Service Provider Contract

LAKELAND CARE
PROVIDER PURCHASE OF SERVICES CONTRACT

I. PARTIES

This contract is by and between Lakeland Care, whose business address is N6654 Rolling Meadows Drive, Fond du Lac, WI 54937, (hereinafter "Purchaser"), and Provider whose business address is (hereinafter "Provider").

II. PURPOSE

Purchaser is a Managed Care Organization (MCO) that has a contract with the Wisconsin Department of Health Services Division of Medicaid Services (DHS) to provide access to services for enrollees of the Family Care Program who are members of Lakeland Care. A copy of the Family Care Program Contract between Purchaser and DHS (hereinafter "MCO Agreement") may be found at https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm.

Purchaser provides access to Family Care benefits and services for Lakeland Care members through purchase of service contracts with providers. This Purchase of Services Contract (hereinafter "Contract") sets forth the terms and conditions under which Provider will provide services to Lakeland Care members. By virtue of executing this Contract, Provider agrees to abide by the terms and conditions of this Contract as well as all applicable provisions of the MCO Agreement relating to the provision of Family Care services. In all cases, this Contract shall be interpreted in a manner consistent with the MCO Agreement.

III. TERM

Subject to Article XV, the term of this Contract shall be from DATE through DATE. This Contract will automatically renew for additional one year terms unless earlier terminated pursuant to Article XV. This Contract may be renegotiated and amended at any time upon the mutual agreement of the parties.

IV. DEFINITIONS

Contract Terms

Business Day: Monday through Friday. Any day that is celebrated by the Purchaser as a holiday shall not be considered a Business Day and shall not be counted as a Business Day for purposes of calculating time under this Contract.

Business Hours: 8:00 a.m. until 4:30 p.m. on a Business Day.

Member – a person voluntarily enrolled in Lakeland Care after having been found to be financially and functionally eligible for Family Care services and benefits.

Member Rights – the rights outlined in applicant information materials and the Member Handbook as approved by DHS consistent with DHS 10.51, Wis. Admin. Code.

Rate and Service Codes Chart – the letter attached to this Contract which identifies the specific services that the Provider will provide under this Contract as they are requested and authorized by Purchaser from time to time and the rate that the Purchaser will pay, and Provider accepts as payment in full, for providing the specific services.

Service Authorization – an authorization sent by Purchaser to the service provider indicating the Purchaser is willing to pay for the requested service(s) that will be provided to the member by the Provider. A Service Authorization will indicate the name of the member authorized to receive the service; the type of service to be provided; the number of units (*amount of service*) to be provided; the rate to be paid per unit for the service; the duration of the authorization; and the funding source.

Interdisciplinary Team (IDT) – consists of a Registered Nurse, Care Manager, the member and their legal representative and/or family members.

V. GENERAL REQUIREMENTS

A. Licensure and Certification

1. Maintenance of Licensure and Certification

Provider shall maintain all required licensure, certification, and/or accreditation necessary to provide the services required of Provider under this Contract during the term of this Contract and shall comply with the applicable state licensure and/or certification requirements specified in state and federal statutes, rules and regulations. Health professionals, who are certified by Medicaid, agree to provide information about their education, board certification, and recertification upon request of the Purchaser. Health professionals and Provider organizations are required to maintain all certification and licensure in accordance with Wis. Admin. Code DHS 105, DHS 107, and all other applicable requirements for licensure and certification. Provider shall ensure that all services under this contract are provided by an entity that is properly enrolled in the Wisconsin Medicaid program, and is eligible to participate in 1915 (c) home and community-based waiver services and receive state and federal Medicaid funds. If newly licensed or certified as a residential provider, Provider shall ensure 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). Provider shall agree to provide verification of compliance with the home and community based setting upon request of the Purchaser. An exception to the requirement is a setting that was operating prior to March 17, 2014 that is subject to heightened scrutiny and is awaiting a determination of compliance from the Center for Medicare and Medicaid Services (CMS). Provider will ensure that its employees, agents, representatives and subcontractors who provide services to members are properly supervised and trained and that they meet all of the applicable licensing, accreditation and certification requirements at all times during the term of this Contract. Provider will provide evidence of licensure, certification, and/or accreditation prior to execution of this Contract and thereafter upon request by Purchaser.

2. Changes in Licensure or Certification

Provider shall immediately notify Purchaser of any changes, or threatened changes, to its employees or any of its subcontractors' Medicaid certification, licensure or other licensure, certification or accreditation. Purchaser shall assure on-going compliance of Licensure or Certification. Provider shall notify Purchaser of any visits or contacts by its licensing entities and shall send the Purchaser copies of any licensing inspection reports within five (5) business days of receipt of such reports.

B. Compliance with Laws and Purchaser's Standards of Performance

1. Compliance with Laws

Provider, its employees, agents, and subcontractors shall observe and comply with all federal and state laws and regulations in effect when this Contract is executed, or which may come into effect during the term of this Contract and any extension, which in any manner affect or apply to the services performed under this Contract including, without limitation, the Occupational Safety and Health Act, the Health Insurance Portability And Accountability Act Of 1996 (HIPAA), applicable immigration laws and all

applicable state and federal laws, rules, requirements, guidelines and regulations governing the provision of services under this Contract. Provider agrees to hold Purchaser harmless, defend and indemnify Purchaser from any claim, liability cost or expense, including without limitation, Purchaser's costs and reasonable attorneys' fees, resulting from Provider's failure to comply with this provision. Provider warrants that Provider and its subcontractors are in compliance with all federal and state laws and regulations applicable to the performance of their obligations and services under this Contract.

2. Standards of Performance

Provider shall comply with the performance standards and requirements set forth in this Contract and as otherwise established by Purchaser to comply with the requirements of the MCO Agreement between Purchaser and DHS. The provider agrees to follow the MCO's policies for MCO employees and contracted providers that prohibit all forms of abuse, neglect, exploitation and mistreatment of members. By signing this contract, Providers are attesting to meeting these standards and requirements. Provider agrees to abide by all applicable provisions of the MCO Agreement between Purchaser and the Department of Health Services Division of Long-Term Care, the terms of which are incorporated fully herein by reference.

A. Standards, Training, and Competency

Providers of services shall meet the standards of this agreement; and if applicable, agrees to retain licensing in good standing during contract period. Provider shall ensure that staff providing care to members is adequately trained and proficient in both the skills they are providing and in the needs of the member(s) receiving the services.

Training of staff providing services shall include:

1. Provider agency recording and reporting requirements for documentation, critical incident reporting, and other information and procedures necessary for the staff to ensure the health and safety of member(s) receiving supports
2. Training on the needs of the target group for the member(s) served under this agreement
3. Training on the provision of the services being provided
4. Training on the needs, strengths, and preferences of the individual(s) being served
5. Training on rights and confidentiality of individuals supported
6. Information and provider procedure for adherence to the LCI policies below:
    a. Incident Management System
    b. Restraint and Seclusion Policy and Procedure
    c. Communication Expectations
    d. Unplanned use of restrictive measure
    e. Confidentiality

B. Background Checks

Providers of services shall meet the standards of this agreement as specified in section XVI of this contract.

C. Civil Rights Compliance

Providers of services shall comply with Civil Rights Compliance as specified in section XIV of this contract.

D. Debarment

Provider of services shall have a Debarment Policy and Procedure, and shall supply it upon request of the Purchaser.

C. Independent Contractor

It is the parties' intent that the Provider is and will be an independent contractor, and not Purchaser's employee, for all purposes relating to this Contract including, without limitation, the performance of the services, responsibilities and activities under this Contract, application of the Fair Labor Standards Act, Federal Insurance Contribution Act, the Social Security Act, the Federal Unemployment Insurance Act,

the provisions of the Internal Revenue Code, any state workers compensation laws and regulations, any state unemployment compensation laws and regulations and any state revenue and tax laws and regulations. Provider will retain sole, exclusive and absolute control over the means, manner and method of performing the services, responsibilities and activities under this Contract including, without limitation, the means and methods of complying with the service standards and requirements hereunder. Provider agrees and represents that it is a separate and independent enterprise from the Purchaser, that it is in the business of providing the services under this Contract and holds itself out to others as providing such services, that it has a full right and opportunity to find other business, that it has made its own investment in its business and that it has the requisite skill to provide the services in compliance with the standards and requirements of this Contract. Provider will provide all personnel required to perform the services under this Contract. The provider is responsible to ensure that if there is a contractual, legal or employment relationship between their employee and the Purchaser that the provider ensures that there is no conflict of interest created by the employment relationship.

Provider shall be solely responsible for supervising and controlling the details of the work of its employees and other personnel who provide services under this Contract. Purchaser shall not be liable for any obligation incurred by Provider including, but not limited to, unpaid wages and overtime premiums. Purchaser and Provider agree that Provider is not an employee of the Purchaser and nothing herein shall be deemed to create an employer/employee relationship, joint venture, partnership, or any other relationship, other than that of an independent contractor. Provider shall indemnify, defend and hold Purchaser harmless from, any and all claims, losses, liabilities, damages, costs and expenses, including actual attorneys' fees, arising from any claim by Provider or Provider's employees for unpaid wages, unemployment compensation, worker's compensation and any other employment-based compensation.

