

**AGREEMENT FOR SERVICES**

**BETWEEN**

**CARE WISCONSIN FIRST, INC.**

**AND**

THIS AGREEMENT is made by and between Care Wisconsin First, Inc., a Wisconsin nonprofit, tax-exempt organization (“Care Wisconsin,” or “MCO” for “Managed Care Organization”) and \_\_\_\_\_ (“Provider”).

WHEREAS, Care Wisconsin Health Plan, Inc. (the “Health Plan”), a subsidiary of Care Wisconsin, operates Family Care Partnership (“Partnership”), a Medicare Advantage Special Needs Plan (“SNP”) and Wisconsin Medicaid Program (“WMP,” operated by the State of Wisconsin Department of Health Services, hereafter “DHS”), to provide or arrange for the provision of comprehensive health and long-term care services to eligible persons (“Members,” as defined below);

WHEREAS, Care Wisconsin has entered into a Health and Community Supports Contract (“MCO Contract”) with the State of Wisconsin, represented by its Division of Long Term Care, of the DHS to provide or arrange for the provision of certain health and long-term care services to Members (“Family Care”).

WHEREAS, Provider desires to enter into an agreement with Care Wisconsin to provide the services described in this Agreement; and

NOW THEREFORE, it is agreed as follows:

**I. DEFINITIONS**

1.1 Agreement. Shall mean this Agreement for Services and all exhibits, attachments, schedules and amendments hereto.

1.2 Covered Services.

1.2.1 For Family Care Partnership, Covered Services include all Medicaid State Plan services required under [WI Stats. s.49.46 \(2\)](#), [Wisconsin Administrative Code HFS 107](#) and all Medicaid waiver services in the Partnership Program [s. 1915 \(c\) waiver](#).

1.2.2 For Family Care, Covered Services include the services defined in Wisconsin’s Centers for Medicare & Medicaid Services (“CMS”) approved s. 1915 (c) home and community-based waiver services waivers: #0367.90 and #0368.90 under s. 46.281 (1) (c) Stats.

1.3 Critical Incident. An event, incident, or course of action or inaction that is either:  
a) associated with suspected abuse, neglect and financial exploitation, other crime, or a violation of member rights,

- b) or that:
  - i. resulted in serious harm to the health or well-being of a member, or
  - ii. resulted in serious harm to the health or well-being of another person as a result of the member's actions; or
  - iii. resulted in substantial loss in the value of the personal or real property of a member or of another person as a result of the member's actions, or
  - iv. resulted in the unexpected death of a member; or
  - v. posed an immediate or serious risk to the health, safety, or well being of a member, but did not cause harm because of chance or preventive intervention.
  
- 1.4 Emergency Medical Condition. Shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
  - a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
  - b) Serious impairment to bodily functions.
  - c) Serious dysfunction of any bodily organ or part.
  
- 1.5 Interdisciplinary Team. Shall mean the team that includes the Member, social service care managers and RN care manager, for Family Care, and, for Family Care Partnership, shall mean the team that includes the Member, a nurse practitioner, RN care managers and social services care manager.
  
- 1.6 Medicaid. Shall mean the WMP operated by the DHS under Title XIX of the Federal Social Security Act, Ch. 49, Wis. Stats. and related state and federal rules and regulations.
  
- 1.7 Medicaid Covered Services. Shall mean those services reimbursed for by the WMP for people eligible for Medicaid benefits under §49.46(2), Wis. Stats. and Ch. HFS 107 of the Wisconsin Administrative Code.
  
- 1.8 Medicare. Shall mean the health insurance program operated by the U.S. Department of Health and Human Services ("DHHS") under 42 CFR subchapter B, and 1965 Act, Title I of Public Law 89-97, as amended.
  
- 1.9 Medicare Covered Services. Shall mean those services reimbursed for by the CMS for people eligible for Medicare benefits.
  
- 1.10 Member. Shall mean a person who is enrolled in Family Care Partnership or Family Care.
  
- 1.11 Network Physician – A licensed doctor of medicine or osteopathy with which Care Wisconsin has an Agreement for Services for the provision of medical services to Members.

- 1.12 Primary Care Physician. Shall mean any Network Physician (MD or DO) whose primary care specialty is family practice or general internal medicine and who has agreed to work within the parameters of Care Wisconsin's model of care.
- 1.13 Provider. Shall mean a care provider who will provide the health and/or long-term care services specified in Appendix A of this Agreement.
- 1.14 Reasonable Efforts. Shall mean with respect to a given goal, the efforts that a reasonable person in the position of Provider or MCO would use so as to achieve that goal as expeditiously as possible.
- 1.15 Special Needs Individual. Shall mean a Medicare Advantage-eligible individual who would benefit from enrollment in a specialized Medicare Advantage plan.
- 1.16 Special Needs Plan ("SNP"). Shall mean any type of Medicare Advantage Coordinated Care Plan that exclusively enrolls, or enrolls a disproportionate percentage of, Special Needs Individuals.
- 1.17 Urgent Care. Shall mean medically necessary care that is required by an illness or accidental injury that is not life-threatening and will not result in further disability but has the potential to develop such a threat if treatment is delayed longer than twenty-four (24) hours.

## II. SERVICES

Subject to the terms and conditions herein, Provider:

- 2.1 Will provide to Members the Covered Services specified in Appendix A affixed hereto and made a part hereof.
- 2.2 Will not create barriers to access to care by imposing requirements on Members that are inconsistent with the provision of necessary Covered Services (e.g., third party liability recovery procedures that delay or prevent care).
- 2.3 Agrees to cooperate with the Health Plan and MCO to ensure that Members receive timely access to Covered Services, that such services meet community standards of quality, and to ensure continuity of care, consistent with the requirements of CMS Guidelines for Access Standards and any other applicable access requirements mandated by law. Health Plan and MCO will not be required to use any specific amount of services.
- 2.4 Will obtain Health Plan's and MCO's prior authorization, if such prior authorization is required, before providing or arranging for the provision of services for which the Health Plan and MCO require prior authorization. Provider will not independently arrange or refer Members for services. Prior authorization is required from the Health Plan and MCO medical director or the Interdisciplinary Team for certain services. Provider acknowledges that the Health Plan and MCO may change such prior authorization requirements from time to time, and agrees to verify such requirements in the online version of the Care Wisconsin Provider Manual, to which the Provider has access, before providing or arranging for the provision of such services.

## III. TERM AND TERMINATION

- 3.1 Term. The initial term of this Agreement shall be from \_\_\_\_\_ through December 31, \_\_\_\_\_. Thereafter, this Agreement will automatically renew each January 1, subject to the terms and conditions of this Agreement.
- 3.2 Termination or Suspension. This Agreement may be terminated:
- 3.2.1. At anytime by mutual agreement of the parties
- 3.2.2 Without cause at anytime by either party upon sixty (60) calendar days prior written notice to the other party, and without pursuing dispute resolution as set forth in Section X herein.
- 3.2.3 With cause if there is any material breach in the performance of the terms and conditions of this Agreement (breach), which breach has not been cured within thirty (30) calendar days following written notice of such breach. Material breaches shall not be subject to the dispute resolution process described in Section X herein.
- 3.2.4 By Health Plan and MCO if Provider or any of Provider's employees or subcontractors:
- 3.2.4.1 loses any required liability insurance coverage
- 3.2.4.2 loses any required Medicaid or Medicare certification
- 3.2.4.3 loses any license(s) required to perform the services to be rendered under this Agreement
- 3.2.5 Notwithstanding any other provision herein except 3.2.8, 4.7 and 8.4.2, by Provider upon thirty (30) calendar days prior written notice to Health Plan and MCO if the Health Plan and MCO are unable to pay for services rendered under this Agreement
- 3.2.6 The rights of Provider or of any personnel employed or subcontracted by Provider to provide Covered Services to Members may be reduced, suspended or terminated indefinitely and immediately by Health Plan and MCO whenever Health Plan and/or MCO determine that such action may be necessary in order to safeguard the health and welfare of Members, including but not limited to gross misconduct by Provider, and violations of professional ethics. The Health Plan and/or the MCO shall notify Provider of such reduction, suspension or termination of participation in the Health Plan and MCO provider network within seven (7) calendar days of the decision by the Health Plan and/or the MCO, as the case may be. The Health Plan and/or the MCO shall duly consider any objections or concerns that Provider may raise with regard to any such action as soon as reasonably possible, but the decision whether to effect or continue any such action shall rest solely with the Health Plan and/or the MCO. If this Agreement is terminated or suspended on this basis, Provider may appeal the termination or suspension decision. The process for filing such an appeal is described in the Care Wisconsin Provider Manual.
- 3.2.7 Termination will have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

Nothing in this Agreement will be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

- 3.2.8 In the event this Agreement is terminated for any reason, Provider agrees to collaborate with the Health Plan and MCO to ensure continuity of care for Members receiving services from Provider at the time notice of termination is provided.

