

Lakeland Care District

**Service Provider
Contract**

Lakeland Care District PROVIDER PURCHASE OF SERVICE CONTRACT

This contract is between the Lakeland Care District, a Managed Care Organization, and PROVIDER NAME, hereinafter referred to as Provider. This contract will begin on Effective Date. Contract # PROVIDER NUMBER-2012

Lakeland Care District Information

Lakeland Care District:
Address

N6654 Rolling Meadows Drive
Fond du Lac WI 54937

Provider Network Director:
Telephone
Fax
E-Mail

Jill Krzanowski
920-906-5127
920-906-5859
jill.krzanowski@lakelandcaredistrict.org

Service Provider Information

PROVIDER NAME:
Address

Name of Contract Administrator:
Telephone
Fax
E-Mail

Name of Provider Personnel Responsible for Ensuring Adherence to Civil Rights Compliance:

In the event either entities administrator is unable to administer this contract, entity will contact the other and designate a new administrator within ten (10) business days of the change.

The definition(s) listed below shall be the definition(s) of service for this contract.

Definitions

Business Hours/Days – Defined as 8:00am-4:30pm, except for Holidays.

Contract – This contract as well as all addendums, attachments, schedules amendments, exhibits and RATES and Service Codes Chart

Eligible LCD Member

An individual who meets functional and financial eligibility for the Family Care program and successfully enrolls in the LCD

Evergreen Contract – An Agreement between LCD and Provider that is automatically renewed after each completion until canceled by either party.

Family Care (FC)

Family Care is a capitated Medicaid managed care program for the delivery of all Medicaid long-term care services. Members enrolled in Family Care may be eligible at a Wisconsin Medicaid nursing home-certifiable

level of care or at a non-nursing home level of care. One of these functional levels of care is required as a condition of eligibility.

Lakeland Care District (LCD)

A Managed Care Organization contracted with Wisconsin Department of Health Services (DHS) to administer the Family Care benefits in Fond du Lac, Winnebago, and Manitowoc counties, per the Department of Health Services, Division of Long Term Care Contract and HFS 10.

Provider

The organization, entity or individual contracting with LCD to provide authorized services per this contract

Signatures

This contract becomes null and void if the time between the Lakeland Care District authorized representative signature and Provider’s authorized signature on this contract exceeds sixty days.

Lakeland Care District

Print Name Katherine L. Mnuk
Print Title Chief Executive Officer

Signature _____ Date _____

PROVIDER NAME

Print Name
Print Title

Signature _____ Date _____

Notices: CONTRACT ADMINISTRATOR at PROVIDER NAME shall be Provider’s representative and, Jill Krzanowski at Lakeland Care District shall be LCD representative for purposes of receiving notices, requests for information and other communications.

Assignment: This contract is not assignable by Provider either in whole or in part, without written consent of Lakeland Care District.

PROVIDER NAME
Contract # PROVIDER NUMBER-2012-Evergreen

RATES and Service Codes Chart

Purpose

It is understood that LCD has entered into a contract with DHS, a Department of the State of Wisconsin. The purpose of this contract is to:

- Formalize the terms and conditions of the Provider's services to eligible LCD members receiving authorized services, and
- Meet the obligations of LCD's contract with the DHS.

This contract is to be effective upon signing and will continue for a term of five (5) years from the date of signing. Unless either party gives notice of termination sixty (60) calendar days prior to the expiration of any five-year term, or otherwise terminates the contract as provided below, the contract will automatically renew for additional five (5) year terms.

Caregiver Background Checks

Provider agrees to comply with the provisions of Wisconsin Administrative Code, DHS 12 & 13, and the Caregiver Background Check Manual. Provider shall conduct caregiver background checks at its own expense on people paid to provide direct care services to a LCD member in accordance with DHS 12. A copy of Provider's policy and procedure for conducting, maintaining and assessing results of background check information must be submitted to LCD during the application process and anytime the Provider's policy and procedure change. Annually, when requested by LCD Provider Network Team, the Provider must also submit to LCD the background checklist of all employees that have direct contact/care with LCD members. The attestation letter stating that Provider has a background check policy and they follow it will be submitted with application process and anytime when the Provider's policy and procedure change related to caregiver background checks.

Provider shall retain in its personnel files all pertinent information, to include a Background Information Disclosure (BID) Form and/or search results from the Department of Justice (DOJ), the DHS, and the Department of Regulation and Licensing, as well as, out of State records, tribal court proceedings and military records.

Provider shall maintain the results of background checks on its own premises for at least the duration of the contract. LCD may audit provider personnel files to assure compliance with the State of Wisconsin Caregiver Background Check Policy.

Non-Payment

The LCD maintains the ability to not pay or contract with any provider if the LCD deems it is unsafe based on the findings of past criminal convictions stated in the caregiver background check and the background check records are available for LCD to review, upon reasonable request, on Provider's premises. Provider shall not assign any individual to conduct work under this contract who does not meet the requirements of the law. Provider shall require employees to notify provider of charges, convictions and investigations in accordance with DHS 12.07(2).

Civil Rights Compliance and Affirmative Action Plan

The Provider agrees to submit to the LCD a copy of the Sub recipient Civil Rights Compliance Action plan for meeting Equal Opportunity Requirements under Title VI and VII of the Civil Rights Act of 1964, Section 503 and 504 of the Rehabilitation Act of 1973, Title VI and XVI of the Public Health Service Act, the Age Discrimination Act of 1975, the Age Discrimination in Employment Act of 1967, the Omnibus Budget Reconciliation Act of 1981, the American with Disabilities Act (ADA) of 1990, and the Wisconsin Fair Employment Act except if you meet the following criterion:

- A Provider that provides only services in the benefit package
- A Provider that is paid less than \$25,000 annually from Purchaser
- A Provider that has less than 25 employees regardless of the amount of the contract
- Is a federal government agency or Wisconsin municipality

- Has a balanced work force

The provider shall attach its individual CRC Action Plan as part of this contract if they are not excluded in list above. If an approved plan has been received during the previous calendar year, a plan update is acceptable. The plan may cover a two year period. Information on these requirements can be found at <http://www.dhfs.state.wi.us/civilrights/Index.HTM> or through the DHS, Office of Affirmative Action and Civil Rights Compliance, P.O. Box 7850, 1 West Wilson Street Madison, WI 53707-7850.

The Provider agrees to the following provisions:

No otherwise qualified person shall 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.

Except where s.111.337 Wis. Stat. applies, no otherwise qualified person shall be excluded from employment, 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, color, sex, national origin, ancestry, handicap (as defined in Section 504 and the American with Disabilities Act (ADA), arrest or conviction record, sexual orientation, political affiliation, marital status, or military participation. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

The Provider shall post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and clients of services, and applicants for employment and employees. The complaint process will be according to LCD's standards and made available in languages and formats understandable to applicants, clients and employees.

The Provider agrees that through its normal selection of staff, it will employ staff with special language skills or find persons who are available within a reasonable period of time and who can communicate with limited or non-English speaking or hearing impaired clients at no cost to the client; provide aids, assistive devices, and other reasonable accommodations to the client during the application process, in the receipt of services, and in the processing of complaints or appeals; train staff in human relations techniques and sensitivity to cultural patterns; and making the 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 impaired; posted and/or available informational materials in languages and formats appropriate for the needs of the client population.

Audit Requirements

If the Provider receives payments from the LCD that exceed \$75,000 for the year (January 1 – December 31, YEAR), the Provider shall provide an independent audit which must be in accordance with the State Single Audit Guidelines (SSAG), including the provisions of the Department of Health Services Audit Guide which is available at: www.dhs.wisconsin.gov/Grants/Audit/auditdept/index.htm

If non-allowable costs are identified in the audit, which have been paid by the LCD, the LCD reserves the right to recoup such costs.

If the Provider already has an independent audit conducted due to other Federal and State requirements, the Provider may submit such audit to the LCD if the audit includes the provisions of the Department of Health Services Audit Guide.

In certain circumstances, the LCD may choose an alternate reporting requirement with a limited scope for providers that receive payments that exceed \$75,000 from the District. This limited scope engagement shall consist of agreed-upon procedures conducted in accordance with either the American Institute of Certified Public Accountants (AICPA) generally accepted auditing standards or attestation standards. This type of engagement must address the following types of compliance requirements; activities allowed or disallowed, allowable costs and costs principles, eligibility and reporting.