D. Subcontracting

1. Subcontracts

Provider may engage subcontractors to furnish services covered by this Contract provided that Provider gives Purchaser prior notice of its intent to subcontract and identifies the subcontracting party. If Provider uses any subcontractors that are "Business Associates" (as that term is defined by HIPAA), then Provider shall use the Business Associate Agreement attached as Exhibit 1, and all access to or use of protected health information by Provider's subcontractors shall be subject to such Business Associate Agreement. Purchaser reserves the right to approve, suspend or terminate any subcontractor selected by Provider. At any time, Purchaser may, but shall not under any circumstance be required to, review, approve, approve with modification, impose conditions or limitations or deny any and all subcontracts under this Contract at its sole discretion and without the need to demonstrate cause. Provider shall ensure that its subcontractors are bound by, and comply with, the terms and conditions of this Contract.

2. Responsibility and Indemnity

In the event that the Provider subcontracts services, Provider shall remain responsible to Purchaser for the performance of the subcontracted services and shall be responsible for, and shall indemnify, defend and hold Purchaser harmless from, any and all claims, losses, liabilities, damages, costs and expenses, including actual attorneys' fees, arising in whole or in part out of any acts or omissions of its subcontractors, any failure of Provider's subcontractors to comply with any term, requirement, standard or condition of this Contract as well as any breach of any term or condition of this Contract by Provider's subcontractors. Any action of a subcontractor, which, if done by Provider, would constitute a breach of this Contract, shall be deemed a breach by Provider and have the same legal effect. Provider shall further indemnify, defend and hold harmless Purchaser and DHS from and against any and all claims, demands, liabilities, suits, actions, damages, losses, costs and expenses of every kind and nature whatsoever, arising from Provider's breach of any of Provider's subcontracts, including, without limitation, Provider's failure to pay any and all amounts due by Provider to any subcontractor. Purchaser shall indemnify, defend and

hold Provider harmless from, any and all claims, losses, liabilities, damages, costs and expenses, including actual attorneys' fees, caused solely by Purchaser's gross negligence or intentional misconduct.

E. Federal Program Qualification/Ineligible Organizations

Provider represents and warrants that neither it, its owners, employees or subcontractors are excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-tb(f), DHS 12 Wis. Admin. Code, or any form of State Medicaid program, and to Provider's knowledge, there are no pending or threatened governmental investigations that may lead to such exclusion. Provider agrees to notify Purchaser of the commencement of any such exclusion or investigation within seven (7) business days of first learning of it. Purchaser shall have the right to immediately suspend or terminate this Contract, and to take any other action Purchaser deems reasonably necessary, upon learning of any such exclusion and shall be kept apprised by the other party of the status of any such investigation.

Provider further represents and warrants that neither it, its owners, employees nor subcontractors are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations or from participating in non-procurement activities as a director, officer, partner, or person with a beneficial ownership of more than 5% of the entity's equity, or have an employment, consulting, or other agreement for the provision of items and services that are significant and material to Purchaser's obligations under the MCO Agreement.

F. Quality Management

Provider will participate in Purchaser's Quality Management programs and shall provide Purchaser with all information necessary to allow Purchaser to monitor the performance of Provider and collect evidence that Provider, its employees and subcontractors meet required licensure, certification or other standards and expectations in this Contract, including those for:

a. Caregiver background checks; and
b. Education or skills training for individuals who provide specific services; and
c. Reporting of member incidents to the MCO; and
d. Advance Directives; and
e. Provider Preventable Conditions; and
f. Immunization Programs.

If the Purchaser identifies deficiencies or areas for improvement, Provider shall take corrective action to bring Provider into compliance with applicable laws, rules, regulations, standards and guidelines.

G. Utilization Data

Provider will submit utilization data in the format specified by Purchaser so as to allow Purchaser to fulfill its Reports and Data requirements under the MCO Agreement. The data submitted by Provider shall comply with state and federal laws regarding confidentiality of member information.

H. Member Funds and Conflicts of Interest

Provider is discouraged from handling member funds unless expressly authorized by member and/or their legal representative in writing which specifically states that it is an agreement to hold limited amounts of member funds. Provider shall establish safeguards to prevent their employees, consultants or representatives from using their positions for purposes that are, or given 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.

I. Confidentiality of Records

Provider shall preserve the full confidentiality of records in accordance with this Contract and the MCO Agreement (including Section XII.A.) and protect from unauthorized disclosure all information, records and data collected under this Contract. Access to this information shall be limited to the Purchaser, agencies such as the DHS and (CMS and legally authorized persons who may require such information in order to perform duties related to this Contract.

J. Necessary Acts and Further Assurances

Upon reasonable request by Purchaser, the Provider shall execute and deliver such further documents and shall take such actions as may be reasonably necessary or appropriate to evidence or carry out the intent and purposes of this Contract or to show the ability to carry out the intent and purposes of this Contract.

VI. SERVICES

A. Service Quantity

Provider agrees to provide the services described in the attached Rate and Services Code as those services are requested and authorized by Purchaser from time to time pursuant to Service Authorizations issued by Purchaser. Purchaser does not guarantee that it will purchase, and has no obligation to purchase, any amount or quantity of services from Provider or to issue any service Authorization to Provider.

B. Procedures Governing Authorization of Services

The following procedures govern the provision of Services under this Contract. Provider agrees to clearly specify authorization requirements in this Contract to its providers and subcontractors and ensure their compliance.

Type and Quantity of Services Purchaser will be the sole decision maker regarding the type and quantity of services that are authorized to be provided to each member.

Prior Authorization of Services All services provided to a member under this Contract must be prior authorized under a written Service Authorization issued by Purchaser. Purchaser may, in its sole discretion and at any time with sufficient notice, increase, limit or discontinue the services provisioned to Provider under a Service Authorization. Service authorizations may be obtained by contacting the Purchaser's office location associated with the member. Purchaser will issue service authorizations prior to the start date of designated services whenever practicable. When prior written authorization is not practicable, verbal authorization may be provided by Purchaser, with written authorization following thereafter. Services provided on an emergency basis will be followed by a written authorization from Purchaser.

During regular business hours (Monday through Friday, 8 a.m. to 4:30 p.m.) providers are to use the general business numbers for authorizations:

- (920) 906-5100 for the Fond du Lac Office (Fond du Lac County)
- (920) 652-2440 for the Manitowoc Office (Manitowoc County)

- (920) 456-3200 for the Oshkosh Office (Calumet, Outagamie, Waupaca and Winnebago Counties)
- (920) 425-3900 for the Ashwaubenon (Green Bay) Office (Brown, Door, Kewaunee, Shawano, Menominee, Oconto and Marinette Counties)
- (877) 227-3335 Toll-Free number (Forest, Florence, Marathon, Langlade, Lincoln, Oneida, Portage, Vilas, Wood Counties)

Outside of regular business hours, Lakeland Care has established a single toll-free number (866-359-9438) for on-call, after-hours service authorizations throughout Lakeland Care.

Revised service authorizations shall be issued to Provider promptly, with sufficient notice to allow Provider to comply with the terms of the revised service authorization (for example, to prevent Provider from unknowingly exceeding reduced authorized service units) and to timely submit accurate claims during the appropriate billing period.

Provision of Services The quantity of services provided by a Provider to a member may not exceed the amounts authorized by Purchaser in the Service Authorization. Provider accepts full responsibility for the cost of any services provided by Provider that exceed the amounts authorized by the Purchaser or that have otherwise not been approved under a valid Service Authorization. Under no circumstances shall Provider or its subcontractors seek payment from Purchaser or a member for the cost of services exceeding the total amount(s) authorized under this Contract. Provider understands that it will not be reimbursed for unauthorized services provided to members or provided in amounts that exceed the amounts authorized by Purchaser.

Electronic Visit Verification Provider must utilize the Department of Health Services (DHS) Electronic Visit Verification (EVV) system for any service that DHS or Purchaser deems subject to EVV.

Additional Services Provider may request an additional Service Authorization or extension of an existing Service Authorization for a member by requesting additional services to the IDT staff. No services may be provided by the Provider unless and until the request is granted in writing by the Purchaser through the issuance of an additional Service Authorization or the extension of an existing Service Authorization.

Service Availability Provider agrees that services will be available to members throughout the entire period of this Contract and to accept appropriate members referred by the Purchaser as long as Provider has capacity and ability to serve members. Provider shall immediately notify Purchaser, in writing, whenever it is unable to provide the required quality or quantity of services or anticipates a lag or delay in the provision of services. Upon such notification, Purchaser will determine whether such inability or delay requires a corrective action plan, suspension or early termination of this Contract.

Remote Waiver Services and Interactive Telehealth Certain services are, or may become, available via interactive telehealth or otherwise delivered remotely. If in-person service is available, Provider may not require any member to receive the service via telehealth or remotely. Telehealth services must be functionally equivalent to the services provided in-person.

Functionally Equivalent: means a service provided via telehealth where the transmission of information is of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Telehealth: means the use of telecommunications technology by a Medicaid-enrolled provider to deliver services allowable under s. DHS 107.02 (5) and ss. 49.45 (61) and 49.46 (2)(b) 21. To 23. Stats., including: assessment, diagnosis, consultation, treatment, and transfer of medically relevant data in a

functionally equivalent manner as that of an in-person contact. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a certified provider and a recipient that consists solely of an electronic mail message, text, or facsimile transmission.

Timeliness and Access to Services Provider shall not create barriers to access to care by imposing requirements on members that are inconsistent with the services authorized by Purchaser or the member's care and treatment plan. Provider agrees that services will be made available to members at any time that provider is open for business or otherwise serving customers, members, or patients funded by any other revenue source. Providers shall make all reasonable efforts to initiate service provision at the date and time requested by the LCI IDT staff on behalf of the member. In the event that initiation of the service at the member's preferred time is not possible, the provider will express such to the LCI IDT staff, who will arrange an alternative start date of services, or, if necessary, arrange to meet the member's needs by other means.