#### IV. COMPENSATION

- 4.1 Services. The Health Plan and MCO will reimburse the Provider according to the terms and conditions of Appendix B. For Medicaid Covered Services, Care Wisconsin reimburses nursing homes based on the RUGs-Based Acuity Method for MCOs mandated by DHS. If Provider is a nursing home, Provider shall provide Care Wisconsin's claims manager with a copy of its Medicaid Fee-for-Service ("FFS") rate letter within two (2) business days of receiving it in order to ensure Care Wisconsin can load the nursing home's RUGs rates into the claims system before the new rates take effect.
- 4.2 Rate Renegotiation. Care Wisconsin reserves the right to renegotiate mutually agreeable rates for services offered under this Agreement.
- 4.3 Coordination of Benefits. Provider shall submit directly to Care Wisconsin or Care Wisconsin's designee, as specified prior to or when a Member presents for services, all claims for Covered Services rendered to a Member. If applicable to Provider type, Provider agrees to follow Coordination of Benefits ("COB") procedures established by CMS and WMP, acknowledging that the Health Plan or MCO may be the secondary payer in circumstances when a Member is covered by a third-party payer. If the Health Plan or MCO is not primary in a COB situation, Provider will bill other primary third-party payers first; in the event that the primary payer denies the claim or makes only a partial payment on the claim, Provider will submit invoices to Care Wisconsin or Care Wisconsin's designee within sixty (60) calendar days of receiving the primary payer's denial or partial payment.
- 4.4 Hold Harmless. The payments by the Health Plan and/or the MCO under Section 4.1 of this Agreement, together with any copayment, deductible or coinsurance for which the Member is responsible, are payment in full for a Covered Service. Provider represents and warrants that Provider agrees not to bill Members and not to accept any payment from a Member or anyone acting on behalf of a Member, in excess of payment in full as provided in this Section 4.4. Provider agrees that in no event, including but not limited to non-payment by Health Plan or MCO, insolvency of Health Plan and/or MCO, or breach by Health Plan and/or MCO of this Agreement, will Provider charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or person (other than the Health Plan and/or the MCO, as the case may be) acting on behalf of the Member for Covered Services provided under this Agreement.
- 4.5 This obligation to refrain from billing Members applies even in those cases in which Provider believes that the Health Plan or MCO has made an incorrect determination. In such cases, Provider may pursue remedies under this Agreement against the Health Plan or MCO, as the case may be, but must still hold the Member harmless.

The provisions of this Section will be construed in favor of the Member, and will survive the termination of this Agreement regardless of the reason for termination and will supersede any oral or written contrary agreement between Provider and Member or the representative of a Member if the contrary agreement is inconsistent with this Section.

- 4.6 Obligation to Pay. The obligation of the Health Plan and MCO or the Member, as the case may be, to pay all amounts owing to Provider under this Agreement shall survive any termination of this Agreement.
- 4.7 Member Protection. Provider agrees that in the event of the Health Plan's or MCO's insolvency or other cessation of operations, Provider will continue to provide Covered Services to a Member for the duration of the contract period for which CMS and DHS payments have been made to Health Plan or MCO.

## V. BILLING AND CLAIMS

- 5.1 Claims. If applicable to Provider type, Provider will directly bill all insurance in effect that is primary to Medicare and WMP as provided in Section 4.3 herein. Provider will submit all claims payable by the Health Plan and MCO under this Agreement to Care Wisconsin's third-party claims processing service ("TPA"), or to Care Wisconsin, as instructed, in standard industry format acceptable to Medicare and/or WMP (including, in the latter case, the Member-specific RUGs rate), or in an alternate format approved by Health Plan and MCO. For Medicare Covered Services, Provider will complete the claims in the same manner required for reimbursement under Medicare, including but not limited to, all appropriate CPT, ICD9-CM and related HCPCS codes, except when such codes are not applicable based on the services provided under this Agreement. Provider's claims shall be in compliance with the standards for electronic transactions set forth in 45 CFR 162.
- 5.2 Timeliness of Claims. A completed claim for which the Health Plan or MCO is the primary payer will be submitted no later than sixty (60) calendar days after the date of service.
- 5.3 Timeliness of Payments. The Health Plan and MCO (or the TPA) will make payment to the Provider within thirty (30) calendar days of receiving a properly submitted claim.
- 5.4 Adjustments. All claims will be considered final unless Provider requests an adjustment in writing within sixty (60) calendar days after Care Wisconsin or Care Wisconsin's TPA receives Provider's invoice. If Provider is a nursing home and there is a retroactive change in the RUGs rates for Provider's facility based on the final FFS rate letter, please contact Care Wisconsin's claims manager to request a retrospective reconciliation related to the RUGs rates in your facility's final rate letter.
- 5.5 Claim Denial and Appeal Process. Provider may submit an appeal to the Health Plan or MCO if the Health Plan or MCO denies payment in full or in part for services rendered by Provider. The Health Plan or MCO will provide a representative to review the denial with the aggrieved party, and, if appropriate, will reprocess the claim for payment. In the event of any dispute arising from any claim or bill submitted by Provider, each party will have access to all reasonable and necessary documents and records that would, at the discretion of either party, tend to sustain its claim. Patient records will be released only to the extent allowable under

Wisconsin and federal law. The Health Plan or MCO will not be liable to pay the Provider for services the Provider provided to Members without having obtained any required prior approval. If the Provider is not satisfied with the outcome of his or her appeal to the Health Plan or MCO, the Provider may appeal the Health Plan's or MCO's decision to DHS, as outlined in the MCO Contract and in the Care Wisconsin Provider Manual.

- 5.6 Reports. Provider and the Health Plan or MCO will provide each other with mutually agreed upon, periodic reports regarding Members' utilization.

## VI. CERTIFICATION

- 6.1 Certification. Provider shall maintain Medicare and/or WMP certification, if so required, and appropriate licenses during the term of this Agreement. Provider warrants that Provider and each health care professional employed or subcontracted by Provider to provide services under this Agreement is: licensed to provide services or practice in Wisconsin, and is qualified to provide services under Medicare and the WMP, if applicable.

Provider agrees to verify the credentials of all health care professionals and other staff that will provide services to Members under this Agreement, as required in Section 6.2.

- 6.2 Verification. Credential verification is the review of licenses, diplomas, transcripts, certificates, or other documentation of an individual's qualifications to provide services under this Agreement. For physicians and other licensed health care professionals, including members of physician groups, the process must verify current eligibility to participate in Medicaid and Medicare programs. For other care workers (including employees, subcontractors and volunteers) such as personal care workers and transportation providers, the process includes the completion of any education or skills training necessary to provide specific services and a criminal background check. Provider agrees to verify individual credentials of health professionals and other service workers employed or subcontracted by Provider who provide services under this Agreement. Provider warrants that it is making the necessary criminal background checks required by Chapter HFS 12 of the Wisconsin Administrative Code and is in compliance with the code governing hiring and contracting.