However, the following conditions will automatically require a full independent audit of the Provider.

1. The life-stage of the program delivered by the Provider is less than two years
2. The Provider has a history of performance problems
3. The Provider has experienced recent financial difficulties or problems with financial practices
4. The Provider has compliance or internal control issues
5. The Provider extensively subcontracts with a third party for services rendered under the contract with the LCD

The Provider agrees to adhere to the audit requirements of this contract unless the Provider receives a written waiver of such requirements from the LCD. The Provider's waiver request must identify the year of the requested audit, contact person, contact information and reason for request. The Provider must assure the waiver is received by the LCD prior to the year-end of the year of the requested audit. The waiver request can be mailed to:

Provider Network Director
N6654 Rolling Meadows Drive
Fond du Lac, WI 54937

Submitting the Reporting Package

The Provider agrees to deliver to the LCD, one copy of the audit report that includes:

1. All audit schedules and reports required for the type of audit applicable to the Provider
2. Supplemental Schedule of Revenues and Expenses by Funding Source
3. Management Letter conveying the independent auditor's communication issued as a result of the audit
4. Management's response to and corrective action plan for current year audit findings

With the exception of governmental entities organized under s. 59.01, 66.013, 38.01, 139.30, or 117.01, Wis. Stats., the LCD shall notify the Provider within 180 calendar days of receipt of the audit completed by the independent auditor, as to whether or not the audit meets the requirements of the contract.

Failure to Comply with these Requirements

In the event the Provider fails to have an appropriate audit conducted or fails to submit a complete audit report to the LCD within the specified timeframe, the LCD may:

1. Conduct an audit or arrange for an independent audit of the Provider and charge the cost of the audit to the Provider
2. Charge the Provider for any lost aid and for penalties assessed to the LCD because the provider did not submit a complete audit report timely
3. Disallow the cost of audits that do not meet the standards
4. Withhold payment, cancel the contract or take other actions deemed by the LCD to be necessary to protect the LCD's interests

The LCD will notify the Provider in writing at least fourteen (14) calendar days prior to implementing such action and include all reasons for such action. The Provider will be given the opportunity to negotiate a resolution to the issues involved before any withholding is implemented.

Access to Auditor's Workpapers

When contracting with an audit firm, Provider shall authorize its auditors to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of the LCD or to any agent it names to act on its behalf. Such access shall include the right to obtain copies of work papers and computer disks, or other electronic media, upon which records/working papers are stored.

Claims Submission

Provider shall submit all clean claims as described in this service contract within forty-five (45) days of the last day of the month in which service was provided, or no later than 365 days from date of service for goods and services submitted to other funding sources. The billing address is: N6654 Rolling Meadows Drive, Fond du Lac, WI 54937.

Providers are required to apply for a National Provider Identifier (NPI) for all services that are considered medical services under Family Care Guidelines and must notify the LCD of the NPI number before claims will be paid.

Elements of Clean Claim (manual)

- 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
- g. Total amount billed per service

The following sections are applicable to services billable to Medicaid, Medicare or other insurances:

- a. Detailed Explanation Of Benefits (EOB) for Medicare and other insurances (or disclaimer code if applicable)
- b. Medical Assistance (HCPCS) codes or National Standard Code
- c. Diagnosis Code for member
- d. Amount paid by third party payer
- e. Net balance due

Elements of Clean Claim (Electronic)

Policies/Procedures for electronic claims submissions are available upon request and must meet HIPAA Electronic Transactions (EDI) requirements.

Billing Deadline

Provider shall submit all clean claims to Lakeland Care District within forty-five (45) days of the last day of the month in which service was provided or 365 days from the date of services for goods/services billed to other insurances: include Explanation of Benefits (EOB) which is required with the claim when Medicare or other primary insurance is billed primary.

National Standard Codes

In the event a National Standard Code is assigned to the contract service(s), Provider must indicate this code in the billing format.

Coordination of Benefits (payer of last resort)

Provider agrees to follow Coordination of Benefits (COB) procedures established by Wisconsin Office of the Commissioner of Insurance, acknowledging LCD is always the payer of last resort in circumstances where a member is covered by another party payer. If LCD is not primary in a COB situation, **Provider will bill other primary party payers first.** In the event the primary payer denies the claim or makes only a partial payment on the claim, Provider will submit invoices to LCD within forty-five (45) days of receiving the primary payer's denial or partial payment, but no later than 365 days from date of service to LCD. LCD is a Medical Assistance payer, and as such is secondary to Medicare and other third party payers. LCD will pay coinsurance after a third party in accordance with Medical Assistance policies and procedures and criteria indicated above.

Reject Claims

Lakeland Care District shall reject any claim that does not include the elements of a clean claim within thirty (30) days from the date received. LCD shall send via mail or post on the Provider Portal an Explanation of Benefits statement (EOB) to the provider, which will state the reason for denial. Corrected claims may be resubmitted.

Resubmitted Claims

Claims denied or partially paid may be resubmitted for payment if the reason for denial or underpayment can be resolved by the provider. Claim resubmissions must be received at LCD within forty-five (45) days of the date on the denial EOB or letter. For payment, a resubmitted claim must include the following:

- All elements of a clean claim, as listed above.
- Must be clearly marked as “Resubmit” at the top of the first page of the claim.
- Must include only the services that are being resubmitted, or clearly indicate which services on the claim are requested for payment, with any partial payments noted.
- Must clearly indicate the requested balance due.

Medicaid Billing

Claim for Medicaid benefit goods and services authorized by LCD and covered in this contract must be submitted in a format acceptable to Wisconsin’s Medical Assistance program, along with a copy of LCD’s letter of authorization, or the authorization number included on the provider claim form. ([HCFA1500](#), [UB04](#), [UB92](#) are acceptable)

Non Medicaid Billing

Claims for Non Medicaid goods and services authorized by LCD and covered in this contract shall be submitted in a format provided by LCD or provider’s format if prior approved by LCD. Providers choosing to bill in a format other than the format provided by LCD shall submit a copy of their claim form to Lakeland Care District Fiscal Department for review prior to the contract period. Elements necessary for LCD utilization and reporting requirements must be incorporated into claims format to be acceptable to LCD.

Claims Submission and Lakeland Care District Utilization and Reporting Requirements

Provider is required to submit claims and adhere to LCD’s authorization process in order to ensure LCDs ability to meet DHS reporting requirements. Claims that do not meet criteria for clean claims as indicated in this agreement will be denied payment; the provider may resubmit the claim with necessary reporting elements.

Lakeland Care District Claims Appeal Process

Provider may dispute LCDs payment, nonpayment, partial payment, late payment or denial of a claim by filing a written request with Lakeland Care District Fiscal Department within sixty (60) days of LCD action. The LCD fiscal department will review claims for reconsideration when submitted by a provider under this contract.

Appeals from Providers must include the following characteristics:

1. Appeals must be clearly marked as “appeal” and addressed to the fiscal supervisor.
2. Appealed claims must be received within 60 days of the Explanation of Benefits (EOB) or denial letter.
3. 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 EOB. Providers may request another copy of the letter of authorization from the clerical or fiscal staff for the month of the claim if they do not have a copy of their original.
4. Claims must include a written statement indicating why the denial is being appealed. 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.
5. Claims submitted as appeals will be reviewed by LCD one time only.
6. Providers can further dispute an unpaid claim with DHS.

Lakeland Care District will respond to the appeal within forty-five (45) days. Submit appeals to:

Fiscal Supervisor
Lakeland Care District
N6654 Rolling Meadows Drive
Fond du Lac WI 54937

DHS Claims Dispute Process

Providers may appeal Lakeland Care District appeal decisions to the DHS. In filing a request for reconsideration of appeal, provider shall clearly mark it as an “appeal” and indicate the provider’s name, date of service, date of billing, date of rejection, and reasons for provider’s request for reconsideration. The provider may appeal a reconsideration decision or failure of LCD to respond within forty-five (45) days of a reconsideration request by filing a written request to the DHS within sixty (60) days of LCD’s final decision or failure to respond.

