AGREEMENT FOR SERVICES

BETWEEN

CARE WISCONSIN FIRST, INC.

AND

RACINE COUNTY SENIOR NUTRITION PROGRAM

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 Racine County Senior Nutrition Program ("Provider") as of February 1, 2018 ("Effective Date").

WHEREAS, Care Wisconsin Health Plan, Inc. (the "Health Plan"), a sole member of Care Wisconsin First, Inc., operates Family Care Partnership ("Partnership"), a Fully Integrated Medicare Advantage Special Needs Plan ("SNP," via contracts with the Centers for Medicare and Medicaid services, hereafter "CMS") and Wisconsin Medicaid Program ("WMP," via a Family Care Partnership Contract ("Partnership Contract") with the State of Wisconsin, represented by the Department of Health Services' (hereafter, "DHS") Division of Long Term Care, to provide or arrange for the provision of comprehensive health and long-term care services to eligible persons ("Members").

WHEREAS, Care Wisconsin has entered into a Wisconsin Family Care Contract ("MCO Contract") with the State of Wisconsin, represented by its DHS Division of Long Term Care, 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, appendices and amendments hereto.

1.2 Clean Claim. Shall mean a claim that can be processed without obtaining additional information from the provider of the service. A claim is still considered a clean claim if the only error(s) in the submitted information are the result of an error originating in the Department's system or with errors originating from an MCO's claims processing system problem, an MCO's internal claims or an MCO's business process problem. A clean claim does not include a claim that is under review for medical necessity or any claim from a provider who is under investigation for fraud or abuse.

1.3 Covered Services.

1.3.1 For Family Care Partnership, Covered Services include: all Medicaid State Plan services required under WI Stats. S.49.46 (2) and Wisconsin Administrative Code DHS 107 and

all Medicaid waiver services required under the s. 1915 © Home and Community-Based Services Waivers titled "Family Care – Aged / Physical Disability Waiver" and "Family Care MR/DD Waiver;" and all Medicare Parts A, B and D services covered under Care Wisconsin's SNP contracts with CMS.

1.3.2 For Family Care, Covered Services include limited DHS 107 Medicaid State Plan services for long-term care and services required under the s. 1915 © Home and Community-Based Services Waivers titled "Family Care – Aged / Physical Disability Waiver" and "Family Care MR/DD Waiver."

1.3.3 For Medicaid SSI, Covered Services include all Medicaid State Plan services required under WI Stats. S.49.46 (2), s. 49.471(11), s.49.45 (23) and Wisconsin Administrative Code DHS 107.

1.3.4 For Medicare Dual Advantage, Covered Services include: all Medicare Parts A, B and D services covered under Care Wisconsin's SNP contracts with CMS.

1.4 Critical Incident. An event, incident, or course of action or inaction that is either:

1.4.1 Associated with suspected abuse, neglect and financial exploitation, other crime, or a violation of member rights,

1.4.2 Or that:

1.4.2.1 Resulted in serious harm to the health or well-being of a member, or

1.4.2.2 Resulted in serious harm to the health or well-being of another person as a result of the member's actions; or

1.4.2.3 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

1.4.2.4 Resulted in the unexpected death of a member; or

1.4.2.5 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.

1.5 Downstream Entity. Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a Medicare Advantage organization or applicant and a first tier entity. These written arrangements continue down to the level of ultimate provider of both health and administrative services.

1.6 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:

1.65.1 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.

1.65.2 Serious impairment to bodily functions.

1.65.3 Serious dysfunction of any bodily organ or part.

1.7 First Tier Entity. Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.

1.8 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, or other care management staff designated by the Health Plan.

1.9 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.

1.10 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. DHS 107 of the Wisconsin Administrative Code.

1.11 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.

1.12 Medicare Advantage ("MA"). An alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

1.13 Medicare Advantage Organization ("MA organization"). A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

1.14 Medicare Covered Services. Shall mean those services reimbursed by CMS guidelines for people eligible for Medicare benefits.

1.15 Member. Shall mean a person who is enrolled in Family Care Partnership, Family Care, Medicaid SSI and Medicare Advantage.

1.16 Network Physician. Shall mean a licensed doctor of medicine or osteopathy with which Care Wisconsin has an Agreement for Services for the provision of medical services to Members.

1.17 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.

1.18 Provider. (1) Any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

1.19 Provider. Shall mean a care provider who will provide the health and/or long-term care services specified in Appendix A of this Agreement.

1.20 Provider Manual. Shall act as a reference tool for information pertaining to the Care Wisconsin First, Inc. and Care Wisconsin Health Plan programs and their relationship with Providers.

