Scope of Service

Financial Management Services (FMS) for Self-Directed Supports

This Scope of Service defines requirements for this service type for the
*i*Care Family Care (branded "Inclusa") and Family Care Partnership programs

Family Care Partnership: Attachment to Description of Long-Term Care Provider Services and Payment
Family Care Only (If applicable): Appendix N to Subcontract Agreement

Purpose: This document defines requirements and expectations for the provision of subcontracted, authorized and rendered services. The services shall be provided in compliance with service expectations in the Agreement and Wisconsin licensing and certification standards, as applicable. Provisions of this Scope of Service supersede any other agreements, including agreements between the Enrollee and Provider, such as intake agreements. All references to Enrollee include the Enrollee and as applicable any of the Enrollee's authorized representatives.

1.0	Definitions
1.1	**Service Definition** **Financial management services** assist members and their families in managing service dollars or their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member or legal decision maker authorizes payment to be made for services included in the member's approved self-directed supports plan. This service includes facilitation of the employment of staff by the member or legal decision-maker by a financial management services provider or fiscal intermediary performing as the member's agent such employer responsibilities as processing payroll, withholding federal, state and local tax and making tax payments to appropriate tax authorities; and performing fiscal accounting and making expenditure reports to the member or family and state authorities as indicated in the individual's self-directed supports plan and budget for services. Financial management services are purchased directly by the MCO and made available to the member to ensure that appropriate compensation is paid to providers. Additionally, this service includes the provision of assistance to members who are unable to manage their own personal funds.
1.2	A financial management services provider must meet the following requirements: • is an agency, unit of an agency or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; • has training and experience in accounting or bookkeeping; and • has a system in place that recognizes the authorization of payment by the participant or legal decision maker, that promptly issues payment as authorized and that documents budget authority and summarizes payments in a manner that can be readily understood by the participant or legal decision maker.
2.0	**Service Description/ Requirements**

2.1	**WI DHS Minimum Fee Schedule Requirements for Self-Directed Services** MCOs are required to increase self -directed services budgets of members so that all members have sufficient budget authority to pay a 15-minute unit of self-directed Supportive Home Care (SHC) minimum fee rate of $4.08 and an additional $0.48 of state and federal payroll taxes and workers compensation for all units of SHC they receive through self-direction. MCOs are required to pay at least $4.56 per 15-minutes for self-directed SHC worker wages, state and federal required payroll taxes, and workers compensation. Members who are self-directing SHC services must pay their SHC workers at least the $4.08 per 15-minute minimum rate unless a worker voluntarily opts out of the minimum rate. Members must pay SHC daily or hourly rates that are greater than or equal to what the member would pay if they were paying the 15-minute unit self-directed SHC minimum rate, as set forth above, multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care. Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision. For the purposes of enforcement DHS will consider that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.
2.2	SDS SHC workers may voluntarily opt out of the minimum rate payment requirement. If an SDS SHC worker voluntarily opts out of the MCO minimum rate payment requirement, they must sign a form designated by the Department confirming their decision to do so and the self-directing member and MCO must retain the signed form. Fiscal Employment Agencies (FEA's) will retain the initial signed form and secure the updated opt-out form annually thereafter on behalf of iCare and will provide to the MCO upon request.
2.3	Fiscal Employer Agency (FEA) refers to the model whereby the enrollee is the employer of record. The agency manages all payroll and related functions on behalf of the enrollee. Co-Employment/Agency with Choice refers to the model whereby the FMS agency or SHC agency is the employer of record. Specific employer-related functions (such as determining wages, scheduling, and employee supervision) are divided between the enrollee and the employing agency with the intent of maintaining as much control and authority with the enrollee as he/she desires. Fiscal Conduit refers to the model where the FMS agency processes vendor payments for goods and services.
2.4	Obtain federal and state (if applicable) approval to be a FEA vendor which includes obtaining a separate FEIN specifically to file the IRS form 2678, Employer Appointment of Agent and other federal tax forms and to make federal tax payments on the behalf of individuals.