- 6.3 Notification. Provider agrees to promptly notify Care Wisconsin as specified in Section XXI:

- 6.3.1 if Provider loses his or her Medicaid or Medicare certification;
- 6.3.2 if Provider or any of Provider's employees or subcontractors loses organizational or individual professional licensure for any of the services provided under this Agreement;
- 6.3.3 of the termination or limitation of staff privileges;
- 6.3.4 of changes in malpractice insurance coverage;
- 6.3.5 of the imposition of a Statement of Deficiency issued by the Division of Quality Assurance, DHS; and
- 6.3.6 of the imposition of sanctions by the Medicare or the WMP against a physician, health care professional or other care giver employed or subcontracted by Provider, for those individuals providing services under this Agreement. Loss of such certification or licensure may constitute a breach subject to termination, in the sole discretion of the Health Plan, as described in Section III herein. In the sole discretion of the Health

Plan, the Health Plan may request that Provider bar from participation under this Agreement any individual employee or subcontractor whose continued participation represents a threat to the health or welfare of a Member.

- 6.4 Provider shall make Reasonable Efforts to provide notice to the Health Plan of termination of an employed or contracted Primary Care Physician under this Agreement at least thirty (30) calendar days before the termination effective date to all Members seen on a regular basis by the Primary Care Physician whose contract is terminating, irrespective of whether the termination was for cause or without cause.
- 6.5 If a Statement of Deficiency has been issued by the Division of Quality Assurance, DHS, Provider shall, upon request by Health Plan or MCO, provide a correction action plan to Health Plan or MCO, as the case may be.

## VII. ASSIGNMENT

This Agreement cannot be assigned or delegated by either party hereto without the prior written approval of the other party hereto.

## VIII. COOPERATION

- 8.1 Cooperation Between the Parties. Health Plan, MCO and Provider agree that to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits and access to care for Members at the most reasonable cost consistent with quality standards of care.
- 8.2 Quality Assurance and Improvement.
- 8.2.1 Provider agrees to cooperate with Care Wisconsin in its implementation of effective quality assurance and quality improvement programs, subject to state and federal laws applying to access to records. Provider agrees to:
- 8.2.1.1 allow Care Wisconsin access to appropriate records in the Health Plan's and MCO's conduct of oversight and review;
  - 8.2.1.2 cooperate with CMS and DHS in their quality assurance oversight activities, including assisting CMS, DHS and/or any reviewing bodies under contract with CMS or DHS in identification of Provider and Member data required to carry out on-site medical chart review;
  - 8.2.1.3 report Critical Incidents.
- 8.2.2 Provider agrees to provide services in accordance with the services authorized through the Member's Interdisciplinary Team, and to submit reports as required by the Health Plan and MCO.
- 8.2.3 Provider acknowledges its access to the Care Wisconsin Provider Manual, which describes the Health Plan's and MCO's grievance resolution, utilization management, quality improvement, quality assurance, and provider credentialing and re-

credentialing programs. Provider shall comply with the requirements thereof, as reasonably amended from time to time by the Health Plan and MCO. The Care Wisconsin Provider Manual is incorporated herein and made a part hereof by reference.

- 8.3 DHS and CMS Requirements. Provider represents that Provider understands the Health Plan and MCO are subject to Medicare and WMP laws, regulations, CMS and DHS instructions, and contractual obligations with CMS and DHS, and Provider agrees to fully assist the Health Plan and MCO in complying with the terms and conditions of these laws, regulations, instructions, and Health Plan's and MCO's contracts with CMS and DHS, as modified from time to time by CMS or DHS, as the case may be. Provider has reviewed DHS' contract requirements for Health Plan's and MCO's subcontracts, attached hereto as Appendix C. Subject to its right to terminate this Agreement pursuant to Section III herein, Provider represents that Provider will also cooperate with Health Plan and MCO in complying with any amendments or additional requirements for the Health Plan's and MCO's Providers. Health Plan and MCO will give Provider at least thirty (30) calendar days' prior written notice of any such amendment(s) or additional requirements, whenever Health Plan and MCO have been given sufficient time to ensure compliance with this requirement; in any other situation, Health Plan and MCO will provide such notice as soon as it is practicable to do so.
- 8.4 Compliance with Federal and State Laws, Continuity of Care. Provider represents and warrants that it requires its employees, subcontractors and any other individuals who may provide services under this Agreement to:
- 8.4.1 comply with federal and state laws; and
  - 8.4.2 cooperate with the Health Plan and MCO to ensure continuity of care for Members.

## IX. GRIEVANCES AND APPEALS

Provider agrees to cooperate with, and upon request, to furnish all relevant information to the Health Plan, MCO, CMS or DHS in resolving any Member's grievance or appeal related to the provision of services under this Agreement. Provider agrees to forward to the Health Plan or MCO any medical records pursuant to grievances or appeals, within fifteen (15) working days of the Health Plan's or MCO's request, or immediately, if the grievance or appeal is expedited. If Provider does not meet the fifteen-(15-)day requirement, Provider will explain the reason for the delay and indicate when the medical records will be delivered. Provider agrees to comply with the Health Plan's and MCO's adjudication process for any Member's grievance or appeal. This procedure allows Members to appeal any Health Plan and MCO denial or reduction of Medicare or Medicaid services or denial of payment for Medicare or Medicaid services through the Health Plan's or MCO's appeals committee. A description of the Member's grievance or appeal process is found in the Member's Evidence of Coverage document. This document is available on line at [www.carewisc.org](http://www.carewisc.org).

## X. DISPUTES

If any dispute shall arise with regard to the interpretation of any of the terms of this Agreement, the parties hereto agree to resolve disputes by meeting or teleconference within sixty (60) calendar days of the date such dispute was brought to the attention of one party by the other party. If the parties are unable to reach a resolution of the dispute within said sixty (60) calendar days, either party may give

the other party thirty (30) calendar days prior written notice of its intent to terminate this Agreement.

## XI. INSURANCE AND INDEMNIFICATION

- 11.1 Insurance for Provider. If and as applicable to provider type provider shall secure and maintain, at its sole cost and expense throughout the term of this Agreement such policy or policies of general liability insurance and professional liability insurance (malpractice insurance) as shall be necessary to insure Provider, its employees and subcontractors and its agents against any claims for damages arising by personal injury or death, occasioned directly or indirectly in connection with the performance of any services by said employee, subcontractor or agent. For physicians, coverage limits shall be in at least the amount specified in Ch. 655.23(4) Wis. Stats. For other provider types, coverage limits shall be in at least the amounts required by law, if any. Provider will give thirty (30) calendar days' notice of termination of insurance. Upon entering into this Agreement, Provider will provide the Health Plan and MCO with a Certificate of Insurance to confirm compliance with this Section XI. Prior to any modification, expiration and/or cancellation of insurance coverage, Provider will secure replacement coverage and provide the Health Plan and MCO with a revised or new Certificate of Insurance within ten (10) calendar days of each policy renewal.
- 11.2 Insurance for the Health Plan and MCO. The Health Plan and MCO, at their sole cost and expense, shall procure and maintain in full force and effect throughout the term of this Agreement, general comprehensive liability insurance in the amount of not less than one million dollars (\$1,000,000). Upon request, the Health Plan and MCO will provide Provider with a Certificate of Insurance to confirm compliance with this Section XI.
- 11.3 Notice of Potential Complaint or Grievance. The Health Plan and MCO will promptly advise Provider in the event it has reason to believe a complaint or grievance may exist against Provider for services performed under this Agreement. Notification under this Section will be for information purposes only and will not substitute for the statutory notification and claim procedure of Section 893, Wis. Stats.

Provider will promptly identify complaints and grievances against Provider for services performed under this Agreement and will forward these complaints and grievances to the Health Plan or MCO.