Provider Appeals Investigator/Division of Long-Term Care
1 West Wilson Street, Room 518 PO Box 7851
Madison, WI 53707-7851

Claims Appeal Policy and Procedure

The LCD must furnish all providers information regarding the provider appeals process at the time providers enter into the contract. This information is posted on the LCD’s website on the Provider Tab. This information can be emailed to providers, upon request. Providers may request additional copies of this policy by contacting:

Provider Network Specialist/Lakeland Care District
N6654 Rolling Meadows Drive
Fond du Lac WI 54937

Conditions of the Parties’ Obligations

Powers and Duties

Nothing contained in this contract shall be constructed to supersede the lawful powers or duties of either party. Provider agrees no terms of this agreement are valid which terminate legal liability of Lakeland Care District.

Items Comprising the Contract

It is understood and agreed that the entire contract between the parties is contained herein. This contract supersedes all oral agreements and negotiations between the parties related to the subject matter thereof.

Confidentiality

Member Confidentiality

Provider shall not use or disclose any information concerning eligible members receiving services from provider for any purpose not connected with the administration of provider and LCD responsibilities under this contract, except with the informed, written consent of member or their legal guardian, or as otherwise required by law. Access to this information shall be limited to persons who, or agencies such as the DHS and CMS which, require information in order to perform their duties related to this contract.

Contract not Confidential

Except for documents identifying specific members, the contract and all related documents are not confidential.

Debarment and Suspension

Provider certifies through signing of this contract that neither provider nor any of its principals are debarred, declared ineligible, or voluntarily excluded from participating in federal assistance programs by any federal department or agency.

Reporting Debarment or Suspension

Provider shall notify Lakeland Care District within five business days in writing if provider or its principals receive a designation from the federal government that they are debarred, suspended, proposed for debarment, or declared ineligible by a federal agency.

Eligibility

Provider shall provide services under this contract to individuals authorized for services. Provider and LCD agree the eligibility of individuals to receive services from provider under this contract is to be determined by LCD. Provider and LCD agree a member's continued stay at provider's facility is contingent upon the member's compliance with the admission agreement and provider's policies and procedures. Provider reserves the right not to accept a member. Provider will submit the admission agreement to LCD if provider requires LCD members to sign such agreement.

Member Rights concerning Eligibility and Services

Persons interested in enrolling in Lakeland Care District can contact the Aging and Disability Resource Center (ADRC) for information. Providers can receive information on the ADRC by calling 920-929-3466 in Fond du Lac, 920-683-4180 in Manitowoc, and 877-886-2372 in Winnebago.

Lakeland Care District Members' services are identified in the Member Center Plan (MCP), developed by the member, guardian and Lakeland Care District Care Manager and Registered Nurse. All services funded and reimbursed under this contract are to be prior authorized by LCD Interdisciplinary Team (IDT) staff. Members have a right to appeal decisions of eligibility and services authorized by LCD.

Members have a right to appeal decisions of eligibility and services authorized by Lakeland Care District. Providers can obtain information to assist members with this process by contacting the Lakeland Care District at 920-906-5100 or toll free at 877-227-3335.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 Applicability

General HIPAA Applicability

Provider agrees to comply with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as set forth in Title 45, Parts 160 and 164 of the Code of Federal Regulations (CFR). Refer to the HIPAA addendum attached to this contract.

Member Records

Provider shall maintain and preserve individual member records in accordance with established professional standards, applicable state and federal law and HIPAA Privacy Standards. These records shall be safeguarded against loss, destruction or unauthorized use and shall remain confidential as required by 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.

Provider agrees to make member records available to members and his/her authorized representative within ten business days of the record request if the records are maintained on site and sixty calendar days if maintained off site.

Billing and Collection Procedures

Lakeland Care District and provider must conduct any electronic health care administrative transactions covered by HIPAA consistent with the Electronic Transactions and Code Sets Rule. Providers interested in conducting electronic transactions with LCD shall contact Contract Administrator for Trading Partners Agreement and related appended to this contract.

Indemnification and Insurance

Indemnification

The Provider and LCD each agree to indemnify, defend, and hold harmless, to the fullest extent permitted by law, the other, and the other's agents, officers, and employees, from and against all losses or expenses,

including costs and attorney fees, suffered by the other by or reason of liability for injury or damages in suits at law or in equity and caused by any wrongful, intentional, or negligent act or omission on its part, or on the part of its agents and/or subcontractors, that was connected with, or that arose out, of any activity covered by this contract.

Provider agrees to indemnify the LCD for any amount LCD may be required to repay to the DHS by virtue of payments to Provider by LCD under this contract that the DHS determines to be overpayments or inappropriate payment. In the event of any action, suit, or proceedings against Provider upon any matter herein indemnified against, Provider shall within five (5) business days cause notice in writing thereof to be given to LCD by certified mail, addressed to its post office address. Provider shall cooperate with the LCD and its attorneys in defense of any action, suit, or other proceeding.

Insurance Coverage

LCD and provider will at all times, during the terms of this contract, keep in force insurance policies issued by an insurance company authorized to do business and licensed in the State of Wisconsin. Unless otherwise specified in the Wisconsin Statutes for a given type of provider, the types of insurance coverage and minimum amounts shall be as follows:

| <u>COVERAGE</u> | <u>MINIMUM AMOUNT</u> |
|------------------------------------|----------------------------|
| 1. Workers Compensation | Wisconsin Statutes |
| 2. Comprehensive General Liability | minimum amount \$ 500,000 |
| 3. Auto Liability (if applicable) | minimum amount \$ 500,000 |
| 4. Professional Liability | minimum amount \$ 500,000 |
| 5. Umbrella Liability | minimum amount \$1,000,000 |

Private Adult Family Homes Only

| <u>COVERAGE</u> | <u>MINIMUM AMOUNT</u> |
|------------------------------------|----------------------------|
| 1. Comprehensive General Liability | minimum amount \$ 500,000 |
| 2. Auto Liability | minimum amount \$1,000,000 |
| 3. Professional Liability | minimum amount \$ 500,000 |
| 4. Umbrella Liability | minimum amount \$1,000,000 |

Notice

The Provider shall give to LCD a thirty (30) calendar days advance written notice of any cancellation or non-renewal of insurance during the term of this contract.

Certificate of Insurance

Provider shall furnish Lakeland Care District with a “Certificate of Insurance” verifying the existence of such insurance. Coverage limits, effective dates and insurer’s status to do business in Wisconsin will be verified by LCD prior to any payments for services in this contract. In the event coverage ends during the duration of this contract, provider must provide a new Certificate of Insurance to LCD. LCD may terminate this agreement if provider fails to meet these requirements.

Independent Contractor

The LCD and provider agree that each act in an independent capacity in the performance of this contract and not as an employee, agent or volunteer of the other.

License and Certification

Licensure and Certification

Provider shall meet city, state and federal service standards and applicable state licensure and certification requirements as expressed by ordinance, state and federal rules and regulations applicable to the services covered by this contract.

Good Standing

Provider shall maintain in good standing all required permit, licensure, certification and/or accreditation during the term of this contract that allows them to provide services noted in this contract in the State of Wisconsin. A copy of applicable licensure, certification or permit must be returned to LCD.

Medicaid Certified

Provider will be a certified Medicaid provider in the State of Wisconsin or will have met LCD provider standards as prescribed by LCD for services within the Medicaid benefit.

Notification of Changes

Provider shall notify LCD within five (5) business days of any changes, or threatened changes, to its Medicaid certification, licensure, permits or other certification or accreditation.

Licensing Visits

Providers shall notify Lakeland Care District Provider Network Specialist of any visits by their licensing or other regulatory entities within 3 days from the conclusion of the visit.

Revisions, Termination or Suspension

Both LCD and Provider must agree to contract revisions and addenda signed by the authorized representatives of each party. With the exception of changes made to the RATES and Service Codes Chart attached to this contract, no change, such as an amendment, shall be made to this contract, or to any document attached to it or incorporated into it, unless and until an authorized representative of the LCD and an authorized representative of the Provider both agree in writing to making the change and to the date on which it will become effective. Changes in the RATES and Service Codes Chart may be made by the LCD alone. **Providers can submit requests for rates changes to the Provider Network Specialist in the appropriate LCD Branch.**

Termination shall not release the Provider of its obligation to serve members then receiving services until transfer of the case to another service provider can be accomplished. LCD shall pay for services as provided herein.

This contract may be terminated by either party at any time, for any reason or for no reason at all, following sixty (60) calendar days written notice by either party. LCD may immediately terminate the contract if such termination is essential to the health & safety and the well-being of the members served under this contract. In the event that Provider fails to comply with any legal and/or licensure requirements, LCD may terminate the contract effective immediately. LCD is responsible for the costs of services provided after termination until alternative placement is arranged by LCD.