2.5	Ensure an up-to-date working knowledge of state tax, labor, immigration, worker's compensation, and program requirements.
2.6	Obtain a separate FEIN for each employer (if FEA) for the sole purpose of filing certain federal employment tax forms and making federal tax payments and use only to process wages and federal forms and taxes for the individual employers it represents as agent.
2.7	Manage intakes/enrollments within seven (7) business days from the date Provider receives referral. Face-to-face (in person) enrollment is the preferred method and must be offered first and be available statewide. If a member declines an in-person enrollment, a virtual option should be offered. Paper enrollment by mail should be considered only as a last resort. When paper enrollment by mail is utilized, the FEA must clearly communicate potential delays with this method. The care team and SDS Department should be included in all related communication.
2.8	Process criminal and caregiver background checks that are substantially similar to the background checks required under Wis. Stat. § 50.065 and Wis. Admin. Code Chapter DHS 12 on individuals providing services to self-directing enrollees who have, or are expected to have, regular, direct contact with the enrollee. Submit the results of the background checks to SDS staff and care management team for review and approval prior to employment start. Maintain copies of the documentation in the workers' files as required by the state. If a caregiver has had a background check completed within a year of becoming hired through a different enrollee/employer, the previous DOJ report and DHS report can be used, unless there is reason to believe there is a change. The enrollee may still request that a new report be obtained.
2.9	Prepare and distribute individual enrollment and worker employment packages. Electronic versions must be made available as the preferred method.
2.10	FEA's must include in the employer handbook a list of the required trainings in accordance with DHS's Managed Care Organization Training and Documentation Standards for Supportive Home Care (http://www.dhs.wisconsin.gov/publications/p01602.pdf). The handbook should also include training resources or references to ensure members have the guidance necessary to complete and validate required training. If the caregiver is exempt from these trainings, due to experience or certification, those reasons must be documented on the training validation form.
2.11	Electronic Visit Verification (EVV) • Train and provide ongoing assistance to applicable employees or vendors on how to do Electronic Visit Verification (EVV). Electronic Visit Verification (EVV) is a system that uses technology to verify that authorized services are provided. Through EVV, an employee or vendor providing personal care services, applicable supportive home care services or home health services sends visit data to an EVV vendor at the beginning and end of each visit. FMS providers will have the choice of using the EVV system developed by WI Department of Health Services (DHS) or their own existing EVV system as long as it meets DHS policy and technical requirements. Data collected from the EVV system will be used to validate affected service codes against approved authorizations during the claim adjudication process. • The FEA is required to maintain a unified system that integrates EVV with time reporting to promote compliance and simplify the process for both members and their workers. • The FEA must designate established contacts responsible for EVV support to assist care teams, members, and caregivers with any questions or concerns related to EVV. *i*Care does not require EVV for live-in caregivers providing Personal Care or Supportive Home Care services (T1019, T1020, S5125, S5126 or other subject codes or services as required by DHS). See 2.16 for live-in document requirements.

2.12	Budget monitoring, reporting, and notifications
	• Member Portal
	  o The FEA must provide a member portal with real-time access to individual budget information.
	  o Trainings shall be conducted at new enrollments and made available to ensure members can effectively navigate and utilize the portal.
	  o Budget details on the portal must be presented in a clear and understandable format, with information broken down by week or month, and expressed in hours, days, and miles rather than units.
	  o For members without access to technology, alternative options must be available, including the ability to mail or email a monthly budget statement upon request.
	• Payor Portal
	  o The FEA must provide a payor portal with real-time access to budget data and comprehensive reporting capabilities.
	  o Budget information shall be presented in a clear and understandable format, broken down by week or month, and expressed in hours, days, and miles rather than units.
	  o The portal must also include real-time tracking of both member and caregiver status, including progress within the enrollment and required paperwork.
	• FEA must have Internal policies and procedures for receiving and maintaining individual's budgets and authorizations.
	• FEA must have systems and processes in place to track and monitor budget funds.
	• FEA must provide notifications to the care teams and the SDS Department when members demonstrate over utilization or under-utilization at designated checkpoints within the member's six-month budget.
	• FEA must provide notification and reporting each pay period identifying overtime utilization. Notification should go out to care teams and the SDS Department. Reports may be provided in aggregate across all members or on a per member basis.
	. Offer additional utilization reports that are not available in the payor portal upon request.