- 11.4 Indemnification. Each party will be responsible for its own acts or omissions and any and all claims, liabilities, injuries, suits, and demands and expenses of all kinds which may result in or arise out of any conduct, negligence or willful misconduct caused or alleged to have been caused by that party, its employees or non-physician agents, in the performance or omission of any act or responsibility of that party under this Agreement (Losses). In the event that a claim is made against both parties, it is the intent of both parties to cooperate in the defense of said claim and to cause their insurers to do likewise. However, both parties shall have the right to take any and all actions they believe necessary to protect their interest. In the event that either party incurs damages, costs or expenses solely by reason of the other party's criminal conduct, negligence or willful misconduct pertaining to this Agreement, then, in addition to any right of contribution or other cause of action that may be provided by law, the damaged party shall be indemnified by the other party for Losses incurred by such damaged party.

## XII. NONDISCRIMINATION/CIVIL RIGHTS COMPLIANCE/LIMITED ENGLISH PROFICIENCY

In connection with the performance of work under this Agreement, both parties agree to comply with applicable federal and state laws regarding nondiscrimination and equal employment opportunities, including the Americans with Disabilities Act of 1990, 42 U.S.C., Section 12101, et seq., and the regulations promulgated thereunder, if applicable. Both parties agree not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, gender, physical condition, developmental disability as defined in § 51.01(5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Both parties further agree to post in conspicuous places, available for employees and applicants for employment, notices of the provisions of the nondiscrimination clause.

Provider understands that it must be in compliance with the equal opportunity policy and standards for all applicable state and federal statutes and regulations relating to nondiscrimination in employment and service delivery as described in Appendix D hereto. Provider also understands that it is required to provide equal opportunity for Members with Limited English Proficiency (LEP) and provide language access services to populations of persons with LEP who are eligible to be served by Provider.

Provider acknowledges that Provider must be prepared to demonstrate Provider's compliance with the requirements of this Section XII and Appendix D affixed hereto and made a part hereof, in the event Provider is audited by the Wisconsin Office of Affirmative Action and Civil Rights Compliance.

Provider understands that complaints of Members or applicants related to civil rights compliance must be reported to the Health Plan or MCO and shall be investigated by Provider and the Health Plan or MCO.

## XIII. RECORDS

13.1 Maintenance of Records. Provider will maintain books and records pertaining to this Agreement in a form consistent and in compliance with confidentiality provisions of applicable federal and state laws and regulations. Provider agrees to preserve the full confidentiality of medical and other Member records and protect from unauthorized disclosure all information, records, and data collected under this Agreement. Access to this information shall be limited to persons who, or agencies which, require the information in order to perform their duties related to the Health Plan's contract with CMS and DHS and the MCO's contract with DHS. Members and their authorized representatives shall have access to a Member's medical records upon reasonable notice and in accordance with applicable law, including but not limited to, the requirements of Wisconsin Statutes. Provider will forward to the Health Plan or MCO medical records pursuant to appeals within fifteen (15) working days of the record request, or immediately, if the appeal is expedited. If Provider does not meet the fifteen- (15-) day requirement, Provider must explain reason(s) for the delay and indicate when Provider will deliver the required medical record.

13.2 Access to Records. Provider will allow duly authorized agents or representatives of the Health Plan and MCO, the state or federal government, including the Department of Health and

Human Services, the Comptroller General, or their designees, during normal business hours, access to its premises to inspect, audit, monitor, copy or otherwise evaluate the performance of Provider's contractual activities and will forthwith produce all records requested as part of such an audit or review. Such access shall include the right to reproduce all such records and material and to verify reports furnished in compliance with the provisions of the Health Plan's contract with CMS and DHS and the MCO's contract with DHS. In the event right of access is requested under this Section, Provider will, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate federal personnel conducting the audit or inspection effort. Provider agrees to comply with any requirements issued by CMS or DHS as a result of such inspection or audit. All inspections or audits will be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information obtained during an audit or review will be treated as confidential.

- 13.3 Permission for Governmental Review of the Records Related to this Agreement. Upon written request by the Secretary of the Department of Health and Human Services or Comptroller General of the United States, or by any of the Secretary's or Comptroller General's duly authorized representatives, Provider will make available those contracts, books, documents or records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available up to ten (10) years after the rendering of such services. If Provider carries out any of the duties of this Agreement through a subcontract with a value of ten thousand dollars (\$10,000) or more over a twelve (12) month period with a related individual or organization, Provider agrees to include this requirement in any subcontract. This Section is included pursuant to and is governed by the requirements of 42 CFR 422.504(e)(2), 42 CFR 422.504(e)(4), and 422.504(i)(2)(ii), as amended, 42 U.S.C. § 1395x(v)(1), and the regulations promulgated thereunder.
- 13.4 Record Copying Costs. Provider will copy and provide Member records for the Health Plan and MCO, as requested, to provide continuity of health care. Provider will not seek reimbursement from the Health Plan or MCO for copies of medical records.

#### XIV. SUBROGATION

State statutory subrogation rights have been extended to the Health Plan and MCO under Subch. 49.89(9), Wis. Stats. The Health Plan and MCO are obligated to collect recoverable amounts arising out of the settlement of personal injury, medical malpractice, product liability and Workers' Compensation on behalf of its Members. Recoverable amounts include monies paid by the Health Plan or MCO for the Member for all services related to the injury, not limited to health care expenses. Provider agrees to cooperate with the Health Plan and MCO on all subrogation matters, including but not limited to notifying the Health Plan and/or the MCO, as the case may be, within twenty-four (24) hours of an incident, and forwarding to the Health Plan or MCO copies of all documents and reports pertaining to the incident as they become available.

#### XV. CONFIDENTIALITY

The Health Plan and MCO and Provider agree that performance of this Agreement will result in their employees having access to confidential and/or proprietary information. Such information may include but not be limited to Member medical records, staff compensation, and certain proprietary and

management information concerning both organizations. The Health Plan, MCO and Provider agree that any employees assigned to perform services or who otherwise have access to such information will be made aware of the confidential nature of such information.

Provider will comply with applicable federal and state rules and regulations, including but not limited to those promulgated from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Title XIII of the American Recovery and Reinvestment Act of 2009 (also cited as the “HITECH Act”). If Provider uses or discloses Protected Health Information (PHI), as defined by HIPAA, on behalf of, or in the provision of services to, Care Wisconsin or the Health Plan, Provider must also execute the Business Associate Agreement attached hereto as Appendix E, unless Provider is a Covered Entity as defined by HIPAA and the use or disclosure of PHI is for Treatment of an individual as defined by HIPAA.

If Provider provides any of the services listed below, Provider must execute the Business Associate Agreement in Appendix E, unless Care Wisconsin has received satisfactory assurances from Provider that the Business Associate Agreement is not required by federal regulations:

- Adaptive Aids (general and vehicle)
- Adult day care
- Alcohol and other drug abuse day treatment
- Alcohol and other drug abuse services
- Care/Case Management (including Assessment and Case Planning)
- Communication Aids/Interpreters
- Community Support Programs
- Consumer Education and Training
- Counseling and Therapeutic Resources (including art therapy, music therapy, massage etc.)
- Daily living skills training
- Day services/Treatment
- Financial management services
- Home Health
- Home modifications
- Housing counseling
- Meals: Home delivered
- Mental Health Day Treatment Services
- Mental Health Services (non-healthcare)
- Personal Care
- Personal Emergency Response Systems services
- Prevocational Services
- Relocation Services
- Residential Services; Certified Residential Care apartment complex (RCAC); Community Based Residential Facility(CBRF); and Adult Family Home (AFH)
- Respite Care
- Self Directed Supports (Service brokers)
- Supported employment
- Supportive home care
- Transportation (non-emergency)
- Vocational Futures Planning

**XVI. INDEPENDENT CONTRACTOR**

The relationship between Provider and the Health Plan and/or the MCO under this Agreement will be construed and deemed to be between independent contractors and for the sole purpose of carrying out the terms of this Agreement. Nothing in this Agreement will be construed to create a partnership, joint venture, employer-employee or principal-agent relationship between the parties, nor will the parties hold themselves out as being a partnership, joint venture, and employer-employee or principal-agent relationship. As between Health Plan and/or MCO and Provider, each has full, complete, absolute and sole authority and responsibility regarding its own operations; and none shall have any direction or control over the manner in which any other performs its obligations.