Accessibility*:* Provider agrees to provide, as appropriate, physical access, reasonable accommodations, and accessible equipment to members with physical and/or mental disabilities.

C. Service Warranty

Provider warrants and represents that all services under this Contract shall be performed: (a) in a professional manner according to the highest standards recognized in the industry; (b) in a quality, safe, competent, timely and workmanlike manner, consistent with industry standards for analogous services; (c) in accordance with all applicable state and federal laws, rules, requirements, guidelines and regulations governing the provision of such services; (d) according to the terms and conditions of this Contract; and (e) in a culturally competent manner as required by Section VI D. 5. of this Contract.

D. Service Standards

In addition to any and all state and federal laws, standards, requirements governing the provision of services by Provider, Provider will provide the services in accordance with the following standards and requirements. Purchaser will monitor Provider's performance to ensure compliance with the provisions of this Contract, including formal review according to a periodic schedule, consistent with industry standards or state laws and regulations. Purchaser may immediately terminate or suspend this Contract based on Provider's and/or its subcontractors' quality deficiencies, failures to otherwise meet the performance, compliance of law, licensure, safety or other standards and requirements set forth in this Contract.

1. <u>Member Specific Planning Standard</u>

Provider's services shall be tailored to individual member needs as measured by the following criteria/evidence of compliance:

a. Member and/or legal representative reports that needs are being satisfactorily met;
b. Member and/or legal representative reports that he/she is adequately involved in care plan/individual service plan; and
c. Provider is following and complying with the individual service plan.

2. <u>Communication Standard</u>

Provider will communicate in an effective, timely and appropriate fashion with the member, Purchaser, IDT staff and natural supports as measured by the following criteria/evidence of compliance:

a. Change in Condition/Hospitalization. Provider will promptly report any change in member's condition, injury, illness, hospitalization, and deterioration to Purchaser. A change in condition that does not require an additional Service Authorization may be reported by phone during normal business hours to a representative of the member's care management team or the on-call worker of the Purchaser. If the member is hospitalized or if the change in condition necessitates, or might necessitate, additional or different services to be authorized by the Purchaser or an increase or decrease in the level or hours of care, the Provider shall immediately call the Purchaser at 1-866-359-9438
b. Licensure, Reviews and Citations. Provider will notify the Purchaser of any licensure visits, reviews, and/or citation within three (3) business days;
c. Inability to Provide Services. Provider will promptly notify Purchaser if there is a situation where Provider cannot provide authorized services. (*Some examples may be member refusal to accept service, or member hospitalization, etc*.)
d. Surveys. Provider will: (i) participate in and receive information from member satisfaction surveys; and (ii) share internal and external survey information with Purchaser;
e. Case Review, Staffing and Service Planning. Provider will participate, as requested, in case review, staffing and service planning;
f. Grievances and Appeals. Provider will notify Purchaser of all grievances or appeals or the occurrence of the complaint or grievance upon receipt and as otherwise directed by Purchaser's MCO complaint and grievance policy. Provider shall participate in training on the MCO's grievance and appeal policy and procedure, if requested by Purchaser.

3. Safety Standard

Provider will ensure that members are safe and that unacceptable risk is avoided as evidenced by the following criteria/evidence of compliance:

a. Provider shall comply with all applicable state and federal rules, regulations and licensure relative to the provision of services under this Contract as evidenced by review of appropriate documentation;
b. Staff shall be appropriately screened and trained in accordance with requirements for the service being provided and have required background checks completed by the hire date and within every four (4) years after hire or as otherwise required by applicable law or regulation;
c. Provider shall share member complaints, grievances and incident reports with Purchaser upon receipt;
d. Provider shall communicate to Purchaser any unsafe condition associated with a member when observed;
e. Provider shall work with Purchaser to determine member-accepted risk;
f. Provider shall comply with the procedures for responding to member incidents and emergencies set forth in Article VII of this Contract.

4. Isolation, Seclusion, Restraint, and Restrictive Measure Standard

Provider will comply with DHS's written guidelines and procedures and the MCO Agreement regarding the use of isolation, seclusion, and restrictive measures in community settings and follow the required process for approval of such measures. Provider shall comply with ss. 51.61(1)(i) and 46.90(1)(i) of the Wis. Stats., and Wis. Admin. Code s. DHS 94.10 in any use of isolation, seclusion, and restrictive measures. The following are criteria/evidence of compliance with this standard:

a. Provider has written policy and procedure consistent with the DHS's written guidelines use of isolation, seclusion, restraint, and restrictive measures in community settings;

b. Provider demonstrates through practices and procedures that it understands what restrictive measures are and how they are regulated;
c. Provider reports any unauthorized or emergency use of isolation, seclusion, restraint, and restrictive measures as a member incident;
d. Provider has collaborated with Lakeland Care's IDT staff to evaluate all alternatives to isolation, seclusion, restraint, and restrictive measures prior to request for use of restrictive measures; and
e. Provider demonstrates evidence of having trained staff in the use of restrictive measures.

5. Equity and Inclusion Standard

It is Purchaser's policy to encourage and foster Equity and Inclusion among its own staff and its services providers. Accordingly, Provider shall ensure that all services are delivered to members in a culturally competent manner. Provider shall incorporate in its policies, administration, contract and service practice the values of honoring members' beliefs, being respectful to member and staff culture, heritage, and other identity facets including members with limited English proficiency, diverse cultural and ethnicity, disabilities, sexual orientation, gender identity, and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds and other identify facets.

6. Service Access Standards

Provider shall comply with access standards provided in Article VII, Services, of the MCO Agreement. Provider and its subcontractors must meet all state standards for timely access to care and services taking into account the urgency of the need for services. Provider shall offer hours of operation that are no less than hours of operation offered to commercial members or comparable to Medicaid fee-for-service members, whichever provides greater service availability to members.

VII. PROCEDURES FOR RESPONDING TO MEMBER INCIDENTS, EMERGENCIES, AND ADVERSE EVENTS – INCIDENT MANAGEMENT SYSTEM (IMS)

Incident Management System Terms

Adverse event means any circumstance, event, or condition resulting from either action or inaction that:

a. Was undesirable and unintended; and
b. Did not result in any serious harm to a member's health, safety or well-being; and
c. Indicates or may indicate a quality issue with the services provided by the Provider or any of its subcontractors;

Emergency means an unforeseen combination of circumstances or the resulting state that calls for immediate action.

Incident describes a circumstance, event or condition resulting from action or inaction that has either caused harm or had the potential to cause harm.

Incident Management System a system that manages incidents occurring at the member and provider levels, in order to ensure member health and safety, reduce member incident risks, and enable development of strategies to prevent future incidents from occurring.

A. Member Incidents, Emergencies, and Adverse Events

To the extent permitted by law, the Provider shall fully cooperate with any member-related investigation conducted by the Purchaser, the Department of Health Services, the Federal Department of Health and

Human Services, CMS, law enforcement, or any other legally authorized investigative entity. Provider shall comply with the following procedures relative to the response to member incidents, emergencies, and/or adverse events as part of the IMS. Compliance with these procedures does not relieve Purchaser, the Provider or Provider's subcontractors of other certification, licensing, statutory or regulatory requirements for reporting member incidents, including requirements to report and investigate deaths or abuse and neglect of residents of certain facilities (e.g. Wis. Stat. §§ 49.60, .50.034, 50.04, 55.043(1m), Wis. Admin. Code DHS 12, 13, 83, and 88).

1. Identification and Reporting of Member Incidents, Emergencies, and/or Adverse Events

Provider must identify, document and report all member incidents, emergencies, and/or adverse events to Purchaser no later than one (1) business day after the incident and/or event is discovered. Reporting shall be accomplished by calling Purchaser directly during business hours or after hours at (866)359-9438.

2. Ensuring Safety of Members Involved In Member Incidents, Emergencies, and/or Adverse Events

Provider shall ensure the immediate safety of members involved in member incidents, emergencies, and/or adverse events by taking any steps necessary to assure that the member is protected from the risk of continued harm from the incident and/or event in which the member has been, or is, involved.

3. Cooperation with Purchaser's Investigation of Member Incidents, Emergencies, and/or Adverse Events

Provider shall fully cooperate with any investigation of an actual or alleged member incident, emergency, and/or adverse event conducted by the Purchaser, the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity. Such cooperation shall include, but not be limited to, the Provider's sharing with the Purchaser information in the Provider's possession that is, or may be, relevant to the Purchaser's investigation and the Provider's giving the Purchaser access to the Provider's staff and records so that the Purchaser may obtain information that is, or may be, relevant to the Purchaser's investigation.

4. Compliance with Wisconsin Statute 46.90

Whenever an employee of the Provider believes that abuse, neglect, or self-neglect of an elderly person has occurred, the employee shall make a report to Purchaser as required under Wisconsin Statute 46.90.

VIII. INSURANCE

A. Minimum Insurance Requirements

Provider will, at all times during the terms of this Contract, keep in force the following insurance policies issued by a company or companies authorized to do business in the State of Wisconsin and licensed by the Office of the Commissioner of Insurance. Prior to execution of this Contract, Provider shall furnish Purchaser with written verification of the existence of such insurance. Unless otherwise indicated in writing by Purchaser in connection with the execution of this Contract, the types of insurance coverage and minimum amounts shall be as listed in attachment 5.