Members are not required to give notice prior to the termination of services with a service provider. In the event a member does terminate service with a service provider, the LCD is not obligated to continue payments for the member except for services already utilized.

Provider shall notify LCD, in writing, whenever it is unable to provide required quality or quantity of services. Upon such notification, LCD and Provider shall determine within five (5) business days whether such inability will require a corrective action plan or early termination of this contract.

Notwithstanding any other right of termination, LCD reserves the right to immediately terminate, or reduce in scope, its obligations under this contract in the event that sources of funding to the LCD derived through state or federal grants or contracts are terminated or reduced.

In the event that the contract is terminated or not renewed by either LCD or Provider, the LCD and Provider agree to cooperate in transitioning services provided members under this contract to LCD or to another provider designated by LCD.

Monitor Performance

LCD will establish mechanisms to monitor provider's performance to ensure compliance with the provisions of this contract on an ongoing basis, including formal review according to a periodic schedule, consistent with industry standards or state laws and regulations.

LCD shall identify deficiencies or areas for improvement, and will take corrective action if there is a failure to comply, which may include termination of this agreement.

60 days

This contract may be terminated for any reason upon mutual consent or upon sixty (60) calendar days prior written notice by the party wishing to terminate. Provider must send written notice to the Provider Network Director. Provider Network Director must send written notice to the Provider Contract Administrator.

Material Breach of contract

A material breach of contract shall include, but is not limited to:

- Provider rendering services determined to be in conflict with the member's Member Centered Plan (MCP) or physician order
- Provider refusing to participate in or cooperate with the LCD Utilization Management or Quality Improvement Program
- Provider seeking or collecting payment from a member except as provider in section Members Use of Personal Resources
- Failure of Provider to supply medical records, pursuant to a Member grievance or appeal, within thirty (30) days after written request by the LCD

Notice

The LCD will provide the Provider with written notice if the Provider commits a material breach of any provision in this contract.

Cure Period

If LCD determines that material breach to be correctable, LCD will provide thirty (30) calendar days (the 'Cure Period') following the Providers receipt of written notice from LCD of such material breach, to cure the breach. LCD may remove the Member(s) or suspend the provision of service by Provider at any point during the 'cure period' if LCD has determined that the Member(s) may be at risk.

Failure to Cure

LCD, at its discretion, may terminate this contract at the expiration of the Cure Period if the breach cannot or has not been cured.

Termination of contract with Cure Period

LCD may terminate this Contract immediately if LCD, in its sole professional determination, has reason to believe that the general welfare or safety of the Members(s) may be compromised, that the quality of the care being rendered is deemed to be substandard, or any material breach cannot be cured.

Transition

Upon notice of termination, for all applicable sections of the Contract, both parties agree to provide up to thirty (30) days to transition the Member(s) from the Provider to another Provider's facility or services, chosen by LCD, IDT staff and the guardian. During the thirty (30) calendar day period, both parties agree to work in good faith to arrange for other suitable services for the Member(s). The thirty (30) calendar day transition period may be waived in any situation wherein welfare or safety of the Member(s) or that the quality of care being rendered is deemed to be substandard.

Suspension

Lakeland Care District may suspend referrals and/or expansion in use of provider services for any violations of terms of this agreement pending correction of breach or termination of contract if resolution is not reached.

Appeal of Lakeland Care District Termination or Suspension of Contract

Providers may appeal the Lakeland Care District's decision to terminate or suspend this contract within 30

days of notice by submitting written appeal to:
Provider Network Director/Lakeland Care District
N6654 Rolling Meadows Drive
Fond du Lac WI 54937

Written appeals received within 30 days of LCD notice will be reviewed by LCD Management Team.

Payment

Amount paid under contract

Total payment under this contract will be based upon the amount of service authorized by LCD IDT staff and the actual amount of service performed by the provider. It is understood and agreed by all parties Lakeland Care District assumes no obligation to purchase from provider any minimum amount of services. Family Care services administered by the Lakeland Care District are funded by state and federal tax dollars through the Medical Assistance program. As a publicly-funded system, LCD strives to maintain the integrity of the program by ensuring that all services are billed as authorized by the LCD, and as rendered to our members. The LCD reserves the right to request documentation from the provider to verify the services billed were actually rendered. LCD will regularly conduct random reviews of claims submitted by its contracted providers. This could include but is not limited to providers' case notes, files, documentation and records. Providers of Medicare/ Medicaid benefits services agree to submit Medicare EOB to LCD for goods and services payable by Medicare.

Rates

Lakeland Care District shall pay provider unit rate(s) listed in Rates and Services Codes Chart of this contract. Units of service will be determined through the Resource Allocation Decision Method (RAD) and prior authorized by LCD IDT staff for each member.

Prior Authorization

Lakeland Care District will prior authorize service(s) for each individual member. The authorization will include the specific service to be provided, the amount of service (number of units), the rate to be paid, the funding source and the duration of the service to be provided. A written authorization for each and every service will be sent at least monthly via mail.

Providers are responsible for obtaining prior authorization before delivery of services. In some circumstances, initially, a verbal authorization will be given by the IDT staff which should be documented by the provider and the IDT staff.

When a LCD member receives a service where Medicare is primary, the LCD IDT staff do not need to prior authorize the service. While the LCD is not the primary payer source, LCD requests all Providers notify the IDT staff for the complete coordination of care for the LCD member. This is to ensure the member's health and safety needs are being addressed. Additionally, if co-payment is necessary or if primary payer funding ends, the IDT staff need to complete the authorizing process of the RAD worksheet exploring all options to meet the member's health and safety needs. This process requires collaboration between the member, family supports, and the provider involved. The more communication up front, the more effective the LCD and the Provider is in meeting the members needs.

Business Hours Prior Authorization

For prior authorization request during business hours, Provider shall contact the IDT staff. Provider agrees to accept LCD's method of authorization as described in this contract. Provider may request additional service authorization(s) (new/additional service(s)) or extensions of existing authorizations by contacting the IDT staff. Requests for new/additional or extensions of existing authorizations may be considered by the LCD IDT staff, but the mere factor of a request does not in any way imply that there will be any change in service level, service type or duration of service. The final decision for any change or increase in services rests with the LCD IDT staff and the eligible member.

After Hours Authorization

For prior authorization needed outside of regular business hours, provider can contact LCD's on-call answering service at 866-359-9438. The answering service will then contact the on-call IDT Staff person for the Central, East, or West office.

Prior Authorization Elements

The letter of authorization from LCD includes:

- a. Service Type
- b. Number of Units
- c. Funding Source
- d. Effective Dates
- e. Frequency Schedule

Services in Excess of Authorization

Lakeland Care District will not be obligated to pay for services not prior authorized or for services that exceed the authorized rate or units.

Payment Amounts/Billing LCD Members

For services performed under this contract and provided to a member, provider agrees to accept payments made by LCD and/or any third party payers as payment in full. The provider agrees not to bill LCD members and to hold harmless individual members, the Department of Health Services (DHS) and Centers for Medicare and Medicaid Services (CMS) in the event LCD cannot pay for services that are the legal obligation of the LCD to pay, including, but not limited to, the LCDs insolvency, breach of contract, and provider billing.

Providers failing to comply with these criteria for billing Members will be subject to termination of this agreement for failure to comply.

LCD shall immediately inform provider in writing of any circumstance or event which could affect provider's ability to receive payment for services, including, without limitation, the insolvency of LCD, or the threatened or actual termination of LCD's agreement with DHS.

Penalties for Billing Members

Any provider who knowingly and willfully bills a LCD member for a Medicaid covered service may be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in s. 1128B(d)(1)[42 U.S.C. 1320-7b] of the Social Security Act and s. 49.49(3m), Wis. Stats.

Member Use of Personal Resources

The LCD is responsible for services and items in the benefit package that are necessary to support the member's individual personal outcomes. The LCD and its providers are strictly prohibited from billing members for such services/items. Any use of personal resources for services/items within the Family Care benefit package must be wholly voluntary on the part of the member. For circumstances where the member is choosing to use their personal funds for a service/item, the LCD must assure that the member has been educated on their rights and that the purchase is wholly voluntary. The LCD assures this by drafting a Member's Use of Personal Resources Agreement or an Enhanced Service Agreement. These are written agreements between the member, the LCD, and provider of service/item which outlines the dates, costs, and signatures by all parties, that this is the member's choice to voluntarily fund the service/item, and that the bill will be sent directly to the member by the provider. A contracted LCD provider may only bill a member directly upon receiving either a

Member's Use of Personal Resources Agreement or an Enhanced Service Agreement that has been signed by all parties.