**XVII. OSHA REQUIREMENTS**

If Provider employs staff to provide services under this Agreement, Provider agrees to require its employees to comply with all applicable OSHA requirements. This provision does not apply in situations when Provider does not employ or subcontract staff to provide services under this Agreement.

**XVIII. ADVERTISING**

Care Wisconsin and Provider agree to provide and obtain, in advance, the other party's written approval of all advertising and promotional materials, regardless of medium, which refer to the other party. No reference to the other party shall be made in any materials unless prior written approval is obtained. In the event of a termination under this Agreement, all advertising and promotional materials, in any medium whatsoever, shall be revised by the parties hereto as soon as possible to eliminate references to the other party.

**XIX. NONEXCLUSIVITY**

The parties enter into this Agreement on a nonexclusive basis.

**XX. EXCLUSION FROM STATE AND FEDERAL HEALTH CARE PROGRAMS**

All parties represent and warrant that, to the best of each party's knowledge, Provider and the Health Plan and MCO and their owners and employees are not excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-7b(f), and to each party's knowledge, there are no pending or threatened governmental investigations that may lead to such exclusion. Each party agrees to notify the other party of the commencement of any such exclusion or investigation within seven (7) business days of first learning of it. All parties shall have the right to immediately terminate this Agreement upon learning of any such exclusion and shall be kept apprised by the other party or parties of the status of any such investigation.

**XXI. NOTICE**

Any notice, demand or communication required, permitted or desired to be given under this Agreement will be deemed effectively given when personally delivered or mailed by prepaid certified mail, return receipt requested, addressed as follows:

**Care Wisconsin First, Inc.:**

**Provider:**

Provider Services Manager  
P.O. Box 14017  
Madison, WI 53708-0017

XXII. MISCELLANEOUS

- 22.1 Entire Agreement. This Agreement contains all the terms and conditions agreed upon by the parties hereto regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.
- 22.2 Modifications. This Agreement constitutes the entire understanding between the parties hereto, and no changes, amendments, or alterations shall be effective unless agreed to in writing by both parties. Notice to or consent of Members shall not be required to effect any modifications to this Agreement.
- 22.3 Invalidity or Nonenforceability. The invalidity or non-enforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other term or provision.
- 22.4 Enforcement. This Agreement shall be interpreted in accordance with the laws of the state of Wisconsin. Unless waived by both parties, venue for any action to enforce or interpret the provisions of this Agreement shall be in Dane County, Wisconsin. This section is subject to Wisconsin Statute 788.02 to permit disputes to be resolved in accordance with Section X, except as otherwise specified herein.
- 22.5 Third Party Beneficiaries. Except as otherwise specified herein, nothing herein shall be construed as, or deemed to create, any rights or remedies to any third-party, including, but not limited to, any Members.
- 22.6 Neither Health Plan nor MCO will be required to use any specific amount of Provider's services.

IN WITNESS WHEREOF, the undersigned concur with the terms, conditions and understandings as set forth in this Agreement and have executed the Agreement as of the date and year first written above:

CARE WISCONSIN FIRST, INC.

PROVIDER

By: \_\_\_\_\_  
Wayne P. Hagenbuch  
Vice President of Health Plan Operations

By: \_\_\_\_\_  
Signature

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
NPI

\_\_\_\_\_  
Tax Identification Number

\_\_\_\_\_  
Billing Address

\_\_\_\_\_  
Billing City, State, Zip

**APPENDIX A**

**SERVICES INCLUDED UNDER THIS AGREEMENT**

Provider agrees to arrange for the provision of services to Members. The duties and responsibilities of Provider(s) are limited to the service or services indicated below:

Note: If adding mental health services, specify the provider/practitioners must be Medicare-certified. Then remove this note.

**APPENDIX B**  
**COMPENSATION**

**FOR FAMILY CARE MEMBERS:**

*For Members eligible for Medicaid only:*

Covered Services. Care Wisconsin will reimburse Provider for Medicaid Covered Services for which Care Wisconsin has issued prior approval, at the WMP rate in effect at the time the service was provided.

*For Members with dual Medicare/Medicaid eligibility:*

- a. Medicare Covered Services. Provider shall bill Medicare directly for Medicare Covered Services.
- b. Medicaid Covered Services. Care Wisconsin will reimburse Provider for all Covered Services for which Care Wisconsin has issued prior approval and that qualify as Medicaid Covered Services per the WMP guidelines, at the WMP rate in effect at the time the service is provided. For nursing home admissions, the WMP rate is the rate established using the RUGs-Based Acuity Method for MCOs. In the absence of a Member-specific RUGs rate, Care Wisconsin will reimburse Provider at Provider's composite WMP rate for the facility.
- c. Unlisted Service or Procedure, and Special Reports. Provider and Care Wisconsin must mutually agree upon reimbursement rates for any unlisted service or procedure, and any special reports prior to service delivery.
- d. Non-Medicaid Covered Services. For non-Medicaid Covered Services, or for services with no listed WMP rate for which Care Wisconsin has issued prior approval, Care Wisconsin will reimburse Provider at sixty-five percent (65%) of billed charges.
- e. Rate increases/changes. Care Wisconsin will adopt all rate changes upon the effective dates issued by WMP.

**FOR PARTNERSHIP MEMBERS:**

*For Members with dual Medicare/Medicaid eligibility:*

- a. Medicare Covered Services. Care Wisconsin will reimburse Provider for services for which Care Wisconsin has issued prior approval and that qualify as Medicare Covered Services per the Medicare guidelines, at the Medicare rate in effect at the time the service was provided. Provider agrees to accept Care Wisconsin's payment as payment in full. Up to four (4) home health visits will be reimbursed at the LUPA rate. If the number of visits for an episode of care is more than four (4), Care Wisconsin will reimburse at PPS rates. Provider agrees to bill Care Wisconsin with a RAP (Request for Anticipated Payment) after the first billable visit, with a final bill at the end of the episode of care.
- b. Medicaid Covered Services. Care Wisconsin will reimburse Provider for all services for which Care Wisconsin has issued prior approval and that qualify as Medicaid Covered Services per the

WMP guidelines, at the WMP rate in effect at the time the service is provided. For nursing home admissions, the WMP rate is the rate established using the RUGs-Based Acuity Method for MCOs. In the absence of a Member-specific RUGs rate, Care Wisconsin will reimburse Provider at Provider's composite WMP rate for the facility.

- a. Unlisted Service or Procedure, and Special Reports. Provider and Care Wisconsin must mutually agree upon reimbursement rates for any unlisted service or procedure, and any special reports prior to service delivery.
- b. Non-Medicaid Covered Services. For non-Medicaid Covered Services, or for services with no listed WMP rate Wisconsin for which Care Wisconsin has issued prior approval, Care Wisconsin will reimburse Provider at sixty-five percent (65%) of billed charges.
- e. Rate increases/changes. Care Wisconsin will adopt all rate changes upon the effective dates issued by the CMS and the WMP, as the case may be.

***For Members eligible for Medicaid only:***

Covered Services. Care Wisconsin will reimburse Provider for Medicaid Covered Services for which Care Wisconsin has issued prior approval, at the WMP rate in effect at the time the service was provided. For nursing home admissions, the WMP rate is the rate established using the RUGs-Based Acuity Method for MCOs. In the absence of a Member-specific RUGs rate, Care Wisconsin will reimburse Provider at Provider's composite WMP rate for the facility.

**APPENDIX C**

**DHS CONTRACT REQUIREMENTS  
FOR SUBCONTRACTS WITH CARE WISCONSIN**

Subcontractor compliance with this contract specifically includes, but is not limited to, the requirements listed in the MCO Contract between Care Wisconsin and DHS, except for specific areas that are inapplicable in a specific subcontract. Below are provisions and references to the current MCO Contract, which is available online at <http://dhs.wisconsin.gov/ltcare/StateFedReqs/FC-RC-CMO-Contracts.htm>

Please note the DHS updates the MCO Contract annually, so the requirements and references listed below may be different from those on the DHS website. The provisions and references on DHS website prevail over those listed below.