When the Provider Manual is referenced in the Agreement (Sections III, V, VIII, IX and XII) it establishes the same terms and conditions for Services and made a part hereof.

1.21 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.

1.22 Related Entity. Any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

1.23 Special Needs Individual. Shall mean a Medicare Advantage-eligible individual who would benefit from enrollment in a specialized Medicare Advantage plan.

1.24 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.

1.25 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 Delineates the purpose of the services in Appendix A.

2.2 Will provide to Members the Covered Services defined in Appendix A, and Appendix B affixed hereto and made a part hereof.

2.3 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).

2.4 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.

2.5 Agrees to 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 serves only Medicaid members.

2.6 Will obtain Health Plan's and MCO's prior authorization, if such prior authorization is required, by contacting the member's Interdisciplinary Team or other care management staff designated by

the Health Plan 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 or revise the amount of service authorized without contacting the member's Interdisciplinary Team prior to providing or arranging for the provision of services.

MCO shall issue service authorizations to Provider prior to the start date of designated services by the provider. MCO shall issue revised service authorizations to Provider promptly, with sufficient notice to allow Provider to comply with the terms of the revised service authorization and to timely submit accurate claims during the appropriate billing period.

For more information on contacting the Interdisciplinary Team or other care management staff designated by the Health Plan reference the Provider Manual at https://www.carewisc.org/provider-manual-and-policies.

III. TERM AND TERMINATION

3.1 Term. The initial term of this Agreement shall become effective as of the Effective Date and shall continue in effect for one year. Thereafter, this Agreement will automatically renew for periods of one year subject to the terms and conditions of this Agreement unless terminated in accordance with Section 3.2 below.

3.2 Termination or Suspension. This Agreement may be terminated:

3.2.1 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.

3.2.2 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.

3.2.3 By Health Plan and MCO if Provider or any of Provider's employees or subcontractors:
3.2.3.1 loses any required liability insurance coverage
3.2.3.2 loses any required Medicaid or Medicare certification
3.3.3.3 loses any license(s) required to perform the services to be rendered under this Agreement

3.2.4 Notwithstanding any other provision herein except 3.2.7, 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.

3.2.5 The rights of Provider or of any personnel employed or subcontracted by Provider, including if the MCO or Health Plan has delegated provider selection to another entity, 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 and section 9.2 of this Agreement.

3.2.6 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.

3.2.7 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 A.

4.2 Rate Negotiation. Provider acknowledges and agrees that Care Wisconsin may change the fees for non-residential services set forth in Appendix A at its sole discretion by issuing to Provider a notice in the form of a replacement Appendix A for non-residential services or a sixty (60) days in advance of the date that the new fees are to take effect. If Provider chooses not to continue the Agreement for non-residential services under the new fees, Provider may terminate this Agreement in accordance with Section 3.2 of 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 including DHS and CMS. The MCO and Provider agree to follow Article VII. J. Billing Members and K. Department Policy for Member Use of Personal Resources in the contract between DHS and the MCO.

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.

4.5 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.

4.6 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, ICD 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 following the service being rendered. The provider must submit the claim no later than sixty (60) calendar days after the last 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 Clean Claim. Claims that are not submitted on a claim form approved by the Health Plan and MCO and/or are not clean, meaning the claim does not contain all data required by the Health Plan and MCO to process the claim and/or the data on the claim is not legible or readable by scanning equipment, will be denied.

When claims are denied for the reasons stated in the prior sentence, Provider will be required to submit a corrected claim in order to receive reimbursement.

5.4 Adjustments. All claims will be considered final unless Provider requests an adjustment in writing within sixty (60) calendar days after receipt of payment.

5.5 Claim Denial and Appeal Process. Provider may submit an appeal within 60 calendars days of the initial denial or partial payment 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 must inform providers in writing of the Health Plan or MCO's decision to limit or deny provider's original claims within forty-five (45) calendar days, including:

i. A specific explanation denial or payment amount or specific reason for non-payment.

ii. A statement explaining the appeal process and the provider's rights and responsibilities in appealing the Health Plan or MCO's determination by submitting a separate letter or form which:

a) Is clearly marked "appeal";

b) Contains the provider's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration for each appeal; and,

c) Is submitted to the Care Wisconsin claims manager at:
Claims Manager
Care Wisconsin
PO Box 14017
Madison, WI 53708-0017

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 or if the Health Plan or MCO has not responded in writing within forty-five (45) calendar days, the Provider may appeal the Health Plan's or MCO's decision to DHS. The Provider has sixty (60) calendar days to submit a written appeal to DHS from either the date of the written notification of the MCO's final decision resulting from a request from reconsideration or after the MCO's failure to respond within forty-five (45) calendar days to the provider's request for reconsideration. The Provider agrees to abide by the terms outlined in Section O of the contract between DHS and the MCO, Appeals to the MCO and Department for Payment/Denial of Provider Claims, and as may be amended in future contracts, as outlined in the Partnership Contract, and the Family Care Contract, and the Medicaid SSI Contract between DHS and MCO. Additional information can also be found in the Care Wisconsin Provider Manual at https://www.carewisc.org/provider-manual-and-policies.