2.13	Communication and timeliness expectations • A standardized communication process will be used for all intakes and new caregiver onboarding. Communication will be clear, consistent, and accurate, ensuring members and caregivers receive the same information. • One business day expectation for outreach to member and/or caregivers when a new referral is received or when a new caregiver is being added. • If a member or caregiver does not respond within 2-3 business days, the FEA must make a second outreach attempt. If there is still no response within one business day following the second outreach, the care team and SDS Department will be notified. • Paperwork will be processed within 1-2 business days of receipt, with sufficient follow-up on the status provided to the member, caregiver, care team, and SDS Department (e.g., receipt, processing status, missing documentation, etc.) • One business day response time for inquires. • Notify members, caregivers, care team, and SDS Department when caregivers can start. • Communicate and educate caregivers when code changes occur. • All designated communications – including background checks, overtime, overages, and start dates – must utilize iCare standardized templates.

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- FEA must have a designated associate or team assigned as a single point of contact for members and caregivers, providing timely and accurate responses.

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<tr><td>2.14</td><td>Process payroll, including a system with written policies and procedures. Withhold, file and deposit all applicable taxes (FICA, FUTA, SUTA, federal and state income). Ensure workers are paid in compliance with federal and state Department of Labor wage and hour rules for regular and overtime pay. Apply live-in and companionship exemptions.</td></tr>
<tr><td>2.15</td><td>Process payments for independent contractors who provide services and supports.</td></tr>
<tr><td>2.16</td><td>FEA must provide a designated fiscal conduit point of contact or team with full knowledge of the independent contractor process to assist with initial paperwork and EVV requirements.</td></tr>
<tr><td>2.17</td><td>Complete end of year federal tax processes, with a system in place and written policies and procedures and internal controls.</td></tr>
<tr><td>2.18</td><td>Cost-effectively obtain worker’s compensation insurance for employers and maintain relevant documentation in each individual’s file.</td></tr>
<tr><td>2.19</td><td>For live-in workers, verification of the workers’ permanent residence must be maintained annually based on the Forward Health definition of a live-in worker. The Provider is required to retain all documentation supporting live-in worker status. Upon request, Provider may be asked to submit verification to the MCO.</td></tr>
<tr><td>2.20</td><td>Maintain a FEA Policies and Procedure Manual.</td></tr>
<tr><td>2.21</td><td>

Sustain a customer service system that includes:

- A toll-free number
- A fax line
- Web-based information regarding services
- Ability to provide translation and interpreter services
- Materials available in alternate formats
- Methods for receiving, returning, and tracking calls and complaints from individuals and support service workers during and after regular business hours within one business day,
- Methods for acting as a mandatory reporter, particularly for financial fraud and abuse issues, to the appropriate state agencies
- Developed and implemented orientation and skills training for individuals
- Developed and implemented customer service training for Financial Management Agency staff
- Developed and implemented an individual/representative satisfaction survey

Developed policies and procedures that emphasize the application of the philosophy of individual direction and being culturally sensitive in all business practices in order to communicate effectively with a diverse population of participants of all ages and with a variety of needs, disabilities, and chronic conditions.

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<tr><td>3.0</td><td>Unit of Service</td></tr>
<tr><td>3.1</td><td>

Provider must bill using appropriate procedure codes and modifiers.

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<tr><th>Service Code</th><th>Modifier</th><th>Service Description</th><th>Unit of Service</th></tr>
<tr><td>T2025</td><td>U9 U5</td><td>SDS Financial Money Management</td><td>Per Month</td></tr>
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3.2	The FEA may bill the administrative fee for any month in which payroll was processed for corresponding self-directed services provided during that same month. In addition, the FEA is permitted to bill the administrative fee for the first month of service even if no payroll was processed, due to required provider enrollment activities and initial communication expectations.
4.0	**Documentation of Service**
4.1	All SDS referrals will be received, recorded and processed in a timely and accurate manner within 1-2 business days. Updated referral information must be reviewed and entered correctly into the FEA's system to ensure records remain current and accurate.
4.2	Provider must respond to the IDT within two (2) business days to accept or decline a referral. Provider must work with IDT to ensure services begin on the planned date and time. If the planned start date is delayed, Provider shall immediately notify the IDT to ensure the needs of the Enrollee are met.
4.3	IDT must prior authorize all services prior to being rendered by Provider. Notification of authorization to Provider shall include expected start date, duration of authorization, units authorized and any expected outcomes, if applicable.
4.4	The Provider must retain copies of the authorization notification.
4.5	The IDT shall issue a new authorization notification to Provider when the tasks assigned, amount, frequency, or duration of the service changes.
4.6	The FEA must maintain an electronic time reporting system as the preferred method. Paper timesheets should be limited to vendor or approved exceptions.
4.7	The Provider must retain the following documentation and make available for review by *i*Care upon request: • Proof that Provider meets the required standards for applicable staff qualification, training and programming. • Policy and procedure for verification of criminal, caregiver and licensing background checks as required. • Evidence of completed criminal, caregiver and licensing background checks as required. • Policy and procedure related to supervision methods by the provider agency including frequency, intensity, and any changes in supervision. • Policy and procedure for responding to complaints, inappropriate practices or matters qualifying as Enrollee-related incidents. The policy and procedure should also cover expectations of work rules, work ethics and reporting variances to the program supervisor. • Employee time sheets/visit records which support billing to MCO.
4.8	Information regarding authorization and claims processes are available at: **Family Care:** Providers/Claims and Billing at www.Inclusa.org **Family Care Partnership:** Provider/Claims section and Provider/Prior Authorization section at www.icarehealthplan.org