Member Freedom of Choice

Under federal law, DHS, as the State Medicaid Agency, is required to assure the federal government that any Medicaid participant has freedom of choice to obtain covered services from any willing provider qualified to perform the service. In Wisconsin, it is the role and responsibility of the ADRC to provide long-term care options/enrollment counseling to Medicaid participants and prospective participants. The ADRCs do not have a vested interest in the program or provider. The individual chooses the program and so the ADRC is able to offer unbiased and objective information about those choices.

An LCD Provider must not attempt to influence a participant/member freedom of choice of long-term care program, provider or MCO through communications with participants/members that are inaccurate, misleading or coercive. Federal Regulations 42 CFR 438 and the DHS's MCO contracts require LCD and its Providers to ensure that communications that are intended to influence member choice are accurate and do not mislead, confuse, or defraud members. LCD providers who consider it in the best interest of a member to learn about other options, the LCD Provider must refer the member to the ADRC to learn about alternatives; the LCD provider must not provide options/enrollment counseling directly. In addition, the ADRC has the responsibility to inform the member about his/her rights as a program member or facility resident, in order to prevent intimidation or coercion of a member by a LCD Provider.

DHS and LCD will investigate interference with members' rights when it is reported and impose sanctions as appropriate. If any LCD provider is found to have attempted to influence a member to enroll or disenroll from a long-term care program or from a MCO, DHS and LCD may disqualify that provider from receiving future Medicaid funding for the provision of services under any Medicaid program.

Timeliness of Payment

Lakeland Care District processes claims in the order they are received. LCD shall pay clean claims within thirty (30) calendar days of receipt of the claim.

Prohibited Practices

Providers are prohibited from any communication, activities or written material making any assertion or statement, that LCD or provider is endorsed by CMS, the Federal or State government, or any other entity. Any marketing material or presentations by provider which claim that LCD will pay for an individual to continue to receive services from provider after the individual's private financial resources have been exhausted are prohibited.

Provision of Services

Access and Timeliness of Services Standard

The LCD must meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services. Provider agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services in the benefit package which are necessary to achieve outcomes.

Providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service members, if the provider services only Medicaid members.

Member Specific Services Standard

Provider will provide services that are individually tailored to meet member outcome(s).

Cultural Competency and Values

LCD agrees to deliver services in a culturally sensitive manner. The LCD's approach to service delivery must honor the member's beliefs and customs and be sensitive to the cultural diversity and background of the member. This cultural sensitivity will be demonstrated in written and verbal communication with the member and their family, and in training of the Provider's staff who deliver the service. Provider agrees to provide services in a culturally competent manner; honoring members' beliefs, being sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, and interpersonal communication styles which respect members' cultural backgrounds.

Communication Standards

Provider will appropriately communicate with the member, LCD IDT staff, member's informal supports and any additional LCD staff.

Safety and Risk Standard

Competent members may choose to accept a level of risk which is clearly understood and mutually communicated.

Isolation, Seclusion, Restraint, and Restrictive Measure Standard

Provider shall comply with Division of Quality Assurance (DQA) licensing requirements in regards to Restrictive Measures. Provider shall comply with SS.51.61(1)(i) and 46.90(1)(i) of the WI Stats and s.DHS 94.10 of the WI Admin Code in any use of isolation, seclusion, and restrictive measures.

Critical Incident Reporting Standards

Provider agrees to participate to the extent requested by LCD in quality assurance/quality improvement programs, subject to state and federal laws addressing the confidentiality of provider's information. If such information is not otherwise protected, provider specifically agrees to share service quality information it generates regarding its services provided to LCD members. Provider will identify, respond to, document and report all member critical incidents.

Critical Incident means: a circumstance, event or condition resulting from action or inaction that is either:

- a) Associated with suspected abuse, neglect, financial exploitation, other crime or a violation of member rights or any unplanned, unapproved use of restrictive measures;
- b) Or that:
 - Resulted in serious harm to the health or well-being of the member; or
 - Resulted in serious harm to the health or well-being of another person as a result of a member's action; or
 - Resulted in substantial loss in the value of the personal or real property of a member or of another person as a result of a member's actions; or
 - Resulted in the unexpected death of a member; or
 - Posed an immediate and serious risk to the health, safety, or well-being of a member, but did not cause harm because of chance or improvised preventative intervention.

LCD requires additional reporting of:

- Any emergency use of restrictive measures must be reported as a critical incident
- The use of restrictive measures outside an approved intervention plan will constitute a critical incident reportable to LCD within one (1) business day per LCD policy.

Critical Incident Reporting Evidence of Compliance

- Provider reports critical incidents as defined above to LCD as soon as possible after the discovery of the incident, or within hours of the incident.
- Provider recognizes incidents in which harm has occurred.
- Provider responds to incident(s) in a way that, to the extent possible, ameliorates harm that has occurred and prevents future harm.
- Provider has adequate documentation of Critical Incidents.

- Provider cooperates with LCD in investigation of any alleged critical incident through access to records, staff and any other relevant sources of information.
- Provider agrees to furnish LCD with copies of their incident reports for critical incidents involving Members, if providers maintain such reports.

Quality Assurance/ Quality Improvement Programs

Provider agrees to participate in and contribute required data to the LCD's Quality Management programs as required in the DHS Division of Long Term Care Contract (Quality Management) subject to state and federal laws addressing the confidentiality of Provider's information.

Provider agrees to submit utilization data in the format reasonably specified by LCD, so that LCD can comply with DHS specifications. Unless mutually agreed upon, provider's participation shall not require significant financial or other resource expenditures.

Rights and Grievance Procedure

Providers recognize that members have the right to file appeals or grievances and that such action will not adversely affect the way that provider treats LCD members. Provider will cooperate and not interfere with the members' appeals, grievances and fair hearings procedures and investigations and timeframes. LCD Member's Appeals and Grievance Policy is inserted in this contract.

Provider agrees to forward records to the LCD pursuant to grievances and appeals within fifteen (15) business days of a request from LCD or immediately if the appeal is expedited. If Provider does not meet the fifteen (15) business days requirement, provider must explain in writing why and indicate when the records will be provided.

Records

Maintenance of records

Provider shall maintain and retain records as required by state and federal laws, rules and regulations. Member records shall be retained for a period of not less than five years from the date of the member's discharge. Records involving matters subject of litigation between LCD and provider shall be retained for a period of not less than five years following the termination of litigation.

Lakeland Care District Access to Records

Provider shall permit appropriate representatives of LCD to have timely access to provider's records for LCD members as necessary to review provider's compliance with contract requirements. LCD shall reimburse Provider for the reasonable costs of any copies as allowed under guidelines in 146.83 (1) (f) (a) Wisconsin Statutes.

Access to Premises

The Provider shall allow duly authorized agents or representatives of LCD, Wisconsin DHS, or Federal Department of Health and Human Services (HHS), during normal business hours, access to the providers premises to inspect, audit, monitor, examine, excerpt, transcribe, copy or otherwise evaluate the performance of the providers contractual activities and shall forthwith produce all records, including but not limited to financial, member or administrative records, requested as part of such review or audit.

Provider shall, 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 the state or federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Provider's activities.

Member Access

Provider agrees to make records available to LCD members' and his/her 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. Members shall have access to their records in accordance with applicable state or federal law. Provider shall use its best efforts to make records available to members or their authorized representatives. Members may be charged for copies only in accordance with 146.83 (1) (f)(a) Wisconsin Statutes.

Reporting

Reporting requirements applicable under this contract are indicated in the applicable addendum(s).

Assignment

This contract is not assignable by provider either in whole or in part, without written consent of LCD.

DRAFT

HIPAA Addendum

Provider agrees to comply with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as set forth in Title 45, Parts 160 and 164 of the Code of Federal Regulations (CFR). In the event of conflicting terms or conditions, this addendum shall supersede the contract.