5.6 Claim Recoupments: Claim recoupments can occur any time an overpayment or underpayment is identified. Any overpayment amounts will be recouped from future claims. Any underpayment amounts will be adjusted for reimbursement. All payments related to a claim found to be

fraudulent or improper will be recouped.

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

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

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. All providers offering personal cares Supportive Home Care and Self Directed Supports shall comply with the Managed Care Organization Training and Documentation Standards for Supportive Home Care. This information can also be found at https://www.dhs.wisconsin.gov/publications/p01602.pdf. Provider agrees to verify individual credentials of health professionals and other service workers employed or subcontracted by Provider who provides services under this Agreement. Provider warrants that it is making the necessary criminal background checks required by Chapter DHS 12 of the Wisconsin Administrative Code and is in compliance with the code governing reporting, hiring and contracting required by Chapters DHS 12 and 13. Provider agrees to comply with any requirements issued by CMS or DHS in accordance with verifying compliance of credentials and background checks. 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.

The MCO maintains the ability to not pay or contract with any provider if the MCO deems it is unsafe based on the findings of past criminal convictions stated in the caregiver background check. The caregiver background check shall be made available to the member or entity that is the employer.

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 a governmental regulatory agency and /or regarding any criminal investigations(s) involving the subcontractor. Loss of 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.

6.3.7 if notification received of federal disbarment.

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.

6.6 Upon request of the MCO or Health Plan, Provider shall provide all required documents to maintain participation in the provider network. These documents may include such items as proof of insurance, licenses or certifications, W9's, background and credential verification documents. If Provider, after repeated attempts by the MCO or Health Plan, neglects to provide requested information the MCO or Health Plan may hold provider payments until the information is provided.

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.

To the extent permitted by law, Provider agrees to fully cooperate with any member-related investigation conducted by the MCO, DHS, CMS, law enforcement or any other legally authorized investigative entity.

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 immediately upon discovery and cooperate with Care Wisconsin in the investigation of critical incidents. Ensure incident is promptly addressed and notification occurs as soon as reasonably possible during the business day or next business day if weekend/holiday. The provider must identify, respond to, document, and report member incidents to MCO as outlines in Article V.J.5 of the DHS-MCO contract.

8.2.2 Provider agrees to provide services in accordance with the services authorized through the Member's Interdisciplinary Team, or other care management staff designated by the Health Plan 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 Restrictive Measures. The Provider agrees to work through the Interdisciplinary Team or other care management staff at Care Wisconsin to determine the appropriateness of restrictive measures, any type of restraint, isolation, seclusion, protective equipment, or medical restraint and the development of a Behavioral Support Plan, as indicated. Approval for use of such measures needs to go through the MCO's Restrictive Measure Workgroup. Provider will provide orientation and annual refresher training to personnel that would be involved in evaluation/training or implementation of restrictive measures.

8.4 Utilization Data. The Provider agrees to submit utilization data in the format specified by the MCO as requested by the MCO.

8.5 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. 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.

8.6 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:

8.6.1 comply with federal and state laws; and

8.6.2 cooperate with the Health Plan and MCO to ensure continuity of care for Members.

IX. GRIEVANCES AND APPEALS

9.1 Member Appeals.

9.1.1 Provider recognizes that members have the right to file appeals or grievances and assure that such action will not adversely affect the way that the Provider treats the member.

9.1.2 The Provider agrees to cooperate and not interfere with the members' appeals, grievances and fair hearings procedures and investigations and timeframes.

9.1.3 The Provider may obtain specific information regarding member grievance, appeal and fair hearing procedures and timeframes by contacting Care Wisconsin's Member Rights Specialist at 800-963-0035, ext. 3448. This information can also be found at https://www.carewisc.org/provider-manual-and-policies.

9.1.4 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 online at https://www.carewisc.org/provider-manual-and-policies.

9.2 Provider Appeals.

9.2.1 Provider must submit an appeal to the MCO in writing within sixty (60) days of the denial or notice. The MCO or Health Plan will respond in writing to the provider within forty-five (45) calendar days of receipt of the request for reconsideration.