5.0	**Staff Qualifications and Training**

5.1	**Caregiver Background Checks –** Caregiver and Criminal Background checks must be completed in compliance with Wisconsin DHS Admin. Code Chapter 12 and 13. Provider must maintain and make available for review documentation that caregiver and criminal background checks have been completed timely for all staff.
5.2	Provider must comply with all training requirements as outlined in their licensing/certification standards. If training standards are not specified, Provider must ensure that staff are fully trained to complete the assigned tasks.
5.3	Provider must orient and train their staff on the Family Care and Family Care Partnership Programs. Support materials can be found at: **Family Care:** www.inclusa.org **Family Care Partnership:** www.icarehealthplan.org
5.4	Staff must be trained in recognizing abuse and neglect and reporting requirements.
5.5	Services provided by anyone under the age of 18 shall comply with Child Labor Laws.

5.6	The Provider must ensure that staff have received training on the following subjects pertaining to the individuals served:
	• Policy, procedures and expectations may include the following:
	  ○ Enrollee rights and responsibilities
	  ○ Provider rights and responsibilities
	  ○ Record keeping and reporting
	  ○ Arranging backup services if the caregiver is unable to make a scheduled visit
	  ○ Other information deemed necessary and appropriate
	• Information about individuals to be served including information on individual's specific disabilities, abilities, needs, functional deficits, strengths, and preferences. This training should be person specific for the people to be served and generally focused.
	• Recognizing and appropriately responding to all conditions that might adversely affect the Enrollee's health and safety including how to respond to emergencies and Enrollee-related incidents.
	• Interpersonal and communication skills and appropriate attitudes for working effectively with Enrollees and with IDT.
	• Confidentiality laws and rules
	• Practices that honor diverse cultural and ethnic differences
	• Procedures for following Family Care and Family Care Partnership required processes for handling complaints and grievances (see Section 7.3).

6.0	**Supervision and Staff Adequacy**
6.1	The Provider shall maintain adequate staffing to meet the needs of Enrollees referred by MCO and accepted by the Provider for service.