Use and Disclosure of Protected Health Information

Provider shall use and/or disclose Protected Health Information (PHI) created for or received from or on behalf of LCD only to the extent necessary to satisfy provider's obligations under the contract and only as allowed by the terms of the contract and this addendum. Provider agrees that it will not use or disclose PHI in a manner that violates or would violate the HIPAA regulations. The term PHI shall be limited to the information created or received by provider from or on behalf of LCD and shall not include any PHI that has been altered in a manner to delete any individually identifiable information.

Provider may use PHI as necessary for provider's proper management and administration or to carry out provider's legal responsibilities. Provider may disclose PHI for such purposes only if:

- (a) The disclosure is required by law; or
- (b) Provider obtains reasonable assurance from any organization or person to which provider shall disclose such PHI that such organization or person shall:
 - (i) Hold such PHI in confidence and use or further disclose it only for the purpose for which provider disclosed it to the person or organization or as required by law; and
 - (ii) Notify provider of any instance in which the person or organization becomes aware that the confidentiality of such PHI was breached.

Provider's Obligations

Provider shall not use or disclose PHI other than as permitted or required by the contract and this addendum or as required by law. Provider shall develop, implement, maintain and use appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than as permitted under the Contract and this Addendum.

1. Provider shall develop, implement, maintain and use appropriate administrative, technical and physical security measures in compliance with Section 1173(d) of the Social Security Act, Title 42, Section 1320-2(d) of the United States Code and Title 45, Part 142 of the CFR to preserve the integrity and confidentiality of all electronically maintained or transmitted Health Information received from or on behalf of LCD pertaining to an Individual.
2. If Provider conducts any Standard Transaction for or on behalf of LCD, Provider shall comply, and shall require any subcontractor or agent conducting such to comply, with each applicable requirement of Title 45, part 162 of the CFR. Provider shall not enter into or permit its subcontractors or agents to enter into any trading Partner Contract in connection with the conduct of Standard Transactions for or on behalf of LCD that:
 - a) Changes the definition, Health Information condition or use of a Health Information element or segment in a Standard;
 - b) Adds any Health Information elements or segments to the maximum defined Health Information set;
 - c) Uses any code or Health Information elements that are either marked "not used" in the Standard's Implementation Specification or are not in the Standard Implementation Specification(s); or
 - d) Changes the meaning or intent of the Standard's Implementation Specification(s).
3. Provider shall report to Client any use or disclosure of the PHI not provided by the Contract and this Addendum of which Provider becomes aware.
4. Provider shall require any agent or subcontractor to whom it provides PHI to impose at least the same obligations to protect such PHI as are imposed on Provider by the Contract and this Addendum.
5. Provider shall make available to LCD PHI necessary for LCD to respond to an individual's request for access to PHI. Provider shall forward to LCD any and all requests by an individual to access such records.

6. Provider shall, upon receipt of notice from LCD, amend or correct PHI in its possession or under its control.
7. Provider shall document its disclosures of PHI in a manner sufficient for LCD to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. LCD shall designate the time and manner in which Provider shall provide the accounting of its disclosures to LCD.
8. Provider shall make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary for purposes of determining the LCD's compliance with the Privacy Rule.
9. Provider agrees to mitigate, to the extent practicable, any harmful effect that is known to Provider of a use or disclosure of PHI by Provider in violation of the requirements of the Contract or this Addendum.

LCD's Obligations

LCD shall notify provider of any limitation(s) in its notice of privacy practices of LCD in accordance with 45 CFR Section 164.520, to the extent that such limitation may affect provider's use or disclosure of PHI.

LCD shall notify provider of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Provider's use or disclosure of PHI.

LCD shall notify provider of any restriction to the use or disclosure of PHI that LCD has agreed to in accordance with 45 CFR Section 164.522, to the extent that such changes may affect provider's use or disclosure of PHI.

LCD shall not request provider to use or disclose PHI in any manner that would not be permissible under the law if done by LCD, with the exception that provider may use or disclose PHI for data aggregation or management and administrative activities of provider if required by the underlying contract.

Term and Termination

The term of this contract shall be effective as of the date of the Addendum to this Contract and shall terminate when all of the PHI provided by LCD to Provider, or created or received by or on behalf of LCD, is destroyed or returned to LCD or, if it is infeasible to return or destroy PHI, protections are extended to such information in accordance with the termination provisions in this section.

Termination for Cause: Upon LCD's knowledge of a material breach by provider, LCD shall provide an opportunity for provider to cure the breach or end the violation, and terminate the Contract if Provider does not cure the breach or end the violation within the time specified by LCD. Notwithstanding this provision, LCD shall immediately terminate this Contract if Provider has breached a material term of the Addendum and cure is not possible.

Effect of Termination: Except as provided in paragraph (b) of this section, upon termination, cancellation, expiration or other conclusion of the Contract, provider shall return or destroy all PHI received from LCD, or created or received by provider on behalf of LCD. This provision shall apply to PHI that is in the possession of subcontractors or agents of provider. Provider shall retain no copies of the PHI.

In the event that provider determines that returning or destroying the PHI is not feasible, Provider shall provide to LCD notification of the conditions that make return or destruction infeasible. Upon the mutual contract that return or destruction is infeasible, Provider shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Provider maintains such PHI.

Automatic Amendment

Upon the effective date of any amendment to the regulations promulgated by HHS with respect to PHI, the addendum shall automatically amend such that the obligations imposed on Provider as a Provider remain in compliance with such regulations. The parties further agree to take such action as is necessary to incorporate such amendments into this addendum to comply with such regulations.

Continuing Obligations

Provider’s obligation to protect PHI as set forth in this addendum shall be continuous and shall survive any termination, cancellation, expiration or other conclusion of the contract.

Interpretation and Conflict

Any ambiguity in this addendum shall be resolved to permit the parties to comply with the Health Insurance Portability and Accounting Act of 1996, as amended. In the event of any conflict between the terms of this addendum and any other contracts between the parties, the terms of this addendum shall govern the use and disclosure of PHI.

Effect on Underlying Contract

This addendum does not modify or amend this contract, with the exception of that portion of the contract that is regulated by the privacy rules of the Health Insurance Portability and Accounting Act of 1996, as amended.

| | |
|--|---|
| Lakeland Care District | |
| Appeals and Grievance Policy | |
| Affected LCD Units: | Policy #: 2.40.1 |
| Effective Date: January 1, 2010 | Last Review Date: August 1, 2011 |

Purpose: Lakeland Care District (LCD) Managed Care Organization (MCO) is a professional service organization. This policy defines and outlines the process that Lakeland Care District and members will follow when a member or a member’s representative files a grievance or appeal. It is the intent of LCD to resolve member concerns, appeals and grievances as quickly and equitably as possible as they arise.

Scope: Lakeland Care District (LCD) Managed Care Organization (MCO) is a professional service organization. This policy defines and outlines the process that Lakeland Care District and members will follow when a member or a member’s representative files a grievance or appeal. It is the intent of LCD to resolve member concerns, appeals and grievances as quickly and equitably as possible as they arise.

Policy: Lakeland Care District’s members have the right at any time to raise issues or file written appeals or grievances with LCD or with the Wisconsin Department of Health Services. Members may submit their appeals or grievances at any level at any time. Members have a right to prompt resolution of grievances and appeals. Whenever possible, LCD will attempt to resolve appeals and grievances informally. All appeals and grievances and their resolutions are to be reviewed annually by the Appeal and Grievance Committee. The Appeal and Grievance Committee has been designated by the LCD Board of Directors as the body which will hear and resolve local appeals under this policy. The LCD Governing Board will review summaries of all appeals and grievances at least quarterly during the year.

A. Definitions: The following definitions are from the Department of Health Services Division of Long Term Care Contract will apply, *Definitions*

1. **Action** means:

- (a) The denial or limited authorization of a requested service, including the type or level of service;
- (b) The reduction, suspension, or termination of a previously authorized service;
- (c) The denial, in whole or part, of payment for a service;
- (d) The failure to provide services and support items included in the member’s MCP/ISP in a timely manner, as defined by the State;
- (e) The failure of the MCO to act within the timeframes of this Article for resolution of grievances or appeals;
- (f) The development of an individualized service plan or MCP that is unacceptable to the member because any of the following apply:
 - i. The plan is contrary to a member’s wishes insofar as it requires the member to live in a place that is unacceptable to the enrollee.
 - ii. The plan does not provide sufficient care, treatment or support to meet the enrollee’s needs and identified Family Care outcomes.