B. Subcontractor Insurance, Insurance Certificates, Subrogation Waivers and Additional Insured Provisions

All of Provider's subcontractors shall be required to carry insurance in equal amounts to those required of Provider under this Contract. All insurance required to be maintained by the Provider and its subcontractors hereunder shall include a waiver of subrogation rights against the Purchaser and shall provide that the insurer notify the Purchaser at least thirty (30) days in advance of any cancellation, non-

renewal or material change in the Provider's policies. Purchaser shall be named as an additional insured on all required policies of insurance unless otherwise agreed upon by the parties. The Provider and its subcontractors shall provide the Purchaser with certificates of insurance certifying the coverage that the Provider is required to maintain on behalf of the Purchaser under this Contract. The policies provided by the Provider and its subcontractors shall be primary and non-contributing with respect to any insurance maintained by the Purchaser.

IX. INDEMNIFICATION

In addition to any other indemnification obligations in this Contract, Provider agrees as follows:

A. The Provider agrees to the fullest extent permitted by law to indemnify, defend and hold harmless Purchaser its agents, officers, representatives and employees, from and against all claims, loss, costs and expense, including actual attorneys' fees, by reason of any alleged or actual liability for injury or damages caused by, relating to, or arising in any way, in whole or in part, from: (1) the wrongful, intentional, or negligent acts or omissions of the Provider, its employees, agents, representatives and/or subcontractors in the performance of the services and/or the activities in any manner related to this Contract; (2) any breach of this Contract; (3) the Provider's and/or its subcontractors' performance or attempted performance of this Contract; and (4) any failure by Provider and/or its subcontractors to comply with any provision in this Contract.

B. Provider shall indemnify, defend and hold Purchaser, its agents, officers, representatives and employees from and against all claims, losses, damages, cost and expense, including actual attorneys' fees, arising out of any action and/or award of damages and costs against Purchaser based on, relating to or connected in any way with infringement by Provider, its employees, agents, representatives and/or subcontractors of any intellectual property rights involved in the performance of the tasks and services covered by this Contract.

C. Provider agrees to indemnify the Purchaser for any amount Purchaser may be required to repay to the DHS or the state or federal government by virtue of payments made to Provider that the DHS or the state or federal government determines to be overpayments or inappropriate payment. This includes the costs of defending any enforcement actions arising out of such overpayment or inappropriate payment.

D. Provider agrees to be solely and exclusively liable for any compensation payable at law or damages of any type arising from or in any way connected with any accident, illness or injury sustained by the Provider, its subcontractors or any of their respective employees, agents or representatives arising out of, relating to or in connection with the work performed by the Provider and/or its subcontractors under this Contract. Provider shall indemnify, defend and hold harmless Purchaser from all losses, injuries, damages and wages or overtime compensation due its employees in rendering services pursuant to this Contract including reasonable attorneys' fees and costs in incurred in the defense of any claim under the Fair Labor Standards Act or any other state or federal law. Provider further agrees to defend, indemnify and hold the Purchaser its directors, officers, employees, agents and representatives harmless from and against any and all

claims, losses, damages and expense, including actual attorneys' fees and costs, arising out of or relating to any workers compensation claims, unemployment compensation claims and any and all other statutory claims asserted by Provider, its subcontractors or their respective employees, agents and representatives against Purchaser.

E. Purchaser shall indemnify, defend and hold Provider harmless from, any and all claims, losses, liabilities, damages, costs and expenses, including actual attorneys' fees, caused solely by Purchaser's gross negligence or intentional misconduct.

X. PAYMENT FOR SERVICES

A. Rates

1. Negotiated Services

The Purchaser shall pay the Provider at the rate and according to the provisions listed in the attached Rate and Services Codes Chart. Purchaser may amend or modify the Rate and Services Codes Chart at any time during the term of this Contract, including any extension thereof, by providing notice in writing (which may include mail or email) to Provider. Provider shall have sixty (60) days from the date of the written notice to either accept the rate change(s) or terminate the Contract. If Provider fails to provide written notice of the rejection of the rate change(s) and termination of the Contract within sixty (60) days, Provider shall be deemed to have accepted the rate change(s). In the event that Provider rejects the rate change(s), Provider shall continue to provide services at the previously agreed-upon rate for a period of up to thirty (30) days from the date of the written notice to allow Purchaser to find a new Provider. Providers may submit requests for rate changes to the Provider Specialist in the appropriate Lakeland Care office.

2. Residential Rates

Residential rates shall be for a period of not less than one year, unless there is mutual agreement upon a shorter term. Residential services provider agreements or amendments shall specify a contracted rate, include a fee schedule or reference an acuity-based rate setting model. Rates may be changed:

i. Anytime, through mutual agreement of the MCO and provider.
ii. When a member's change in condition warrants a change in the acuity-based rate setting model.
iii. An adjustment in payment rate made pursuant to VIII.L.6.c-e, whether resulting in a State directed rate increase or rate decrease, shall not be considered a rate change for purposes of this twelve (12) month period
iv. When a rate has been in effect for at least twelve (12) months, and a change is proposed for an individual member or facility:
    1) The MCO must provide a sixty-day written notice to the provider prior to implementation of the new rate.
    2) The rate change may apply to the entire contract or to specific rates within the contract, but only on a prospective basis.
    3) Rates which are reduced using sub iv are protected from additional decreases during the subsequent twelve (12) month period.
    4) A State directed rate increase shall not be considered a rate change for purposes of this twelve (12) month period.

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

3. Home and Community-Based Waiver Services (HCBS) Rates

Residential Providers: The MCO must pay residential providers at least the minimum rates as established in the HCBS minimum fee schedule.

i. Residential Providers are defined as follows:

   a. Certified, corporate-owned 1-2 bed Adult Family Homes ("1-2 bed AFH") as defined in Add. VI.

   b. Certified 3-4 bed Adult Family Homes ("3-4 bed AFH") as defined by Wis. Stat. §50.01(1)(b).

   c. Certified Community-Based Residential Facility ("CBRF") as defined by Wis. Stat. §50.01(1g).

   d. Certified Residential Care Apartment Complex ("RCAC") as defined by Wis. Stat. §50.01 (6d).

ii. The Minimum payment rates by benefit and by member acuity tier are available to providers within their LCI Rate Agreements.

iii. "Member Acuity Tiers" are defined in Table 1, "Member Acuity Tiers: Criteria", with members being assigned to the highest tier for which they have any single need listed in the acuity tier criteria. Members qualify for Acuity Tier 1 if they do not meet any of the needs listed in the higher acuity tiers.

TABLE 1: MEMBER ACUITY TIERS: CRITERIA		
Tier 1	Tier 2	Tier 3
Wandering = 0 • Does not wander	Wandering = 1 • Daytime wandering but sleeps nights	Wandering = 2 • Wanders at night or day and night
Self-Injurious Behaviors = 0 • No injurious behaviors demonstrated	Self-Injurious Behaviors = 2 • Self-injurious behaviors require interventions 2-6 times per week or 1-2 times per day	Self-Injurious Behaviors = 3 • Self-injurious behaviors require intensive one-on-one interventions more than twice each day
Self-Injurious Behaviors = 1 • Some self-injurious behaviors require interventions weekly or less		
Offensive or Violent Behavior to Others=0 • No offensive or violent behaviors demonstrated	Offensive or Violent Behavior to Others = 2 • Offensive or violent behaviors that require	Offensive or Violent Behavior to Others = 3 • Offensive or violent behaviors that require

	interventions 2-6 times per week or 1-2 times per day	intensive one-on-one interventions more than twice each day
Offensive or Violent Behavior to Others = 1 • Some offensive or violent behaviors that require interventions weekly or less		
	Dressing = 2 • Help (supervision, cueing, hands-on assistance) needed- helper MUST be present	Uses Mechanical Lift (not a lift chair) selected for Transferring ADL.
	Toileting = 2 • Help (supervision, cueing, hands-on assistance) needed- helper MUST be present	Tracheostomy Care selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day
	Transferring = 2 Help (supervision, cueing, hands-on assistance) needed- helper MUST be present	Tube Feedings selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day
	Ostomy – Related Skilled Services selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day	Positioning in Bed or Wheel Chair every 2-3 hours selection is any of the following: 3-4/Day, or 5+/Day

iv. Member acuity tiers are to be calculated or re-calculated according to the timelines found in Articles III.F.4-5.

v. Minimum payment rates for owner-occupied 1-2 bed AFHs:
   a. Owner-occupied 1-2 bed Adult Family Homes (AFHs) are not subject to the DHS minimum rate tiers.

b. The minimum payment rates for owner-occupied 1-2 bed AFHs are to be no less than the equivalent of the 15-minute MCO-directed supportive home care (SHC) minimum payment rate, as contained in Article VIII.L.6.d.i, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision.
c. For the purposes of enforcement DHS will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.
d. Encounters for owner-occupied 1-2 bed Adult Family Homes (AFHs) are identified with Revenue Code "0240", procedure code "T2031" and modifier "U5" to indicate owner-occupied.

vi. MCO-Residential Provider contracts shall include the following:
a. One or more of the following according to the services being contracted for:
1. Tier structure
2. The minimum payment rates for owner-occupied 1-2 bed AFHs
b. The Rate per tier for the applicable provider type.
c. Provisions stating that the contracted rate will be no less than that listed for a member meeting the tier requirements.

vii. MCO-Supportive home care provider contracts shall include the following:
a. One or more of the following according to the services being contracted for:
1. The requirement in Article X. A. 4 or
2. The requirements in Article X. A. 5

viii. MCO-Residential Provider authorization requirements: MCO-Residential Provider authorizations shall include the following for each member:
a. The acuity tier that is applicable to the member;
b. The date the acuity tier was determined.
c. Whether the member's plan of care requires 1 or more staff dedicated solely to the individual member for 24-hours a day on a daily basis.
d. Changes to member's acuity tier:
1. In the event of a change in the member's acuity tier, the MCO shall have 60 (sixty) days to implement an updated authorization that reflects the member's updated acuity tier and associated minimum payment rate. The member's updated acuity tier and associated minimum payment rate shall be calculated as of the date of the functional screen result that caused a change to the member's acuity tier.
2. The effective date of the updated rate in the authorization under 1) shall be 30 days following the date of the functional screen result that caused a change to the member's acuity tier.