9.2.2 If the MCO fails to respond within forty-five (45) days of the submitted appeal or the provider is unsatisfied with the MCO response, the Provider can seek a final determination from DHS. All appeals must be submitted to DHS within sixty (60) days of the date of the written notification of the MCO's final decision or MCO's failure to respond within forty-five (45) days. A description of the Provider Appeals process is available on line at https://www.carewisc.org/provider-manual-and-policies.

X. PROHIBITED PRACTICE AND DISPUTES

The MCO and the Provider 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.

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.

Provider is prohibited from influencing member choice of long-term care program, provider or managed care organization (MCO) through communications that are misleading, threatening or coercive under federal managed care regulations 42 CFR4381. DHS may impose sanctions against a provider that does so under Wisconsin Administrative Code DHS 106.08(2)€.

XI. INSURANCE AND INDEMNIFICATION

11.1 Insurance for Provider. Depending on 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, professional liability (malpractice coverage), auto liability, and workers compensation as shall be necessary to insure Provider, its employees and subcontractors and its agents against any claims for damages arising by personal injury, death, or property damage or loss, occasioned directly or indirectly in connection with the performance of any services by Provider or by said employee, subcontractor or agent. For physicians, coverage limits shall be in at least the amount specified in Chp. 655.23(4) Wis. Stats. For other provider types, the types of coverage required are set forth in the Care Wisconsin Provider Manual.

Upon entering into this Agreement, Provider will provide the Health Plan and MCO with a Certificate of Insurance in a form acceptable to same to confirm compliance with Section 11 of this Agreement. General Liability policies will be endorsed to specifically name Care Wisconsin First Inc. as an additional insured.

If General or Professional Liability coverage is written on a claims-made form rather than an occurrence form, the insurance policy's retroactive date must be noted on the Certificate of Insurance. Provider agrees to either 1) purchase claims made coverage in subsequent years with retroactive date not later than retroactive date noted on certificate or 2) purchase an Extended Reporting Period endorsement of not less than two years.

Required coverages will be provided by insurers with an A.M. Best Company general policyholder's rating of "A-" or better and a financial performance index rating of VI or better in Best's Insurance Reports or Best's Key Rating guide.

Prior to modification, expiration 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), and will hold the other party harmless for those losses.

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.

11.5 Legal Liability. The subcontract must not terminate legal liability of the MCO. 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.

XII. NONDISCRIMINATION/CIVIL RIGHTS COMPLIANCE/LIMITED ENGLISH PROFICIENCY

Provider shall comply with all non-discrimination requirements and all applicable Affirmative Action and Civil Rights Compliance laws and regulations (refer to http://DHS.wisconsin.gov/civilrights/Index.HTM as a resource). At a minimum, Provider agrees to the following:

12.1 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. The MCO shall encourage and foster cultural competency among providers, further information is available in the Provider Manual at https://www.carewisc.org/provider-manual-and-policies page 6-1.

12.2 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 term 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.

12.3. Provider shall report to Health Plan or MCO complaints of Members or applicants related to civil rights compliance. Civil rights complaints must 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. The Provider will meet the requirements for maintenance and transfer of member records stipulated in Article XIII.A., Member Records, and Article XIV.F., Records Retention of the Health Plan and MCO's contract with DHS. 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. 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 record. Further Records Retention information is available in the Provider Manual at https://www.carewisc.org/provider-manual-and-policies.

13.2 Members and their authorized representatives shall have access to a Member's records within ten (10) business days of the record request if records are maintained on site and sixty (60) calendar days if records maintained off site in accordance with the standards is 45 CFR 164.524 (b)(2).

13.3 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 personnel conducting the audit or inspection effort. If deficiencies are found during review a corrective action plan may be required to address areas of needed performance improvement. 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.

13.4 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.

13.5 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").

Provider, Health Plan and MCO agrees that all rate negotiations, verbal or written, are confidential and not to be shared with employees or outside agencies not participating in rate negotiations. Rate negotiations are also confidential between the Health Plan and MCO and Provider and not to be shared with members, guardians, family members or member representatives.

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 appraised 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.:

Chief Executive Officer
1617 Sherman Ave.
P.O. Box 14017
Madison, WI 53708-0017
Facsimile: 608-245-3571

Racine County Senior Nutrition Program:

Director
2302 DeKoven Ave. #10
Racine, WI 53406

XXII. FRAUD, WASTE AND ABUSE

22.1 Provider shall report suspected Fraud, Waste or Abuse to Health Plan or MCO within a reasonable period of time after discovery of the suspected misconduct. Health Plan and MCO have a strict policy against retaliation or retribution against any employee or subcontractor who reports suspected misconduct in good faith. Provider is afforded anti-retaliation protections under applicable state and federal laws, including 31 U.S.C. § 3730(h) for False Claims Act complaints.