6.2	Provider must ensure: • Staff are supervised and assessed to assure they are working effectively and collaboratively with Enrollees by conducting adequate on-site supervision and review. • Performance issues with staff are addressed promptly and IDT is kept informed about significant issues that affect the Enrollee. • Supervisory staff are involved in assessment, goal planning and tracking, and supervision for Enrollees. • Provider staff are working collaboratively and communicating effectively with MCO staff
7.0	**Communication and Reporting Requirements**
7.1	It is the responsibility of the Provider to ensure the MCO has the most accurate and updated contact information to facilitate accurate and timely communication.
7.2	The Provider shall report to the IDT whenever: • There is a change in service provider • There is a change in the Enrollee's needs or abilities The Enrollee or provider is not available for scheduled services (within 24 hours unless an alternate date is scheduled between provider and Enrollee)
7.3	Provider shall notify IDT of formal complaints or grievances received from Enrollees within 48 hours of receipt. Written notification of completed complaint investigations must be submitted to the IDT.
7.4	Provider must notify the Enrollee and IDT when the contracted service is unable to be rendered such as closing for inclement weather or widespread illness outbreak.
7.5	The IDT must be notified in a timely manner if the Provider, through its experience in providing services to the Enrollee, believes that the Enrollee's needs have changed, and a modification of the service level is indicated. ***i*Care will not pay for services that have not been authorized.**
7.6	Provider shall follow up with the Enrollee or IDT to determine the reason for an unplanned Enrollee absence.
7.7	**Member Incidents:** Provider must communicate and report all incidents involving an *i*Care Enrollee to the IDT– the Care Coach or the Field Care Manager Nurse within **24 hours** via phone, fax or email. If the reporter is unable to reach someone from the care team, they may leave a message reporting details of an incident that has been resolved and did not result in serious harm or injury to the Enrollee. If the incident is not yet resolved or resulted in serious harm or injury to the Enrollee, the provider must attempt to contact the IDT via phone. **Family Care:** If unable to contact IDT, call 1-877-622-6700 and ask to speak to a Care Management Support Manager to immediately make a report. If a manager is unavailable, the provider will speak with the receptionist to be redirected or leave a message**.** **Family Care Partnership:** If unable to contact IDT, call 1-800-777-4376 and ask to speak to a Care Management Support Manager to immediately make a report. If a manager is unavailable, the provider will speak with the receptionist and ask to be redirected or leave a message. All reported incidents will be entered into the MCO Incident Management System and reported to DHS in accordance with MCO contract requirements. Providers may be asked to provide any

	additional information or details necessary to complete the investigation of reported incidents. The provider will inform the MCO when notifying their regulatory authority of incidents. A copy of the report may be submitted as a form of notification. Incident reporting resources and training are available at: **Family Care**: Providers section of the Inclusa website at www.inclusa.org **Family Care Partnership**: For Providers/Education/Resources section of the *i*Care website at www.iCarehealthplan.org
7.8	The Provider agency shall give at least 30 days' advance notice to the IDT when it is unable to provide authorized services to an individual Enrollee. The provider agency shall be responsible to provide authorized services during this time period. The IDT or designated staff person will notify the Provider agency when services are to be discontinued. The IDT will make every effort to notify the provider at least 30 days in advance.
8.0	**Quality Program**
8.1	*i*Care quality assurance activities are a systematic, measured approach to ensuring and recognizing a specified standard or level of care expected of subcontracted providers. These methodologies are established to review and inspect subcontracted provider performance and compliance.
8.2	It is the responsibility of providers and provider agencies to maintain the regulatory and contractual standards as outlined in this section. *i*Care will monitor compliance with these standards to ensure the services purchased are of the highest quality.

8.3	**Quality Performance Indicators**
	• Legal/Regulatory Compliance- evidenced by regulatory review with no deficiencies, type of deficiency and/or effective and timely response to Statement of Deficiency
	• Education/Training of staff- Effective training of staff Enrollees in all aspects of their job, including handling emergency situations. Established procedures for appraising staff performance and for effectively modifying poor performance where it exists.
	• Performance record of contracted activities-
	  ○ tracking of number, frequency, and outcomes of Member Incident Reports related to provider performance
	  ○ tracking of successful service provision (Enrollee achieving goals/outcomes, increased Enrollee independence and community participation, etc.)
	• Contract Compliance-formal or informal review and identification of compliance with MCO contract terms, provider service expectation terms, applicable policies/procedures for contracted providers
	• Availability and Responsiveness- related to referrals or updates to services, reporting and communication activities with MCO staff.

8.4	**Expectations of Providers and MCO for Quality Assurance Activities** • **Collaboration**: working in a goal-oriented, professional, and team-based approach with MCO representatives to identify core issues to quality concerns, strategies to improve, and implementing those strategies • **Responsiveness**: actions taken upon request and in a timely manner to resolve and improve identified issues. This may include submitted documents to MCO, responding to calls, emails, or other inquiries, keeping MCO designated staff informed of progress, barriers, and milestones achieved during quality improvement activities • **Systems perspective to improvement**: approaching a quality concern, trend, or significant incident with the purpose of creating overall improvements that will not only resolve the issue at hand, but improve service and operations as a whole • **Enrollee-centered solutions to issues**: relentlessly striving to implement solutions with the focus on keeping services Enrollee-centered and achieving the goals and outcomes identified for persons served *i*Care is committed to interfacing with providers to collaboratively and proactively discuss issues identified with processes and assist with implementing improvements and reviewing the impact of the changes as a partner in the mission to serve Enrollees.