- a. Parties of the Subcontract  
The MCO and subcontractor entering into the agreement are clearly defined.
- b. Definitions  
Subcontract defines the terms that may be interpreted in ways other than what the MCO intends.
- c. Services  
Subcontract clearly delineates the services being provided, arranged, or coordinated by the subcontractor.
- d. Compensation  
Subcontract specifies rates for purchasing services from the provider. Subcontract specifies payment arrangements in accordance with Article V.L.5., Thirty-Day Payment Requirement.
- e. Term and Termination  
Subcontract specifies the start date of the subcontract and the means to renew, terminate and renegotiate. Subcontract specifies the MCO's ability to terminate and suspend the subcontract based on quality deficiencies and a process for the provider appealing the termination or suspension decision. If the MCO delegates selection of providers to another entity, the MCO retains the right to approve, suspend, or terminate any provider selected by that entity.
- f. Legal Liability  
Subcontract agrees that no terms of the subcontract are valid which terminate legal liability of the MCO.
- g. Quality Management (QM) Programs  
Subcontractor agrees to participate in and contribute required data to the MCO's QM programs as required in Article XI, Quality Management (QM) and External Review.
- h. Utilization Data  
Subcontractor agrees to submit MCO utilization data in the format specified by the MCO, so the MCO can meet the Department's specifications required by Article XII, Reports and Data.
- i. Restrictive Measures

The MCO must require its subcontractors to follow the MCO's policies and procedures on isolation, seclusion and physical restraints.

j. Non-Discrimination

Subcontractor agrees to comply with all non-discrimination requirements in Article III.B., Civil Rights Compliance/Affirmative Action Plan Requirements.

k. Insurance and Indemnification

Subcontractor attests to carrying the appropriate insurance and indemnification.

l. Independent Contractor

Subcontract recognizes the agreement is between two separate parties that are independently and freely entering into a subcontract.

m. Notices

Subcontract specifies a means and a contact person for each party for purposes related to the subcontract (e.g., interpretations, subcontract termination).

n. Access to Premises

Subcontractor agrees to provide representatives of the MCO, as well as duly authorized agents or representatives of the Department and the Federal Department of Health and Human Services, access to its premises, and/or medical records in accordance with Article III.F., Access to Premises and Information.

o. Certification and Licensure

MCO subcontractors and health care facilities agree to provide licensure, certification and accreditation status upon request of the MCO. Health professions which are certified by Medicaid (e.g., physical therapy) agree to provide information about their education, Board certification and recertification upon request of the MCO. Subcontractor agrees to notify the MCO of changes in licensure.

p. Records

Subcontractor agrees to comply with all applicable Federal and State record retention requirements in accordance with Article XII.F., Records Retention.

q. Member Records

Subcontractor agrees to the requirements for maintenance and transfer of records stipulated in Article III.A., Member Records. Subcontractor 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) days if maintained off site which is based on standards in 45 CFR 164.524(3)(b)(2).

Subcontractors must forward records to the MCO pursuant to grievances and appeals within fifteen (15) business days of the MCO's request or, immediately, if the appeal is expedited. If the subcontractor does not meet the fifteen (15) business day requirement, the subcontractor must explain why and indicate when the records will be provided.

r. Confidentiality

Subcontractor agrees otherwise to preserve the full confidentiality of records, in accordance with Article III.A., Member Records, page 24, and protect from unauthorized disclosure all

information, records, and data collected under the contract. 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 related to this Contract.

s. OSHA Requirement

Subcontractor attests to meeting applicable OSHA requirements.

t. Access to Services

Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services necessary to achieve outcomes that are in the benefit package (e.g., Third Party Liability recovery procedures that delay or prevent care).

u. Authorization for Providing Services

Subcontract delineates the process the provider follows to receive authorization for providing services in the benefit package to members. Subcontractor agrees to clearly specify authorization requirements to its providers and in any sub-subcontracts.

v. Hold Harmless/Billing Members

For Family Care members, Subcontractor agrees not to bill a member for services in the Long-Term Care benefit package that received advance authorization from the MCO and were provided during the member's period of MCO enrollment. This provision shall continue to be in effect even if the MCO becomes insolvent. The subcontractor must operate in accordance with Article IV.R., Billing Members.

For Family Care Partnership members, the payments by the MCO and/or any third party payer will be the sole compensation for services rendered under the contract. Provider agrees not to bill Members and to hold harmless individual Members, the Department and CMS in the event the MCO cannot pay for services that are the legal obligation of the MCO to pay, including, but not limited to, the MCO's insolvency, breach of contract, and provider billing. The subcontractor must operate in accordance with Article IV.R., Billing Members.

w. Appeals

Subcontractor agrees to abide by the terms of Section M, Appeals to the MCO and Department for Payment/Denial of Providers Claims, page 61 in this article.

x. Appeals and Grievances

Subcontractor agrees to comply with the members' appeals, grievances and fair hearings procedures and timeframes in accordance with Article X, Grievances and Appeals, page 130, that may involve the subcontractor including the following provisions:

- i. The enrollee's right to a fair hearing, how to obtain a hearing, and representation rules at a hearing;
- ii. The enrollee's right to file grievances and appeals and their requirements and timeframes for filing;
- iii. The availability of assistance in filing;
- iv. The toll-free numbers to file oral grievances and appeals;

- v. The enrollee's right to request continuation of benefits during an appeal or fair hearing filing and, if the MCO's action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits; and
  - vi. Any state-determined appeal rights to challenge the failure of the organization to cover a service.
- y. **Prohibited Practice**
- The MCO and subcontractor agree to prohibit communication, activities or written materials that make any assertion or statement, that the MCO or provider is endorsed by CMS, the Federal or State government, or any other entity.
- z. **Regulations for Licensed Facilities**
- Subcontractors must be responsible for adhering to regulations for licensed facilities when appropriate and to 51.61(1)(i), 46.90(1)(i) WI Stats and HFS 94.10.

**APPENDIX D**

**AFFIRMATIVE ACTION (AA), EQUAL OPPORTUNITY, AND CIVIL RIGHTS COMPLIANCE (CRC)**

**Civil Rights Compliance/Affirmative Action Plan Requirements**

Providers who receive a contract from MCO in the amount of twenty-five thousand dollars (\$25,000) or more and who have a work force of twenty-five (25) or more employees effective as of the date of award must have a Civil Rights Compliance Plan that contains three (3) components; Affirmative Action Program to comply with s.16.765, Wis., Stats., and ADM 50; Equal Opportunity and Access to Services, and MCO's Language Access Program for Limited English Proficiency Customers/Patients. Instructions and templates for completing the Civil Rights Compliance Plan are found at: <http://DHS.wisconsin.gov/civilrights/Index.HTM>

**Civil Rights Compliance**

**For agreements for the provision of services to clients, the Provider must comply with Civil Rights Compliance Plan Requirements for Recipients of Federal and State Funded Programs, Services, and Activities from the DHS and Department of Workforce Development for the funding period of January 1, 2007 to December 31, 2009, (DWSD-14045 (R 2006). Assurances**

1. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination in any manner on the basis of age, color, disability national origin, race, religion, or sex. 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.
2. No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subjected to discrimination in employment in any manner or team of employment on the basis of age, ancestry, arrest record, color, conviction record, creed, disability or association with a person with a disability, genetic testing, honesty testing, marital status, membership in the national guard, state defense force or any reserve component of the military forces of the United States or this state, national origin, pregnancy or childbirth, race, religion, sex, sexual orientation, use or nonuse of lawful products off the employer's premises during nonworking hours. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.
3. The MCO shall post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the Limited English Proficiency Coordinator, and their informal discrimination complaint procedures and grievance process in conspicuous places available to applicants and clients of services, and applicants for employment and employees. The client discrimination complaint process and grievance process will be according to the Department standards and translated into the major primary languages of

the limited English Proficient (LEP) participants in the Provider's service area. The notice will announce the availability of free oral interpretation of services if needed. The Provider shall not request interpretation services from family members, friends and/or minors.