4. <u>Payment Rates for MCO-Directed Supportive Home Care (SHC) services</u>

i. MCOs must pay at least the 15-minute unit SHC minimum rate of $6.38 when the services are MCO-directed. MCOs must pay SHC daily or hourly rates that are greater than or equal to what the MCO would pay if it was paying the 15-minute unit SHC minimum rate, as contained in Article VIII.L.6.d.i, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or

others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision.

ii. For the purposes of enforcement DHS will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

iii. SHC minimum rates apply to the following medical codes when used for SHC services.
   a. 15-Minute Codes: S5120, S5125, S5130, S5135
   b. Per Diem Codes: S5121, S5126, S5131, S5136

5. Payment Rates for Self-Directed Supportive Home Care (SHC) services

i. The MCO shall increase self-directed services budgets of members so that all members have sufficient budget authority to pay the 15-minute unit self-directed SHC minimum fee rate of $4.08 and an additional $0.48 of state and federal payroll taxes and workers compensation for all units of supportive home care they receive through self-direction.

ii. The MCO shall pay at least $4.56 per 15-minutes for self-directed supportive home care for the sum of supportive home care worker wages, state and federal required payroll taxes, and workers compensation.
   a. Members who are self-directing supportive home care services must pay their supportive home care workers at least the $4.08 per 15-minute minimum rate unless a worker voluntarily opts out of the minimum rate. Members must pay SHC daily or hourly rates that are greater than or equal to what the member would pay if they were paying the 15-minute unit self-directed SHC minimum rate, as contained in Article VIII.L.6.e.i, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision.
      For the purposes of enforcement DHS will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

iii. SDS supportive home care workers may voluntarily opt out of the minimum rate payment requirement.
   a. If an SDS supportive home care worker voluntarily opts out of the MCO minimum rate payment requirement, they must sign a form designated by the Department confirming their decision to do so and the self-directing member and MCO must retain the signed form.

6. Medicaid State Plan Covered Services

If the service provided under this Contract is a Medicaid State Plan covered service, the Contract rate will be the provider's approved Medicaid State Plan rate. Rate increases issued within the Medicaid State Plan shall, as of the date on which the rate increase is made effective by the Wisconsin Medicaid State Plan program, replace the Provider's existing rate. Payment for Medicaid State Plan covered services (as specified in Chap. 49 Wis. Stats. and DHS 107 Wis. Admin. Code) shall be the lesser of the Medicaid rate in effect at the time service is provided or the Provider's billed charges.

B. Claims, Claims Payment, and Overpayment

The Lakeland Care is currently contracted with WPS, a third party administrator (hereinafter "TPA") to provide claims processing and Encounter reporting for the Family Care program. For payment, claims must be submitted to the TPA either electronically or in paper form; general requirements are outlined below. Should the Lakeland Care contract with a different TPA, Provider will be notified of the change.

Providers are required to apply for a National Provider Identifier (NPI) for all services that are considered medical services under the Family Care Benefit Package https://www.dhs.wisconsin.gov/familycare/benpackage.htm and must notify the Purchaser of the NPI number before claims will be paid. In the event a National Standard Code is assigned to the contract service(s), Provider must indicate this code in the claim for payment.

1. Clean Claim Requirement

Claims for payment submitted to the TPA must constitute "clean claims" which are those claims that are completely and accurately filled out. The TPA shall reject, and shall have no responsibility to pay, any claim that does not include the elements of a clean claim. The TPA shall notify the Provider of the reason for denial; Provider may correct the claim and submit it again for payment. The claim for payment of services must include the following in order to constitute a clean claim:

a. Each member's invoice must be a separate bill, including the member's full name;
b. Attach a copy of the letter of authorization for each service billed or include the authorization number on your bill;
c. Invoice must be in readable format;
d. Identify charges by service description or procedure code (as indicated on the authorization);
e. Actual delivery date(s) of EACH service;
f. Number of units of service provided on each date; and
g. Total amount billed per service.

Claims that are denied payment may be corrected and submitted again, including all of the above elements. Claims that have been partially paid may be resubmitted for reprocessing, following the TPA requirements for reprocessing claims.

2. Submission of Claims for Payment to TPA

Provider agrees to submit claims for payment to the TPA no later than ninety (90) calendar days from the date the service was provided if the Purchaser is the primary payor on the claim. For claims involving multiple dates of service, services provided greater than 90 days prior are not considered timely, clean claims. Purchaser may partially reimburse provider for timely portion of the claim in this situation. If the claim is submitted to a third party as the primary payor, the Provider agrees to submit claims for payment to the TPA no later than ninety (90) calendar days from the date of the insurance Explanation of Benefits (EOB), and no later than 365 days after the date of service. Claims that are not submitted timely will be denied by the TPA.

a. In the event of a federal or state declared emergency or disaster, Purchase has the ability to relax timely filing requirements for provider service claims for claims payments submitted in good faith but are delayed.

3. Electronic Submission of Claims

Provider is expected to submit claims electronically via the TPA web-site for all services in which the Purchaser is the primary payor. This requirement may be waived with written approval by Lakeland Care's Provider Relations and Contract Director. Please contact Lakeland Care's Provider Relations and Contract Director to request release from this requirement.

a. When Provider electronically bills or conducts any of the electronic transactions covered by the Health Insurance Portability and Accountability Act (HIPAA) with the Purchaser/TPA, then Purchaser/TPA and Provider shall conduct all electronic health care administrative transactions covered by HIPAA consistent with the Electronic Transactions and Code Sets Rule.
b. Electronic claims must be submitted according to the TPA requirements for billing, including all of the elements of a clean claim, listed above. Information on electronic filing requirements with WPS, Lakeland Care's current TPA, may be found at: https://www.wpsic.com/providers/index.shtml or the Provider page on the Lakeland Care website (http://www.lakelandcareinc.com/).

4. Procedure for Invoicing Services Covered by a Third-Party Payor

a. Provider agrees to follow Coordination of Benefits (COB) procedures established by the Wisconsin Office of the Commissioner of Insurance, acknowledging that the Purchaser is always the payor of last resort in circumstances where a member is covered by a third-party payor. The Provider shall bill all other primary third-party payors first.
b. In the event that the primary third-party payor denies the claim or makes only a partial payment on the claim, the Provider will submit invoices to the Purchaser's TPA within ninety (90) days of receiving the primary payor's denial or partial payment, but in any event no later than three hundred sixty-five (365) calendar days from the date the service was provided.
c. For claims previously billed to a third party payor, a copy of the Remittance Advice and/or Explanation of Medicare Benefits to the claim form is required. The TPA will then determine the appropriate additional payment, if any. Third party payments will be deducted from the contracted rates in calculating payment due
d. Invoicing for services covered by a third-party payor will be submitted as a paper claim to the TPA. Provider shall submit all clean paper claims to the following address:

Lakeland Care
C/O WPS Insurance Corporation
PO Box 211595
Eagan, MN 55121

5. Billing Members

Provider may not bill a member for covered and non-covered services, except in accordance with the provisions of the MCO Agreement (see Article VII, Section J, Billing Members, and K, Department Policy for Member Use of Personal Resources, of the MCO Agreement).

6. Overpayment

a. Provider agrees to report any overpayment to Purchaser as soon as possible upon identification, and no later than two (2) business days from the identification of the overpayment.
b. Provider agrees to return any overpayment to Purchaser within sixty (60) calendar days of the date on which the overpayment was identified.
c. Provider agrees to notify Purchaser in writing of the reason for the overpayment within ten (10) days of identifying the overpayment. Purchaser will reconcile any discrepancies with encounter reporting related to overpayment and reconcile the accuracy of encounter reporting in instances of reported overpayments.

C. Timing of Payment

Purchaser shall pay 95% of clean claims from all Providers within thirty (30) calendar days of receipt of a complete and accurate claim and 99% of those claims within ninety (90) days of receipt.

D. Payment in Full, Withholding of Payments and Payment Dispute Process

1. Acceptance of Payment in Full

Provider agrees to accept payment made by the Purchaser's TPA and/or any third-party payors as payment in full for services performed under this Contract and provided to a member. Any charge for a Medicaid-covered service over and above the Medicaid reimbursement, whether the charge is made through an intermediary or directly with a Medicaid recipient, is prohibited by state and federal law. Provider agrees not to seek additional payments beyond Purchaser payment or bill members and to hold harmless individual members, DHS and CMS in the event Purchaser, for any reason, cannot pay for services that are the legal obligation of Purchaser. This provision shall apply even if the Purchaser's failure to pay for services arises out of a Purchaser's breach of Contract, Purchaser's insolvency, provider billing or discontinuance of Purchaser's Family Care program.

2. Withholding of Payments

Purchaser may withhold or decrease future payments to Provider in the event that Purchaser determines claims have been overpaid, paid in error or that Provider has failed to perform services in accordance with this Contract and/or any addendums, attachments, amendments, or exhibits attached to it. LCI will use all standard practices available to recover claims overpayments/billing errors including provider refund or recoupment.