- iii. The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.
- 2. **Appeal** means a request for review of an action, as "action" is defined in this section. Most actions on the part of LCD will likely be communicated to the member or representative formally via a Notice of Action form or the written individual service plan.
- 3. **Grievance** means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and the DHS level, and access to the State fair hearing process. (Subjects for grievances include any act, decision or omission by the MCO, including but not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights).

B. Authority to File:

- 1. A member or member's representative may file a local grievance or a LCD level appeal, and/or a request for DHS review, and/or may file an appeal for a State fair hearing, separately or concurrently. Members may file at any level at any time (but within 45 days of an action).
- 2. A provider, acting on behalf of the member and with the member's written consent, may file a local grievance or appeal.
- 3. The member shall file the grievance, appeal or request for fair hearing within 45 days from the date on the LCD Notice of Action. Within the 45 days a member may:
 - a. File a grievance either orally or in writing either with LCD or the State
 - b. The member or provider may file a local appeal either orally or in writing, and follow the oral filing with a written, signed appeal
 - c. The member may file a request for fair hearing, in writing, with the Division of Hearing and Appeals in the Department of Administration

C. General Procedure:

- 1. The member will be oriented to the appeal and grievance process within 60 days of enrollment. This orientation will be provided in a manner that is understandable to the member or the member's representative. The orientation will include review of the section on appeals and grievances in the member handbook. The Interdisciplinary Teams will review the appeal and grievance procedures with members at least annually during formal member-centered plan reviews.
- 2. Members are to be encouraged to communicate dissatisfaction to their care management team at any time so issues can be resolved as quickly and simply as possible. Members are further assured that there will be no retaliation against them by Lakeland Care District as a result of their complaint, grievance or appeal and that they can involve an advocate of their choosing. A list of available resources for advocacy will be included in the Member Handbook.
- 3. Appeals and grievances can be filed at any time with any LCD or provider employee, however all appeals and grievances are to be routed by the LCD or provider employee who receives them to a designated individual, the Member Relations Coordinator. The Member Relations Coordinator will review the complaint, grievance, or appeal, and initiate the appropriate response, procedure or process. Additionally, LCD will make the Quality Specialists available to assist members with all aspects of filing and appeal including completion of forms, and assisting with other procedural steps, such as providing interpreter services, toll-free calling and adequate TTY/TTD services.

All LCD care managers, care management assistants and providers will receive training on receiving complaints and grievances and appeals, informal resolution of grievances, and how the various procedures work. The care manager role in prompt informal resolution and mediation will be part of training. Staff will also know their role in the formal process and hearing process. This training for staff on this policy and procedure is part of the new employee orientation, and will be presented at least once annually to all staff.

D. Informal Resolution Procedure:

- 1. The first attempt at resolution may take place informally between the member or the member's representative and the LCD employee who receives the complaint or grievance. The employee will gather as much information about the complaint or grievance as possible and determine what resolution the member expects to the issue. There may be times when the member just wants to bring something to the attention of the LCD, and does not expect us to take any action. The LCD employee and team will enter case notes to document member concerns that are addressed and resolved.

E. Standard Grievance Resolution Procedure:

1. The grievance or appeal will be filed either orally or in writing with the Member Relations Coordinator. Within five days of receiving a grievance or appeal, Lakeland Care District will notify the member in writing that the grievance or appeal has been received. The notification will include:
 - a. an offer of assistance that the member may need to help resolve the grievance or appeal internally, including the right to involve an advocate of his/her choice, significant other, or provider
 - b. the process that LCD will follow in attempt to mediate or to resolve the grievance or appeal
 - c. the notice that the Appeals and Grievance Committee will conduct a hearing in the case of an unresolved appeal or grievance
 - d. the expected date of a decision or resolution
2. Lakeland Care District staff will perform an investigation of the grievance or appeal and interview, as appropriate, the member, care providers and members of the care management team. This investigation will be conducted in accordance with LCD confidentiality and records policies. The person(s) LCD assigns to investigate the grievance or appeal will not be person(s) who have previously been involved in the care of the member, or in decision-making regarding the circumstances of the appeal or grievance.
3. Lakeland Care District will attempt to resolve the grievance or appeal, will schedule an appeal hearing, and notify the member of the resolution as soon as possible, but no later than 20 days after LCD receives the appeal or grievance. This timeline may be extended an additional 14 days if the member requests an extension or if the Department approves the LCD's request for an extension. The Department may approve an extension based on a documented need for more information and an explanation of how the extension meets the interests of the member.
4. Lakeland Care District Appeal and Grievance Committee has a policy and procedure which guides the appeal hearing process and decision making based on the findings of its investigation and the hearing process. The Appeal and Grievance Committee's decision will be communicated in writing to the member within the identified timeframe. The notice of resolution will include:
 1. The name of the contact person at the LCD who received the grievance or appeal
 2. The name of the person(s) who investigated the grievance or appeal
 3. The name of the person(s) who decided how the LCD would respond (Appeal & Grievance Committee)
 4. The date the decision was reached
 5. A summary of the actions taken on behalf of the member to resolve the issue
 6. The name of the person who can be contacted for questions as to the decision
 7. A summary of the rationale for the decision

If the resolution is not wholly in favor of the member, the notice will further include:

 8. The right to request a fair hearing, and how to do so
 9. The right to request to receive benefits while the hearing is pending
 10. That the member may be held liable for the cost of those benefits if the hearing decision upholds the action of Lakeland Care District

F. Appeal Process for Denial or Change in Service:

1. If Lakeland Care District intends to deny, delay, limit, reduce or terminate a service, or deny payment for a service, the organization will give the member a written notice 15 days prior to the intended action. The notification will be made using the approved Notice of Action (NOA) form.
2. If LCD is denying payment, the MCO will mail or hand deliver the NOA at the time of any action affecting the claim.
3. The MCO will mail or hand deliver the NOA within 14 calendar days following the request for service, with a possible extension of up to 14 additional calendar days if the member or the provider requests the extension or if the MCO shows to the satisfaction of the Department that additional information is needed and that a delay is in the member's best interest.
4. If LCD extends the timeframe for issuing the NOA, LCD will:
 - a. Give the member written notice of the reason for the extension and notify the member of the right to file a grievance if the member disagrees with the extension
 - b. Issue and carry out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

5. If LCD fails to make a service authorization within the time limits, a NOA will be mailed on the date the applicable timeframe expires.
6. LCD will mail or hand deliver a NOA within 72 hours for expedited service requests. A possible extension of up to 14 additional calendar days may be made if the member or the provider requests the extension or if the MCO shows to the satisfaction of the Department that additional information is needed and that a delay is in the member's best interest.
7. The Notice of Action shall include the following:
 - a. The action that LCD intends to take;
 - b. The reasons for the intended action;
 - c. Any laws and rules that support the intended action;
 - d. The member's rights, as well as how to file a grievance internally with LCD, the Department, or through a fair hearing process;
 - e. The member's right to appear in person before the LCD Appeals and Grievance Committee assigned to resolve grievances and appeals;
 - f. Notice that if an appeal is filed by the date of the intended action, or within 14 days of receipt of the written Notice of Action from LCD (whichever is later), that current benefits may continue if the member requests, pending resolution of the appeal or issuance of a decision from the Department or the fair hearing process; and
 - g. How to obtain copies of member's records which include but are not limited to medical records.
8. Oral inquiries seeking to grieve or appeal an action are to be treated as appeals. This establishes the earliest possible filing date for the appeal. This oral inquiry will be confirmed in writing.
9. If a member files an appeal he or she can continue receiving benefits pending the outcome of the appeal process. The member must make the request for continued benefits prior to the effective date of any proposed termination, reduction, or suspension of services. The member may be held liable for the cost of those benefits if the hearing decision upholds the action of Lakeland Care District.
10. In appeal regarding a change or denial of service will be processed according to the standard appeal resolution process with the following additions:
 - a. If the determination of LCD to change or deny services to the member is based on a lack of medical necessity, a person with professional experience in treating the member's condition or in the field relative to the denied service will participate in the resolution process.
 - b. The member may participate in a hearing before LCD Grievance and Appeals Committee
 - c. The member or representative must be provided a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.
 - d. The member or representative must be allowed, before and during the appeals process to examine the member's case file, including medical records and any other documents and records considered during the appeals process. LCD will not re-release material generated by other external sources.
11. If Lakeland Care District reverses a decision to deny a service, the organization will authorize or provide the service as expeditiously as the member's situation or health requires, but no longer than 30 days after the receipt of the reversal.