4. The Provider agrees to comply with all of the DHS and MCO's Civil Rights Compliance Plan and/or Letter of Assurance Requirements published in the State of Wisconsin, Civil Rights Compliance Requirements, Affirmative Action, Equal Opportunity, Limited English Proficiency for Recipients of Federal and State Funded Programs, Services, Activities from the DHS and Department of Workforce Development DWSD-14045 (R 2006).
5. MCO will monitor the Civil Rights Compliance of the Provider. The MCO will conduct reviews to ensure that the Provider is ensuring compliance by its subcontractors according to guidelines in the State of Wisconsin Civil Rights Compliance Requirements, Affirmative Action, Equal Opportunity and Limited English Proficiency for Recipients of Federal and State Funded Programs, Services, and Activities from the DHS and Department of Workforce Development DWSD- 14045 (R. 2006). The Provider agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the Provider, as well as interviews with staff, clients, and applicants for services, subcontractors, and referral agencies. All reviews are conducted according to MCO procedures. The MCO may conduct reviews to address immediate concerns of complainants.
6. The Provider agrees to cooperate with the MCO and the DHS in developing, implementing and monitoring corrective action plans that result from grievance investigations or monitoring efforts.
7. The Provider agrees that it will: (1) hire staff with non-English language skills, sign language skills and/or provide staff with special translation or sign language skills training, or find qualified persons who are available within a reasonable period of time and who can communicate accurately, and effectively with limited or non-English speaking or speech or hearing-impaired clients at no cost to the client; (2) provide aids, assistive devices and other reasonable accommodations to the client during the application process, in the receipt of services, and in the process of grievance or appeals; (3) train staff in human relations techniques, sensitivity to persons with disabilities and cultural sensitivity/cultural competency; (4) make programs and facilities accessible, as appropriate, through outstations, authorized representatives, adjusted work hours, ramps, doorways, elevators, or ground floor rooms, and Braille, large print or taped information for the visually or cognitively impaired; (5) post and/or make available informational material in languages and formats appropriate to the needs of the client population.
8. "Affirmative Action Plan" is a written document as defined in s.16.765, Wis. Stats., and ADM 50 Wisconsin Administrative Code that details the MCO's affirmative action program. Key parts of an affirmative action plan are: (1) a policy statement pledging nondiscrimination and affirmative action employment, (2) internal and external dissemination of the policy, (3) assignment of a key employee as the equal opportunity officer, (4) a workforce analysis that identifies job classifications where there is an under representation of women, minorities, and persons with disabilities, (5) goals must be

directed to achieving a balanced work force, specific and measurable, having an implementation target date between six months and two years, have a plan of action or description of procedures to implement the goals, (6) revision of employment practices to ensure that they do not have discriminatory effects, and (7) establishment of internal monitoring and reporting systems to measure progress regularly. Completion of the Civil Rights Compliance Plan and completing the “Workforce Analysis section of the Civil Rights Compliance Plan together with proper attachments will deem the Provider as fulfilling the requirements in s.16.765, Wis., Stats., and ADM 50 Wisconsin Administrative Code.

## SUBCONTRACTS

1. The Provider may subcontract part of this Agreement only with the prior written approval of the MCO. In addition, the MCO’s approval may be required regarding the award process, the terms and conditions of the subcontracts and the subcontractors selected. Approval of the subcontractors will be withheld if the MCO reasonably believes that the intended subcontractor will not be a responsible provider in terms of services provided and costs billed.
2. The Provider retains responsibility for fulfillment of all terms and conditions of this Agreement when it enters into sub-contractual agreements and will be subject to enforcement of the terms and conditions of this Subcontract Agreement including assurance of civil rights compliance.

The Provider (Recipient/Sub-recipient) agrees to comply with civil rights monitoring reviews, including the examination of records and relevant files maintained by the Provider, as well as interviews with staff, clients, and applicants for services, subcontractors, and referral agencies.

The Provider agrees to cooperate with the MCO in developing, implementing, and monitoring corrective action plans that result from complaint investigations or other monitoring efforts.

**APPENDIX E**

**BUSINESS ASSOCIATE AGREEMENT BETWEEN  
CARE WISCONSIN FIRST, INC. AND**

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(“Provider”) is committed to using and disclosing Protected Health Information (“PHI”) in compliance with the Standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”) (45 C.F.R. Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996. The definitions set forth in the Privacy Rule are incorporated by reference into this Appendix (45 C.F.R. 160.103 and 164.501).

Provider agrees to the following provisions as they relate to PHI received from Care Wisconsin, First Inc. (“Care Wisconsin”), received for Care Wisconsin, received from another business associate of Care Wisconsin, and/or created by Provider:

**A. Permitted Uses or Disclosures of PHI**

1. Except as otherwise limited in this Appendix, Provider may use or disclose PHI to carry out the obligations set forth in this Agreement, provided that such use or disclosure would not violate the Privacy Rule if made by Care Wisconsin.
2. Except as otherwise limited in this Appendix, Provider may use PHI to carry out Provider’s legal responsibilities.
3. Except as otherwise limited in this Attachment, Provider may disclose PHI for Provider’s proper management and administration, provided that disclosures are required by law, or Provider obtains reasonable assurances, evidenced by written contract, from the person or entity to which the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person or entity, and the person or entity promptly notifies Provider (which in turn will notify Care Wisconsin in accordance with Section B.8 of this Appendix) of any instances of which it is aware in which the confidentiality of the information has been breached.
4. Provider will, while carrying out the obligations set forth in this Agreement, make reasonable efforts to use, disclose and request of Care Wisconsin only the minimum amount of PHI reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except as otherwise exempt in 45 C.F.R. 164.502(b)(2).

**B. Obligations of Provider**

1. **Uses or Disclosures of PHI.**  
Provider will neither use nor disclose PHI other than as permitted or required by this Appendix, as otherwise authorized in writing by Care Wisconsin subsequent to this Appendix, or as required by law.
2. **General Safeguards for PHI.**  
Provider will employ appropriate administrative, technical, and physical safeguards to protect the

privacy of PHI and to prevent the improper use or disclosure of all PHI in any form or media. These safeguards must reasonably protect PHI against any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures. Provider shall document and keep these security measures current. (See 45 C.F.R. § 164.504(e)(2)(B)).

3. **Security Safeguards for Electronic PHI.**

Provider shall employ appropriate administrative, technical and physical security measures that reasonably and appropriately protect the confidentiality, integrity and availability of all electronically maintained or transmitted PHI received from, or on behalf of, Care Wisconsin. Provider's security measures must be consistent with HIPAA's Security regulations, 45 C.F.R. Part 142 ("Security Rule"). Provider shall document and keep these security measures current and available for inspection, upon request.

4. **Mitigate Harmful Effect.**

In consultation with Care Wisconsin, Provider will mitigate, to the extent possible, any harmful effect that is known to Provider related to the inappropriate use or disclosure of PHI.

5. **Subcontractors and Other Agents.**

Provider will require any of its subcontractors and agents, to which Provider is permitted by this Appendix or in writing by Care Wisconsin to disclose PHI, to provide reasonable assurance, evidenced by written contract, that such subcontractor or agent will comply with the same privacy and security safeguard obligations with respect to Care Wisconsin's PHI that are applicable to Provider under this Appendix.

6. **Compliance with Transaction Standards.**

If Provider conducts any Standard Transaction for, or on behalf, of Care Wisconsin, Provider shall comply, and shall require any subcontractor or agent conducting such Standard Transaction to comply, with each applicable requirement of 45 C.F.R. Part 162. Provider shall not enter into, or permit its subcontractors and agents to enter into, any Agreement in connection with the conduct of Standard Transactions for or on behalf of Care Wisconsin that:

- (i) changes the definition, Health Information condition, or use of a Health Information element or segment in a Standard;
- (ii) adds any Health Information elements or segments to the maximum defined Health Information Set;
- (iii) uses any code or Health Information elements that are either marked "not used" or are not in the Standard's Implementation Specification(s); or
- (iv) changes the meaning or intent of the Standard's Implementation Specification(s).