3. Process for Purchaser Provider Appeals

If Provider disputes a Purchaser's payment, non-payment, partial payment, late payment or denial of a claim, Provider may request reconsideration of Purchaser's action by filing a written appeal with the Purchaser's Fiscal Department within sixty (60) calendar days of Purchaser's initial payment/denial notice. The Fiscal Department will review claims for reconsideration when submitted by a Provider under this Contract. Provider appeals information can also be located on Purchaser's website at: http://www.lakelandcareinc.com/providers/claim-appeal-rights/.

Appeals from Providers must include the following characteristics:

a. Appeals must be clearly marked as "appeal" and addressed to the fiscal supervisor.
b. Appealed claims must be received within sixty (60) calendar days of the Provider Remittance Advice (PRA) or denial letter.
c. Claims must have all the elements of a clean claim as outlined in this contract, including Provider's name, member's name, service description or code, date(s) of service, date of billing, date of rejection, and copy of PRA.
d. Claims must include a written statement indicating why the denial is being appealed and should be reconsidered for payment. If more than one claim is being appealed each must have a reason statement or cover statement indicating that the reason for the appeal is the same for all resubmitted claims.
e. Claims submitted as appeals will be reviewed by Purchaser one time only.
f. Providers can further dispute an unpaid claim with DHS.

Completed appeal requests should be mailed to the following address:

Lakeland Care
Claims Department

N6654 Rolling Meadows Drive
Fond du Lac, WI 54937

All appeals should be clearly marked on the application letter as "appeal."

Purchaser will respond to the appeal within forty-five (45) calendar days from the date of receipt of the request for reconsideration/appeal. If Purchaser fails to respond within forty-five (45) calendar days, or if Provider is not satisfied with the Purchaser's response, Provider may appeal and seek a final determination from DHS.

4. Process for Appeals to DHS

a. The Department will review appeals and make final determinations in cases where;

i. The provider has requested a reconsideration by the MCO according to the terms described above; and

ii. The provider continues to dispute the MCO's appeal determination; or

iii. The MCO or provider fails to respond within forty-five (45) calendar days from the date of receipt of the provider's request for reconsideration.

b. Appeals must be submitted to the Department within:

i. Sixty (60) calendar days of the date of written notification of the MCO's final decision resulting from a request for reconsideration; or

ii. Sixty (60) calendar days after the MCO's failure to respond within forty-five (45) calendar days to the provider's request for reconsideration.

c. The Department will notify the MCO when a provider appeal is received and will share pertinent information so the MCO has an opportunity to respond.

d. The Department will accept written comments from all parties to the dispute prior to making the decision.

e. The Department can make a decision based on the information that it has even if it might not have all of the information that it has requested because the MCO or provider has failed to respond to a request from the Department for information by the deadline set by the Department.

f. The Department has forty-five (45) calendar days from the date of receipt of all written comments to respond to a provider's appeals.

g. The Department determinations may include the override of the MCO's time limit for submission of claims and appeals in exceptional cases. The Department will not exercise its authority in this regard unreasonably.

h. The MCO shall accept the Department's determinations regarding appeals of disputed claims. The MCO shall pay provider(s) within forty-five (45) calendar days of receipt of the Department's final determination.

In filing a request for reconsideration or appeal, Provider shall clearly mark it as an "appeal" and indicate the Provider's name, address, date of service, date of billing, date of rejection, the denial letter from the MCO, and reasons for Provider's request for reconsideration or appeal. An appeal submitted to DHS should be sent to:

Fax: (608) 266 – 5629

or

Mail: Provider Appeals Investigator
Division of Medicaid Services
1 West Wilson Street, Room 518
P.O. Box 309
Madison, WI 53701-0309

XI. MEMBER GRIEVANCES AND APPEAL

Grievance and Appeal Terms

Action means when Purchaser and/or Provider: (a) denies functional eligibility as a result of the administration of the long-term care functional screen, including a change from nursing home level of care to non-nursing home level of care; (b) denies or limits a service within the Family Care benefit package that the member requests; (c) reduces, suspends or terminates a service within the benefit package that the member is receiving; (d) denies payment for a service within the benefit package in whole or in part; (e) does not provide for services or items included in a member's service plan in a timely manner; (f) fails to resolve a member's grievance or appeal with in applicable time frames; (g) develops a service plan that is not acceptable to the member because the plan requires the member to live in a place that the member does not want to live, the plan does not provide care, treatment or support to meet the member's needs or the plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or that the member does not want; and (h) the Purchaser notifies the member of a decision made in response to a member's appeal that is entirely or partially adverse to the member.

Appeal means when Purchaser and/or Provider takes an "action" and the member requests review of the action.

Grievance means a written communication submitted by or on behalf of a member expressing dissatisfaction about any matter other than an "action." A grievance may relate to such things as quality of care or services, rudeness of a provider or employee or the failure of a provider to respect Member Rights.

A. Member Rights to File Grievances and Appeals

Provider recognizes that members have the right to appeal any action of Provider and/or Purchaser and/or file a grievance. Provider assures Purchaser that the filing of a grievance or appeal by a member will not adversely affect how the Provider treats the member or provides services to the member under this Contract. Provider will cooperate and not interfere with members' appeals, grievances and fair hearings procedures and investigations and timeframes.

B. Notification of Grievances and Appeals

Provider shall notify Purchaser in writing within five (5) business days of all member grievances and appeals filed in writing against the Provider and the action taken by the Provider to resolve such grievances and appeals.

C. Cooperation with Purchaser and Provision of Information

Provider agrees to fully cooperate to the extent permitted by law with Purchaser, the Wisconsin Department of Health Services, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity in investigating and resolving member complaints, appeals and grievances regarding Provider's services. Such cooperation will include furnishing information to Purchaser on member grievances and appeals within fifteen (15) business days of its request.

D. Purchaser's Grievance and Appeal Procedures

Purchaser has furnished Provider with a copy of its approved grievance and appeal procedures in Attachment 2. In the event that a member complains directly to the Provider, the member must be given a copy of these procedures which contains information related to:

a. The member's right to a fair hearing, how to obtain a hearing and representation rules at a hearing;
b. The member's right to file grievances and appeals and their requirement and timeframes for filing;
c. The availability of assistance in filing;
d. The toll-free number to file oral grievance and appeals;
e. The member's right to request continuation of benefits during an appeal or fair hearing filing, and, if the information that if the appeal is upheld in a hearing, the member may be liable for the cost of any continued benefits, and;
f. The member's appeals right to challenge the failure of the Purchaser to cover a service.

XII. RECORDS

A. Member Records

1. Provider and its subcontractors shall maintain and preserve individual member records in accordance with established professional and legal standards, applicable state and federal laws, rules and regulations. These records shall be accurate, legible and safeguarded against loss, destruction or unauthorized use and shall remain confidential as required by State and Federal law. Provider will protect from unauthorized disclosure all information, records, and data collected under the provider agreement. Access to this information shall be limited to persons who, or agencies such as the Department and CMS which, require information in order to perform their duties. Documentation in member records must reflect all aspects of care, including documentation of assistance with transitional care in the event of a disenrollment. The use or disclosure by any party of any information concerning members who receive services from Provider and/or Provider's subcontractors for any purpose not connected with the administration of Provider's or Purchaser's responsibilities under this Contract is prohibited except with the informed, written consent of the member or the member's authorized representative and only as permitted by Health Insurance Portability and Accountability Act and all other applicable state and federal law. Members have the right to approve or refuse the release of personally identifiable information, except when such release is authorized by law.

2. Members shall have access to their records in accordance with State and Federal law. Provider agrees to make records available to members and their authorized representatives within ten (10) business days of the record request if the records are maintained on site and sixty (60) calendar days if maintained off site in accordance with the standards in 45 CFR 164.524 (b)(2).

3. Provider agrees to forward records relating to grievances and appeals to Purchaser within fifteen (15) business days of the Purchaser's request or, immediately, if the appeal is expedited. If the Provider

does not meet the fifteen (15) business day requirement, the Provider must explain why and indicate when the records will be provided.

4. Member records shall be readily available for quality management (QM) and utilization review activities. The member records shall provide adequate medical and long term care service information, and other clinical data needed for QM and utilization review purposes, and for investigating member appeals and grievances.

5. Provider and its subcontractors shall implement specific procedures to assure the confidentiality of health and medical records and of other personal information about members including:

a. Members have the right to approve or refuse the release of personally identifiable information, except when such release is authorized by law;

b. Medical records shall be released only in accordance with federal or state law, or court orders or subpoenas;

c. Copies of records and information from the Provider shall be released only to authorized individuals; and

d. Unauthorized individuals shall be prohibited from gaining access to, or altering, member records.

B. Maintenance of Contract and Other Records

Provider shall maintain and preserve all documents and records in whatever format, and however maintained, relating to this Contract, the performance of services and Provider's obligations hereunder and the payment for Provider's services including, without limitation, documents and records relating to the following:

1. The provision, quality, quantity and timeliness of services covered by this Contract including, without limitation, documentation of care and services provided and the dates of services for all the services rendered;

2. Provider's costs of providing services supported by properly executed payrolls, time records, invoices, contracts, vouchers, or other official documentation evidencing in proper detail the nature and propriety of the services provided;

3. Provider's accounting and other financial management records pertaining to this Contract in a form and manner consistent with all applicable State and Federal laws and generally accepted accounting principles and financial management;

4. The provision of and reimbursement for activities contemplated under this Contract;

5. Provider's administration and compliance with the terms and conditions of this Contract;

6. Any complaints, critical incidents, emergencies or adverse events related to Provider's services;

7. Litigation involving this Contract and/or Provider's provision of services under this Contract;

8. Member complaints, appeals and grievances; and

9. Any other matter relevant to Provider's performance or provision of services or payment for those services under this Contract.