G. Lakeland Care Districts' Hearing Procedure:

1. At any time within 45 days of a member's receipt of a Notice of Action, the member or the member's representative may file an appeal of the action. The Member Rights Specialist will attempt additional mediation activity to try to resolve the matter. A grievance can be submitted orally or in writing. An appeal may be submitted orally (to establish the earliest possible filing date for the appeal), and must be reduced to a written appeal.
2. LCD will dispose of each grievance and provide notice as expeditiously as the member's health condition requires but no later than 20 business days after LCD receives the grievance. The appeal hearing with the Appeals and Grievances Committee will be scheduled within 20 business days of the receipt of the appeal.
3. The member and his/her representative or the legal representative of a deceased member's estate, and LCD will be considered parties to the local appeal.
4. The member will be offered the assistance necessary to attend and participate in the hearing, and will be reminded of his/her right to involve an advocate of his/her choice. The member or representative has the following rights:

- a. The right to examine all the documents and records to be used at the hearing at a reasonable time before the date of the hearing, as well as during the hearing.
 - b. The right to present his/her case personally, or have an advocate do so.
 - c. The right to bring witnesses on his/her behalf
 - d. The right to establish all pertinent facts and circumstances to his/her case, including presentation of evidence, both verbally and written.
 - e. The right to question or refute any testimony or evidence, including the opportunity to cross-examine adverse witnesses.
5. The Appeals and Grievance Committee will issue a decision within five working days of the hearing and within the 20 business days to respond to an appeal. The written decision will include all the information required in a standard denial/change process or appeal resolution notice (whichever is applicable). If the decision overturns LCD's action or decision, the organization will restore the services or make accommodations for requested services in accordance with the findings of the committee.
 6. The Appeal and Grievance Committee decisions are limited by having to be congruent with and conform to the current Health and Community Supports Contract in place at the time of the hearing.
 7. If the decision of the Appeals and Grievance Committee is adverse to the member, the member can proceed with the grievance process by appealing to the Department of Health Services review process, or to the Division of Hearings and Appeals for a State Fair Hearing.
 8. The Appeal and Grievance Committee has been established and policy adopted by the LCD Governing Board. Its composition shall include:
 - a. At least one person who meets the eligibility criteria to be a member of Lakeland Care District and is free of conflicts of interest in the case,
 - b. Persons who have not been involved in previous decision making and
 - c. Appropriate health care professionals are included if the appeal is based on a denial due to lack of medical necessity, denial of expedited appeal or a clinical issue.
 9. The Branch Quality Specialist will serve as liaison to the Appeals and Grievances Committee for scheduling, notices, training, and arrangements, but is a non-voting and impartial entity.
 10. The hearing timeline may be extended by up to fourteen (14) days if:
 - a. The member requests the extension, or
 - b. If Lakeland Care District can satisfy DHS that there is need for additional information and how the delay is in the member's best interests. In the event that an extension is granted, LCD will provide the member written notice of the extension and the reason for the extension.

H. Lakeland Care District's Expedited Hearing Procedure:

1. A member may request an expedited resolution to an appeal if the matter involves health issues or the member perceives himself or herself to be at risk. A member must clearly request an expedited resolution and response, and must state the reasons for an expedited response.
2. All oral inquiries are treated as an appeal and will be reduced to writing immediately.
3. An expedited resolution request will result in a response from Lakeland Care District within three (3) working days of receipt of the appeal.
4. The timeline may be extended by up to fourteen (14) days if:
 - a. The member requests the extension, or
 - b. If Lakeland Care District can satisfy DHS that there is need for additional information and how the delay is in the member's best interests. In the event that an extension is granted, LCD will provide the member written notice of the extension and the reason for the extension.
5. LCD will make reasonable efforts to provide prompt oral notice of the results of the expedited appeal.
6. If there is an expedited need for an appeal or grievance resolution or such a request is denied, or there is a denial based on medical necessity, or a grievance or appeal that involves clinical issues, then the LCD Medical Consultant will make the LCD decision on resolution or name a person to decide who has clinical expertise in treating the member's condition.
7. If Lakeland Care District denies a request for an expedited appeal resolution, the appeal will be transferred to the standard appeal resolution process and timeframe (within 20 business days). LCD will give the member prompt oral notice of the denial and send a written notice to the member within two calendar days of the initial request.

I. Department of Health Services Grievance Resolution and Review Process:

Members may access the grievance resolution process of the Department of Health Services unit which monitors Lakeland Care District contract. Members may access this process for any complaint or appeal at any time, and a review will be completed within 20 days, unless the member and the department representative agree to an extension for a specified period of time.

To access the Department of Health Services Grievance Resolution process members (no requirement for written grievance with this option unless the grievance is submitted by someone other than the member) contact: Family Care Grievance/Appeal, c/o MetaStar, 2909 Landmark Place, Madison, WI 53713 and/or by calling 888-203-8338.

J. Fair Hearing Process:

Members may access the Fair Hearing process, which has its own timelines, at any time regarding:

1. Denial of eligibility or of an appropriate level of eligibility
2. Denial of timely services
3. Reduction or termination of services
4. A plan of service offered by the MCO that is unacceptable to the member because it:
 - a. Requires the member to live in a place they do not want to live
 - b. Restricts the member's choice of qualified "critical personal service providers" who will accept the unit cost and other provisions of the MCO standard contract, or
 - c. Otherwise requires the member to accept services or treatments that are insufficient to meet the member's needs, are unnecessarily restrictive, or are unwanted.
5. An involuntary disenrollment.
6. Lakeland Care District makes a decision on an appeal or grievance that is entirely or partially adverse to the member, or
7. The member disagrees with the conclusion following a Department (DHS) investigation of a Department appeal or grievance

The member and his/her representative or the legal representative of a deceased member's estate, LCD, and the Department will be considered parties to the appeal.

To access the Fair Hearing process, members must send a written grievance or appeal, within 45 days of one of the types of incidences noted above, to:

Family Care Request for Fair Hearing
c/o DOA Division of Hearing and Appeals
5005 University Avenue RM 201
Madison, WI 53705-5400

or by calling 608-266-3096 and filing an appeal. Members who need assistance in submitting a written grievance/appeal can request help from their care manager or the Quality Program Specialist.

K. Documentation and Reporting:

If Lakeland Care District or its Appeals Committee makes a decision on an appeal or grievance that is entirely or partially adverse to the member, LCD will submit the decision and all supporting documentation to the Department's External Quality Review Organization (EQRO), MetaStar, Inc., as expeditiously as the member's situation and health condition requires, but no later than 20 days after the member receives notification of the decision.

1. On a quarterly basis LCD shall submit to the Department of Health Services a grievance and appeals report consisting of a summary and a log. The summary shall be an analysis of the trends that LCD has experienced regarding types of issues about which grievances or appeals were filed, and regarding specific providers that are the subject of complaints or grievances. The log shall include the following information about each grievance or appeal
 - a. Whether the issue was a grievance or appeal
 - b. The nature of the grievance or appeal
 - c. The timeline in which it was resolved
 - d. The decision and rationale for the decision
 - e. Whether the member was satisfied with the resolution
 - f. Whether a disenrollment occurred during the course of a grievance or appeal and if so, the reason for the disenrollment
2. The MCO will retain the documents related to each grievance or appeal for three years in a central location

and make them accessible to DHS. If any action involving the documents or log is started before the expiration of the three year period, the MCO shall retain the records until the completion of the action and resolution of the issues which arise from it, or until the end of the regular three year period (whichever is later).

L. Monitoring:

Lakeland Care District will monitor the Appeal and Grievance Process to assure that timelines and procedural safeguards for members are implemented according to this policy. The summary report and log prepared each quarter for state reporting will be scrutinized for compliance with timelines and process. This summary report and log will be presented at least quarterly to the LCD Governing Board and local Long Term Care Council. The materials will be used by the Appeal and Grievance Committee and QA/QI Committee to assure quality in the provision and practice of member procedural safeguards and compliance with the Health and Community Supports contract and HFS 10, Section V.

Reference: Wis Stats 46.297; HFS 10, Subchapter V; Health and Community Supports Contract, Section IV: Protection of Member Rights; and the Lakeland Care District Appeals and Grievance Policy.

DRAFT