7. **Reporting Unauthorized Uses or Disclosures.**

Provider will provide a written report regarding any unauthorized uses or disclosures of PHI by Provider or Provider's subcontractors or agents to Care Wisconsin's Compliance Officer within three (3) business days of the discovery thereof or by some later date as mutually agreed upon. The written report shall:

- (i) Identify the PHI used or disclosed, and the nature of the use or disclosure;
- (ii) Describe the circumstances of the unauthorized use or disclosure; and
- (iii) Identify what measures Provider proposes to take to mitigate any harm resulting from such unauthorized use or disclosure, and what Provider will do to prevent similar unauthorized uses or disclosures in the future.

8. **Tracking and Accounting of Disclosures.**

So that Care Wisconsin may meet its disclosure accounting obligations under 45 C.F.R. 164.528:

- (i) For each disclosure not excepted under subsection ii below, Provider will record for each disclosure of PHI it makes to Care Wisconsin or a third party of PHI that Provider creates or receives for or from Care Wisconsin:
  - (a) Disclosure date;
  - (b) Name and (if known) address of the person or entity to whom Provider made the disclosure;
  - (c) A brief description of the PHI disclosed; and
  - (d) A brief statement of the purpose of the disclosure.
  - (e) For repetitive disclosures which Provider makes to the same person or entity, including Care Wisconsin, for a single purpose, Provider may provide:
    - (1) Disclosure information for the first of these repetitive disclosures;
    - (2) The frequency, periodicity or number of these repetitive disclosures; and
    - (3) The date of the last of these repetitive disclosures.
- (ii) Provider need not record disclosure information or otherwise account for disclosures of PHI that meet each of the following conditions:
  - (a) Disclosures that are permitted under this Appendix, or are expressly authorized by Care Wisconsin in writing; and,
  - (b) The disclosure is for one of the following purposes:
    - (1) Care Wisconsin's Treatment, Payment or Health Care Operations;
    - (2) To an individual who is the subject of the PHI or to that individual's personal representative;
    - (3) Made to persons involved in that individual's health care or payment for health care;
    - (4) For notification for disaster relief purposes;
    - (5) For national security or intelligence purposes; or
    - (6) To law enforcement officials or correctional institutions regarding inmates.
    - (7) And as otherwise exempt from disclosure accounting as specified in 45 C.F.R. 164.528
- (iii) Provider will maintain the Disclosure Information for at least ten (10) years following the date of the accountable disclosure. Provider will make the Disclosure Information available to Care Wisconsin within five (5) days following Care Wisconsin's request.

9. **Making PHI Available for Access.**

At the direction of Care Wisconsin, Provider agrees to provide access to any PHI held by Provider, which Care Wisconsin has determined to be part of Care Wisconsin's Designated

Record Set, in the time and manner designated by Care Wisconsin. This access will be provided to Care Wisconsin or, as directed by Care Wisconsin, to an Individual, in order to meet the requirements under the Privacy Rule. In the event an Individual should contact Provider directly, and request access to PHI, Provider shall, without complying with the request, refer the Individual to Care Wisconsin, and notify Care Wisconsin of the request. Care Wisconsin shall be responsible for coordinating and accommodating all requests for access to PHI.

**10. Making Amendments or Corrections to PHI.**

At the direction of Care Wisconsin, Provider agrees to amend or correct PHI held by Provider and which Care Wisconsin has determined to be part of Care Wisconsin's Designated Record Set, in the time and manner designated by Care Wisconsin. In the event an Individual should contact Provider directly, and request an amendment to PHI, Provider shall within three (3) business days of any such request, and without complying with the request, refer the Individual to Care Wisconsin and notify Care Wisconsin of the request. Care Wisconsin shall be responsible for coordinating and accommodating all amendment requests.

**11. Resources Necessary for HSS Secretary Determinations.**

Provider shall make internal procedures, books, and records relating to the use and disclosure of PHI received from Care Wisconsin, or created or received on behalf of Care Wisconsin, available to the Secretary of the Department of Health and Human Services ("Secretary") or designee, in a time and manner designated by Care Wisconsin or the Secretary, for the purpose of determining Care Wisconsin's compliance with the Privacy Regulation. Provider shall promptly notify Care Wisconsin of communications with the Secretary regarding PHI provided or created by Care Wisconsin.

**12. Sanctions.**

Provider shall implement and maintain sanctions for any employee, agent, or subcontractor who violates the terms of this Appendix.

**C. Obligations of Care Wisconsin.**

1. Care Wisconsin shall provide Provider with the notice of privacy practices that Care Wisconsin produces in accordance with 45 CFR 164.520, as well as any changes to that notice.
2. Care Wisconsin shall provide Provider with any changes in, or revocation of, permission by an individual to use or disclose PHI, if such changes affect Provider's permitted or required uses or disclosures.
3. Care Wisconsin shall notify Provider of any restrictions to the use or disclosure of PHI that Care Wisconsin has agreed to in accordance with 45 CFR 164.522.
4. Care Wisconsin shall provide Provider with access to Care Wisconsin's HIPAA privacy and security policies and procedures.

**D. Termination of the Appendix.**

Care Wisconsin may terminate all agreements with Provider if Care Wisconsin reasonably determines in good faith that Provider has breached a material term of this Appendix. Before termination, Care Wisconsin may choose to:

1. Exercise any of its rights to reports, access and inspection under this Appendix; and/or
2. Require Provider to submit to a plan of monitoring and reporting, as Care Wisconsin may determine necessary to maintain compliance with this Appendix; and/or
3. Provide Provider with a thirty (30) day period to cure the breach; or
4. terminate the Agreement immediately.

Before exercising any of these options, Care Wisconsin shall provide written notice to Provider describing the violation and the action Care Wisconsin intends to take.

**E. Destruction of PHI upon End of Agreement.**

1. Upon termination, cancellation, expiration or other conclusion of the Agreement, Provider shall:
  - (i) Return to Care Wisconsin or, if return is not feasible, destroy all PHI and all Health Information in whatever form or medium that Provider received from or created on behalf of Care Wisconsin. This provision shall also apply to all PHI that is in the possession of subcontractors or agents of Provider. In such case, Provider shall retain no copies of such information, including any compilations derived from and allowing identification of PHI. Provider shall complete such return or destruction as promptly as possible, but not less than thirty (30) days after the effective date of the conclusion of this Agreement. Within such thirty (30) day period, Provider shall certify on oath in writing to Care Wisconsin that such return or destruction has been completed.
2. In the event that Provider determines that returning or destroying the PHI is not feasible, Provider shall provide notice to Care Wisconsin of the conditions that make the return or destruction not feasible. Upon mutual agreement of the Parties that the return or destruction of PHI is not feasible, Provider may continue to use such PHI for those purposes that make the return or destruction not feasible and shall continue to protect such PHI as required under this Appendix for so long as Provider maintains such PHI.

**F. Automatic Amendment.**

Upon the effective date of any amendment to the regulations promulgated by the Department of Health and Human Services with regard to PHI, this Appendix shall automatically amend so that the obligations imposed on Provider remain in compliance with such regulations.

**G. Integration**

This Appendix, along with the original Agreement dated \_\_\_\_\_, contains the entire agreement between the parties and shall insure to the benefit of and shall bind the parties hereto, and their respective successors.

*Confidential*

*Confidential*

The undersigned parties concur with the terms, conditions and understandings as set forth in this Appendix:

**CARE WISCONSIN FIRST, INC.**

**PROVIDER**

**By:** \_\_\_\_\_  
Wayne Hagenbuch, Vice President,  
Health Plan Operations

**By:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Date:** \_\_\_\_\_