Provider shall ensure that its subcontractors comply with all record keeping requirements in this Contract.

C. Access to Premises and Information

1. Access to Premises

Provider shall allow duly authorized agents or representatives of Purchaser, the state or federal government, including CMS, the HHS Inspector General, the Comptroller General, or their designees or representatives, at any time, access to the Provider's premises, physical facilities, and equipment or the Provider's subcontractors' premises, physical facilities, and equipment to inspect, audit, monitor, examine, excerpt, transcribe, copy or otherwise evaluate the performance of the Provider or Provider's subcontractors' contractual activities and shall forthwith produce all records or documents, including but not limited to financial, member or administrative records, books, contracts, and computer or other electronic system requested as part of such review or audit.

The Department may inspect and audit any financial, care management, member, administrative or other records of the Provider and the Provider's subcontractors. There shall be no restrictions on the right of the state or the federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and the reasonableness of their costs or for any purpose the Department deems necessary for the administration or operation of the program. When requested by the Department or CMS, the Provider shall provide access to electronic records in any circumstances when the Provider uses electronic records.

In the event right of access is requested under this section, the Provider or Provider's subcontractors shall, upon request, provide and make staff available to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The Department may perform off-site audits or inspections to ensure that the Provider is in compliance with contract requirements.

All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Provider's or Provider's subcontractors activities. The Provider shall be given fifteen (15) business days to respond to any findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

2. Access to and Audit of Contract Records

Throughout the duration of this contract, and after termination of this contract, the Provider shall provide duly authorized agents of the Purchaser or state or federal government access to all records and material relating to the contract's provision of and reimbursement for activities contemplated under this contract. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as the records are retained, if longer. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of this contract. All information so obtained will be accorded confidential treatment as provided under applicable law. The rights to access, inspect and audit premises and contract records described in the MCO Contract exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines there is a

reasonable possibility of fraud or similar risk, these access and audit rights may be exercised at any time, regardless of any time period specified above.

D. Record Retention Period

The Provider agrees to comply with all applicable Federal and State record retention requirements. Provider shall retain, preserve and make available upon request all records or documents relating to the performance of its obligations under this Contract including, but not limited to, paper and electronic claim forms, for not less than ten (10) years following the end of this Contract period. Records or documents involving matters that are the subject of any litigation, claim, financial management review or audit shall be retained for a period of not less than ten (10) years following the termination or completion of the litigation, claim, financial management review or audit or disposition of real property and equipment acquired with Federal funds. The retention requirements above shall include records or documents related to recoveries of all overpayments from the MCO, to Provider, including recoveries of overpayments due to fraud, waste, or abuse. The Provider shall provide these records or documents to the Purchaser at no charge

XIII. REPORTING

Provider shall meet all reporting requirements imposed by Purchaser for the purposes of reviewing and auditing Provider's performance under this Contract and Purchaser's performance under its MCO Agreement with DHS. Provider's obligations shall include, without limitation, the obligation to timely provide all data requested by Purchaser, in the format specified by the Purchaser, related to Provider's quality assurance/quality improvement programs, utilization review, and encounter reporting, if applicable.

Provider agrees to report to the MCO all Provider preventable conditions with submission of claims for payment or member treatments for which payment would otherwise be made.

XIV. AFFIRMATIVE ACTION/CIVIL RIGHTS COMPLIANCE

A. Requirements

In addition to any requirements set forth in this Contract, Provider is required to comply with all applicable non-discrimination requirements and all affirmative action and civil rights compliance laws, regulations and requirements.

B. Civil Rights Compliance/Affirmative Action Plan

Provider must comply with the Department of Health Services' Affirmative Action/Civil Rights Compliance (CRC) requirements at http://DHS.wisconsin.gov/civil-rights/Index.HTM.The Provider must develop and submit a copy of their CRC/Affirmative Action plan to Purchaser. The civil rights/affirmative action plan requirements do not apply to a Provider that:

a. Only provides services in the Family Care benefit package; or
b. Meets one of the following criteria:
    1. Is under a contract with Purchaser less than $25,000; or
    2. Has less than twenty-five (25) employees regardless of the amount of the contract; or
    3. Is a foreign company with a work force of less than twenty-five (25) employees in the United States; or

4. Is a federal government agency or a Wisconsin municipality, or a federally-recognized Native American Tribe; or
5. Has a balanced work force.

Disability Related

Provider and Provider's subcontractors shall abide by the requirements of 41 CFR 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by Provider and Provider's subcontractors to employ and advance in employment qualified individuals with disabilities.

Veteran Related

Provider and Provider's subcontractors shall abide by the requirements of 41 CFR 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans, and requires affirmative action by Provider and Provider's subcontractors to employ and advance in employment qualified protected veterans.

C. Member Participation

No otherwise qualified person may be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the Provider are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

D. Employment

Except as otherwise permitted under state or federal law, no otherwise qualified person shall be excluded from employment with Provider, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race, religion, sexual orientation, color, sex, national origin or ancestry, handicap (as defined in Section 504 and the ADA), arrest or conviction record, marital status, political affiliation, military participation or other impermissible basis. Provider and its employees are expected to support goals and programmatic activities relating to nondiscrimination in employment. Provider shall post Equal Opportunity Policy, the name of Provider Equal Opportunity Coordinator, including the discrimination complaint process in conspicuous places available to applicants, employees and people who use Provider's services.

E. Compliance

Provider agrees to comply with affirmative action/civil rights monitoring reviews performed by the Purchaser, including the examination of records and relevant files maintained by the Provider. The Provider further agrees to cooperate with the Purchaser in developing, implementing, and monitoring corrective action plans that result from any reviews.

XV. TERMINATION

A. Termination

This Contract may be terminated by either party, for any reason or for no reason at all, following sixty (60) calendar days written notice to Provider. Purchaser may immediately terminate this Contract if such termination is essential to the safety and well-being of the members served under this Contract with the exception of those providers which must meet the notification requirements as applicable in Chapter 50 licensing. Purchaser may also immediately terminate this based on Provider's quality and/or safety deficiencies or failures, if Provider fails to comply with any legal, licensure and/or insurance requirements, in the event that Provider fails to otherwise meet the performance standards and requirements set forth in this Contract or at the direction of DHS. These rights of immediate termination shall be in addition to any and all other rights of immediate termination set forth herein. Unless otherwise directed by Purchaser in writing, termination shall not release the Provider of its obligation to serve members then receiving services until Purchaser can transfer the member or members to another service provider. Purchaser shall be responsible for paying for services provided up to and following termination to the extent that such services are authorized and in accordance with the terms and conditions of this Contract. Purchaser shall have a right to offset any damages sustained as a result of a breach or default by Provider from any amounts due and owing the Provider hereunder. Notwithstanding any other right of termination, Purchaser reserves the right to immediately terminate, or reduce in scope, its obligations under this Contract in the event that sources of funding to the Purchaser derived through State or Federal grants or Contracts are terminated or reduced. Purchaser's termination rights are in addition to any and all termination rights set forth elsewhere in this Contract. Nothing contained in this section shall be construed to limit or affect any remedies which Purchaser may have as a result of Provider's breach or default of this Contract.

B. Termination of Services by a Member

Members may terminate services at any time, and are not required to provide advance notice of termination to a service provider. In the event a member terminates service with a service provider, the Purchaser is not obligated to continue payments for the member beyond the effective date of the termination and any Service Authorization related to the member shall immediately terminate. Should Provider receive notice by a member to terminate services with the service provider, Provider shall notify Purchaser upon receipt of such notice.

C. Cooperation Following Termination or Nonrenewal

In the event that the Contract is terminated by Purchaser or not renewed by either Purchaser or Provider, the Provider agrees to continue services and cooperate with Purchaser or such other provider designated by Purchaser to ensure that there is no lapse in services provided to members.

D. Appeal of Contract Termination or Suspension

1. Appeal Procedure

Provider may appeal Purchaser's decision to suspend or terminate this Contract by submitting a written request for appeal to Purchaser's Provider Relations and Contract Director within ten (10) calendar days of Provider's suspension or termination at the following address:

Lakeland Care
Provider Relations and Contract Director
N6654 Rolling Meadows Drive
Fond du Lac WI 54937

The request for appeal must be in writing, specify Provider's reasons for the appeal and include any and all supporting documentation for the appeal. Failure of the Provider to appeal a suspension or termination

within ten (10) days shall result in a waiver and loss of Provider's appeal rights. This appeal procedure does not apply to a decision by Purchaser to not renew this Contract.

2. Decision

Purchaser's Provider Relations and Contract Director will advise Provider of its decision within forty-five (45) days of receiving the appeal. The decision of the Provider Relations and Contract Director shall be final and binding on the parties. If the appeal is upheld, Provider shall resume providing services under this Contract and all terms and conditions of the Contract will remain in effect. Resumption of services shall be Provider's sole and exclusive remedy in the event Provider's appeal is upheld.

3. Effect of Appeal

This appeal procedure does not stay Purchaser's decision to suspend or terminate Provider or otherwise modify the rights and obligations of the parties upon suspension or termination of this Contract. This appeal procedure is not intended to and does not alter, modify or otherwise restrict Purchaser's suspension or termination rights under this Contract.

