract and pursuant to Wis. Stat. chs. 68 and 227. A clear and equitable dispute resolution process which begins with the purchaser and provider striving to settle disagreements is the best first step to the continuation of amicable, productive relationships. Be as specific as possible in defining the dispute resolution process, as it is a two-way street.

## Revision or Termination of the Contract

Spelling out the expectations for revising or terminating the contract helps manage changes in the relationship between the purchaser and provider in an orderly way. Examples of situations where parties to the contract may need to revise or terminate the contract include:

- Provider fails to have an audit that met applicable standards.
- A different quantity of services is needed.
- The amount to be paid for the services is too high or too low,
- Federal or state laws or regulations or court actions require changes in policy or procedures.
- The funding to pay for the services is no longer available.

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- Provider does not provide the required quality or quantity of services.
- The provider fails to maintain state or federal licensure requirements.
- The provider becomes ineligible for receiving federal funds.

Wisconsin Stat. § 46.036(6) allows renegotiation of the contract. Either party may renegotiate the contract. However, both parties must agree to the change and sign a written amendment to the contract in order for the change to take effect.

The contract may be renegotiated at any point when both parties agree to the change, but the purchaser must keep in mind any deadline for reporting costs to its funding agency. For example, the State County Grant Award Contract specifies the date by which the county can claim state reimbursement for calendar year costs. Renegotiation of contracts for purchase of services must be completed by this date.

Wisconsin Stat. § 46.036(3)(e) allows reimbursement to the provider for its costs when the purchaser terminates the contract for reasons other than nonperformance by the provider. Some particular issues to consider when terminating a contract include:

- The purchaser should have a contingency plan for ensuring continuity in services.
- The nature of the services to be provided may dictate the length of time required to be provided by either party to terminate the contract.
- The purchaser might be able to collect actual damages from the provider. When actual damages are difficult to measure, the purchaser may be able to collect liquidated damages.
- The purchaser and provider can negotiate on reimbursement of the provider's costs when the purchaser terminates the contract for reasons other than nonperformance.
- Depending on the type of provider and the nature of the change, there also could be statutory and regulatory issues to take into account.

### **Services to be Provided/Scope of Work**

This section should include a detailed description of the services the provider will be expected to perform, the standards that must be met, and how performance will be measured. This section is sometimes referred to as the Scope of Work (SOW). Depending upon the complexity of the services to be provided, it is customary for longer, more complex requirements to be spelled out in either an attachment or exhibit to the contract and made part of the contract through reference in this section.

### **Special Provisions for High-Risk Contracts**

Annually, the purchaser should conduct a risk assessment of the provider related to the contract. This assessment may determine that risks exist that may require mitigation through additional monitoring and/or reporting during the contract period. Consideration must be given to situations

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where the purchaser wishes to establish or continue to contract with a provider but believes it imprudent to do so without additional measures to mitigate risk. DHS does not specify the form that a risk assessment must take, but it is best practice for this to be a written document, created specifically for the contract and maintained in the contract file. Please note that risk assessments are specific to a contract, not a provider. It is possible for a provider to be high-risk in relation to one contracted service, but low risk in relation to another.

[2 CFR Part 200.331\(6\)\(b\)](#) includes guidance which serves as a useful starting point for evaluating risks generally. Following are some commonly noted themes which may identify a provider as being high-risk, and potential steps to be taken:

- Provider may be considered high-risk if purchaser determines that provider:
  - Has a history of unsatisfactory performance.
  - Is not financially stable.
  - Has a management system which does not meet the management standards set forth in this part.
  - Has not conformed to terms and conditions of previous awards.
  - Is otherwise not responsible, and if the awarding agency determines that an award will be made, special conditions and/or restrictions shall correspond to the high-risk condition and shall be included in the award.
- Special conditions or restrictions may include:
  - Payment on a reimbursement basis.
  - Withholding authority to proceed to the next phase until receipt of evidence of acceptable performance within a given funding period.
  - Requiring additional, more detailed financial reports.
  - Additional project monitoring.
  - Requiring the provider or sub-provider to obtain technical or management assistance.
  - Establishing additional prior approvals.
- If purchaser decides to impose such conditions, the awarding official will notify the provider or sub-provider as early as possible, in writing, of:
  - The nature of the special conditions/restrictions.
  - The reason(s) for imposing them.
  - The corrective actions which must be taken before they will be removed along with the time allowed for completing the corrective actions.
  - The method of requesting reconsideration of the conditions/restrictions imposed.
- [State Single Audit Guidelines](#)

### Surety Bond

Per Wis. Stat. § 46.036(3)(f), if an advance payment exceeds \$10,000, the provider shall supply a surety bond for an amount equal to the amount of the advance payment applied for. No surety

bond is required if the provider is a state agency. The cost of the surety bond shall be allowable as an expense.

### Subrecipient or Contractor Determination

As defined above, a subrecipient is a non-federal entity that receives a subaward from a pass-through entity to carry out part of a federal program; while a contractor is an entity that receives funds in exchange for providing goods or services in the normal course of business. The relevance of this determination is that there are differing disclosure and audit requirements ascribed to the two statuses where federal funding is involved. As you prepare a contract with a provider, you must be prepared to classify them as either a subrecipient or a contractor, and then adjust your contract accordingly. As a purchaser, the vast majority of the entities with which you contract for the purchase of care and services are in fact contractors. Nonetheless, a determination must be made, and resultant documentation kept with the contract file for audit purposes. The determination relates to the services being provided and the nature of the program, as opposed to the entity per se. It is entirely possible that you may have multiple contracts with the provider, most of which cast the provider as a contractor, but one or more of which may cast the provider as a subrecipient.

The requirement for a subrecipient or contractor determination has its origins in Uniform Guidance 2 CFR Part 200.330, and has the effect of ensuring that federal requirements underlying funding flow through to the ultimate provision of care and services. As mentioned above, the upshot of this determination pertains to disclosures and audit requirements. The determination itself is not difficult, but requires a good faith effort on the part of the purchaser. If the provider is determined to be a subrecipient, this creates a federal assistance relationship, and invokes the provisions of 2 CFR Part 200.92. Characteristics which support the classification of the provider as a subrecipient include when the non-federal entity:

1. Determines who is eligible to receive what federal assistance.
2. Has its performance measured in relation to whether objectives of a federal program were met.
3. Has responsibility for programmatic decision making.
4. Is responsible for adherence to applicable federal program requirements specified in the federal award.
5. In accordance with its agreement, uses the federal funds to carry out a program for a public purpose specified in authorizing statute, as opposed to providing goods or services for the benefit of the purchaser.

By contrast, a contractor represents a procurement relationship. Characteristics indicative of a procurement relationship between the purchaser and the provider are when the contractor:

1. Provides the goods and services within normal business operations.

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2. Provides similar goods or services to many different purchasers.
3. Normally operates in a competitive environment.
4. Provides goods or services that are ancillary to the operation of the federal program.
5. Is not subject to compliance requirements of the federal program as a result of the agreement, though similar requirements may apply for other reasons.

Contractually, this differentiation between subrecipient and contractor requires the development of language regarding the disclosures and audit requirements related to each. The contract with a subrecipient must reflect the required federal disclosures which accompany the funding. Insert these disclosures into a dedicated section of the contract. Additionally, subrecipients receiving over \$750,000 in combined federal funding are subject to federal audit guidelines as found in 2 CFR Part 200, Subpart F. Subrecipients receiving less than \$750,000 in combined federal funding remain subject to the DHS Audit Guide. In contrast, contractors are exempt from the requirement of these federal audit guidelines. However, they are subject to the audit requirements in Wis. Stat. § 46.036(4)(c) (see Audits above).