22.2 Provider shall comply with the Affordable Care Act, 42 CFR 455.2 and 455.23 as relates to the suspension of payments to Provider pending investigation of a credible allegation of fraud. Care Wisconsin will recoup all payments to the Provider for any services deemed fraudulent as a result of an investigation of any credible allegation of fraud.

22.3 Provider shall obtain Fraud, Waste and Abuse ("FWA") training and education and provide FWA training to its employees and subcontractors as appropriate. Health Plan and MCO shall make FWA training and education information available to Provider or provide it upon request.

XXIII. MISCELLANEOUS

23.1 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.

23.2 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.

23.3 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.

23.4 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 the County Court in which such suit is pending. 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.

23.5 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.

23.6 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.

Susan Crowley

Susan Crowley
Senior VP Government Services

3/23/18

Date

RACINE COUNTY SENIOR NUTRITION PROGRAM

Signature

Printed Name

Title

Date

Wendy M. Christenson
Racine County Clerk 3/13/18

JONATHAN DELAGRAVE
RACINE COUNTY EXECUTIVE

REVIEWED BY FINANCE DIRECTOR

2-8-18

Sign Date

Date 3.10.18

Certified to be correct as to form

By

Racine County Corporation Counsel

APPENDIX A

SERVICES AND COMPENSATION 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(s) and reimbursed as indicated below:

Service	Procedure / Revenue Code	Modifier	Unit	Contract Rate	Additional Information
Home Delivered Meals	S5170		Per Meal	$8.30	

2/5/18

APPENDIX B

HOME DELIVERED MEALS

Care Wisconsin, Inc. (CW) members receiving Home Delivered Meal services shall have an identified outcome that necessitates the provision of Home Delivered Meals to support this outcome.

The provision of contracted, authorized, and provided Home Delivered Meal services shall be in compliance with the provision of this agreement and the service descriptions and requirements of this section and state certification criteria.

DEFINITION

Home delivered meals, sometimes called "meals on wheels," include the costs associated with the purchase and planning of food, supplies, equipment, labor, and transportation to deliver one or two meals a day to recipients who are unable to prepare or obtain nourishing meals without assistance. This service will be provided to persons in natural or supportive service settings to promote socialization and adequate nutrition. *(as defined in Wisconsin's s. 1915 (c) home and community-based waiver services waivers #0367.90 and #0368.90 required under s. 46.281(1)(c), Wis. Stats.).*

STANDARDS, TRAINING, AND COMPETENCY

Standard
Home Delivered Meal providers shall be in compliance with all Local, State, and Federal regulations related to meal preparation standards.

Hospitals and nursing homes must comply with Wis. Admin. Code DHS 124, DHS 132 and DHS 134; aging network agencies must comply with Wis. Stats. Chapter 46.82 (3); and restaurants must comply with Wis. Admin. Code DHS 196.

Training
Training of employees delivering meals shall include:

1. Training on the needs of the target group for the individual(s) served under this agreement.
2. Information and Provider procedure for adherence to the following CW policies:
    a. Member Incident Reporting
    b. Member Privacy Rights
    c. Positive Behavioral Supports
    d. Communication Expectations

Competency
Provider shall ensure the competency of employees assigned to prepare and deliver home delivered meals.

COLLABORATION AND COORDINATION OF CARE

Through the use of the Resource Allocation Decision method (RAD), Interdisciplinary Team staff shall assess the member's needs and outcomes to determine the amount of Home Delivered Meals to be authorized. Interdisciplinary Team staff shall exchange pertinent information with the provider at the time of the referral. This information exchange shall include the member's outcomes, assessed needs, and the amount of authorized units as it relates to Home Delivered Meals.

BILLABLE UNITS

Providers should reference Appendix A of the contract to determine the codes, units and rates as indicated in this agreement.

CARE WISCONSIN, INC CONTRACT EXPECTATIONS FOR HOME DELIVERED MEAL PROVIDERS

1. Home Delivered Meal providers shall notify the member's Interdisciplinary Team staff of instance wherein the provider was unable to successfully deliver a meal on two consecutive attempts (i.e., member did not answer the door or previous tray was still outside the member's door).
2. In instances of inclement weather or other circumstances which may prohibit meal delivery, the provider shall contact the Member and CW Interdisciplinary Team.
3. The provider is expected to have adequate staff to assure timely delivery of authorized meals.