XVI. BACKGROUND CHECKS

A. Requirements

Provider shall comply with all background check requirements under state and federal law including, but not limited to, Wis. Stat. § 50.065 and Wis. Admin. Code Ch. DHS 12 regarding caregiver background checks. Provider shall require all subcontractors, to comply with the aforementioned background check laws and this Contract. Provider shall conduct background searches at its own expense of all employees assigned to do work for the Purchaser under this Contract if such employee has regular, direct contact with the members of the Purchaser. Provider shall complete background searches prior to the employee's provision of services to a member. After the initial background check, Provider must conduct a new background check every four (4) years, or at any time within that period when the Provider has reason to believe a new check should be obtained or as otherwise required by law. "Employee" shall mean an employee or prospective employee of the Provider or Provider's, subcontractors, agents and assigns who do any work under this Contract.

Provider shall not assign any employee to provide services to members under this Contract who is barred from providing services under Wis. Stat. § 50.065, Wis. Admin. Code Ch. DHS 12 or other applicable laws or regulations. Provider shall notify the Purchaser in writing within one (1) business day upon discovering that an employee has been charged with or convicted of any crime specified in Wis. Admin. Code DHS 12.07(2). Provider further agrees to indemnify and hold harmless the Purchaser for any and all demands, claims, suits, liability, loss, damage or expense of any kind, including costs, fines and actual attorneys' fees, which results from the acts or omissions of the Provider, its subcontractors or its employees, with respect to the duties and obligations of the Provider in conducting the background investigation required hereunder.

All co-employment and fiscal employer agents under contract are required to perform background checks that are substantially similar to the back ground checks required under Wis. Stat. § 50.065 and Wis. Admin. Code Ch. DHS 12 on individuals providing services to self-directing members who have, or are expected to have, regular, direct contact with the member.

B. Policy

Provider shall maintain a policy that requires employees to notify Provider of criminal arrests and convictions, and policy on conducting new background checks at least every four (4) years or earlier, if Provider has reason to suspect a check is necessary. Provider's background check policy must comply with Wis. Admin. Code DHS 12 and the Caregiver Background Check Manual.

C. Records

Provider will maintain all pertinent records relating to its background checks in its Personnel files which will include a Background Information Disclosure Form and/or search results from the Department of Justice, the Department of Health Services, and the Department of Regulation and Licensing, as well as out of state records, tribal court proceedings and military records. All such records shall be maintained for at least the duration of the Contract and for a period of five (5) years thereafter. Purchaser may audit Provider personnel and subcontractor personnel files to assure compliance with the State of Wisconsin Caregiver Background Check laws and regulations and the terms and conditions of this Contract. The Caregiver Background Check shall be made available to the member.

D. Unsafe Providers

Purchaser reserves the right to not pay Provider and to immediately suspend or terminate this Contract if the Purchaser, in its sole discretion, deems Provider or any of Provider's subcontractors is unsafe based on the findings of past criminal convictions stated in the caregiver background check.

XVII. MISCELLANEOUS

A. General Conditions

1. This Contract is contingent upon: 1) authorization of Wisconsin and United States laws; 2) any amendment or repeal of the same affecting relevant funding; and 3) authority of the Department of Health Services to terminate this Contract.
2. This Contract does not terminate the legal liability of Purchaser under the MCO Agreement.
3. The various rights, powers, options, elections and remedies of Purchaser provided in this Contract, shall be construed as cumulative and not one of them is exclusive of the others or exclusive of any rights, remedies or priorities allowed by law, and shall in no way affect or impair the right of the Purchaser to pursue any other equitable or legal remedy to which it may be entitled.
4. Nothing in this Contract is intended nor shall be construed as creating any exclusive arrangement between Purchaser and Provider and/or its subcontractors. This Contract shall not restrict Purchaser from acquiring similar, equal or like goods and/or services from other entities or sources. Likewise, this Contract shall not restrict Provider and/or its subcontractors from providing equal or like goods and services to other entities or individuals.
5. Provider shall comply with the Affordable Care Act, 42 CFR 455.2 and 455.23 as relates to the suspension of payments to Provider pending investigation of a credible allegation of fraud.

B. Modification

Except as otherwise provided in this Contract, this Contract may only be modified by written mutual consent of the parties. This Contract shall automatically incorporate any modifications that are mandated by changes in federal or state laws, rules or regulations, amendments to Wisconsin's CMS approved waivers or the state plan or modifications required by DHS under the MCO Agreement. Purchaser will provide Provider with notice of any such mandatory contract modifications.

C. Prohibited Practices

Purchaser and Provider will prohibit any communication, activities or written materials that make any assertion or statement, that the Purchaser and/or Provider are endorsed by the CMS, the federal or state government or any other entity. Marketing/outreach activities or materials distributed by a residential services subcontractor, which claim in marketing its services to the general public, that the Family Care, Partnership or PACE programs will pay for an individual to continue to receive services from the subcontractor after the individual's private financial resources have been exhausted are prohibited. The additional 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 insurance product;

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

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

e. Activities and materials that could mislead, confuse or defraud members or potential members or otherwise misrepresent the MCO, 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:

   v. The recipient must enroll in the MCO in order to obtain benefits or in order to not lose benefits; or

   vi. The MCO is endorsed by CMS, the federal or state government, or other similar entity.

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

g. Practices to influence the recipient to either not enroll in or to disenroll from another MCO plan

D. Member Communications by Licensed Providers

Purchaser will not prohibit, or otherwise restrict, a licensed provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is a patient of the licensed provider, including any of the following:

1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
2. For any information the member needs in order to decide among all relevant treatment options.
3. For the risks, benefits, and consequences of treatment or non-treatment.
4. For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

E. Sanctions, Criminal Investigations

Provider must notify the Purchaser of any sanctions imposed by a governmental regulatory agency and/or regarding any criminal investigation(s) involving the Provider.

F. Governing Law and Forum for Disputes

This Contract and any disputes hereunder shall be governed by and construed in accordance with the internal laws of the State of Wisconsin without giving effect to any choice or conflict of laws provision or rule (whether of the State of Wisconsin or any other jurisdiction) that would cause the application of laws of any jurisdiction other than those of the State of Wisconsin. Except as otherwise provided in this Contract, the parties hereto agree that all actions or proceedings arising in connection with this Contract shall be tried and litigated exclusively in Fond du Lac County Circuit Court, State of Wisconsin or the United States District Court for the Eastern District of Wisconsin. The aforementioned choice of venue is intended by the parties to be mandatory and not permissive in nature, thereby precluding the possibility of litigation between the parties with respect to or arising out of this Contract in any jurisdiction other than that specified in this paragraph. Each party hereby waives any right it may have to assert the doctrine of forum non conveniens, lack of personal jurisdiction or similar doctrine or to object to venue with respect to any proceeding brought in accordance with this paragraph, and stipulates that the state court located in Fond du Lac County, Wisconsin or the United States District Court for the Eastern District of Wisconsin shall have subject matter and in personal jurisdiction and venue over each of them for the purpose of litigating any dispute, controversy, or proceeding arising out of or related to this Contract.

G. Notices

Any inquires related to this Contract, its administration and the performance of services under this Contract shall be directed to the following:

1. Purchaser

The Purchaser employee responsible for day-to-day administration of this Contract for purposes of receiving notices, requests for information, and other communications is Purchaser's Provider Relations Director, at 920-906-5100, located at Purchaser's business address.

2. Provider

The Provider employee responsible for day-to-day administration of this Contract will be Name, title whose business address is the same as Provider. In the event that the administrator is unable to administer this Contract, Provider will contact Purchaser and designate a new administrator within ten (10) business days.

H. Severability

If any provision of this Contract is held unlawful or invalid by court or administrative decision, it shall be deemed severable and such unlawfulness or invalidity shall not in any way affect any other provision of this Contract which can be given effect without the unlawful or invalid provision.

I. Waiver

Any failure of a party to enforce, for any period of time, any of the provisions under this Contract shall not be construed as a waiver of such provisions or of the right of said party thereafter to enforce each and every provision under this Contract.

J. Assignment

Provider may not assign any of its rights or obligations hereunder, whether by operation of law or otherwise, without the prior written consent of the Purchaser. For the purpose of construing this provision, a transfer of a controlling interest in the Provider shall be considered an assignment. Any prohibited assignment by a party without such consent shall be null and void. This Contract will be binding upon and will inure to the benefit of a party's permitted successors and assigns.

K. Survival

The terms and provisions of this Contract that, by their sense and context, are intended to survive the completion or termination of this Contract shall so survive the completion of performance or termination of this Contract including, without limitation, hold harmless and indemnification provisions, record retention and confidentiality.

L. Counterparts

This Contract may be executed in one or more counterparts, each of which shall be considered an original, and all of which taken together shall be considered one and the same instrument. A facsimile signature will have the same legally binding effect as an original signature.

M. Entire Agreement

This Contract, the documents incorporated by reference herein and the attachments hereto constitute the entire Contract between the contracting parties concerning the subject matter hereof. All prior contracts, discussions, representations, warranties and covenants are merged herein. There are no warranties, representations, covenants or contracts, expressed or implied, between the parties except those expressly set forth in this contract. Any exhibits, schedules and attachments to this Contract are a part of this Contract and are incorporated into this Contract as if fully set forth herein.

O. Signatures

Each signatory represents that it has the full authority to enter into this Contract and to bind their respective party to all of the terms and conditions herein.

CONTRACT EFFECTIVE DATE: Click or tap to enter a date.

FOR PURCHASER: _____ _____Click or tap to enter a date.
PAIGE DOMACH, PROGRAM OPERATIONS DIRECTOR DATE

PROVIDER ENTITY LEGAL NAME: Click or tap here to enter text.

Tax ID: Click or tap here to enter text.

☐ I acknowledge receipt of this contract and its attachments and corresponding service addenda.

FOR PROVIDER: _____
Provider Signature, Title DATE

PROVIDER CONTACT PERSON (please print): _____