

Scope of Service

Supportive Home Care

This Scope of Service defines requirements for this service type for the iCare 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 this 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	<p>Service Definition</p> <p>Supportive Home Care (SHC) is the provision of services to directly assist persons with daily living activities and personal needs to assure adequate functioning and safety in their home and community.</p> <p>Services include the following:</p> <ul style="list-style-type: none">• Hands-on assistance with activities of daily living, such as dressing/undressing, bathing, feeding, managing medications and treatments that are normally self-administered; toileting; assistance with ambulation (including the use of a walker, cane, etc.); carrying out professional therapeutic treatment plans; and grooming, such as care of hair, teeth or dentures. This may also include preparation and cleaning of areas that are used during provision of personal assistance, such as the bathroom and kitchen.• Direct assistance with instrumental activities of daily living, as well as observation or cueing of the member, to ensure that the member safely and appropriately completes activities of daily living and instrumental activities of daily living.• Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, and arrangement and use of transportation and personal assistance at a job site and in nonemployment related community activities.• Routine housekeeping and cleaning activities performed for a member, consisting of tasks that take place on a daily, weekly, or other regular basis. These tasks may include: washing dishes, doing laundry, dusting, vacuuming, cooking, shopping, and similar activities that do not involve hands-on care of the member. <p>An unrelated live-in caregiver may provide any or all of the types of supportive home care services. Relatives and legal guardians (live-in or otherwise) meeting the requirements under Article VIII.N.2. (of WI DHS Family Care Contract) (see section 2.1) may be paid to provide any or all of the types of supportive home care. Payment of a live-in caregiver may be reduced by the value of room and board in accordance with any applicable wage and hour laws.</p> <p>Excludes training provided to a member intended to improve the member's ability to independently perform routine daily living tasks, which may be provided as daily living skills training.</p>

	<p>Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days when there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment or, if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically related and non-medically related circumstances as applicable to the member:</p> <p><u>Medically- Related</u></p> <ul style="list-style-type: none"> • Hospitalization; • Nursing home or ICF-IID admission; • Receipt of medical or rehabilitative care entailing at least an overnight absence; or • Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175). <p>There is no yearly limit on the number of medically related episodes for which retainer payments may be made.</p> <p><u>Non-Medically Related</u></p> <ul style="list-style-type: none"> • Planned vacation entailing at least an overnight absence and unaccompanied by the worker; • Visit to relatives or friends entailing at least an overnight absence and unaccompanied by the worker; • Obtaining education, employment or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or • Recreational activities unaccompanied by the worker entailing at least an overnight absence. <p>Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.</p> <p>MCO's shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.</p> <p>All workers must comply with the Training and Documentation Standards for Supportive Home Care and In-Home Respite Care.</p>
2.0	Service Description/ Requirements
2.1	<p>An unrelated live-in caregiver may provide any or all of the types of supportive home care services. Payment of a live-in caregiver may be reduced by the value of room and board in accordance with any applicable wage and hour laws. Prior to authorizing payment to family members or legal decision makers (LDM), the following conditions must be met:</p> <ul style="list-style-type: none"> • The service is identified in the Member Centered Plan; • The member's preference is for the family member or LDM to provide the service; • IDT ensures that the service meets identified needs and outcomes in the MCP and assures the health, safety and welfare of the member. Additionally, the purchase of the services from the relative or LDM are cost effective in comparison to the purchase of services from another provider. • The IDT monitors and manages any real or potential conflict of interest situation that may occur as a result of the family member or LDM providing services; • The family member or LDM meets the MCO's standards for its subcontractors or employees providing the same service;

	<ul style="list-style-type: none"> • The service provided by the relative or LDM does not benefit the relative, LDM or other individuals residing in the household with the member; and • For spouses, the individual will either: <ul style="list-style-type: none"> ◦ Provide an amount of service that exceeds normal spousal care giving responsibilities for a spouse who does not have a disability; or ◦ Find it necessary to forego paid employment in order to provide the service. 																																
2.2	Incidental assistance with activities of daily living while in community setting is allowed under the SHC benefit.																																
2.3	Medication reminders are verbal or non-verbal reminders from the worker to the member for the member to take their medications. They are solely communicative. The worker may unlock and lock a container that holds the medication in its container. The worker may need to engage in incidental handling of the medication container but does not handle or dispense any medication from the container. The member understands, handles, and administers own medication. No agency nurse is required.																																
2.4	Providers are required to monitor conflict of interest related to their staffing patterns and report any potential situations to the IDT if hiring family members or legal decision makers to support MCO enrollees.																																
3.0	Unit of Service																																
3.1	<p>Provider must bill using appropriate procedure codes and modifiers.</p> <table border="1"> <thead> <tr> <th>Service Code</th> <th>Modifier</th> <th>Service Description</th> <th>Unit of Service</th> </tr> </thead> <tbody> <tr> <td>S5125</td> <td></td> <td>Attendant Care Services</td> <td>Per 15 min</td> </tr> <tr> <td>S5125</td> <td>U3</td> <td>Attendant Care, travel time</td> <td>Per 15 min</td> </tr> <tr> <td>S5135</td> <td></td> <td>Companion Care Services</td> <td>Per 15 min</td> </tr> <tr> <td>S5135</td> <td>U3</td> <td>Companion Care, travel time</td> <td>Per 15 min</td> </tr> <tr> <td>S5126</td> <td></td> <td>Attendant Care Services</td> <td>Per Day</td> </tr> <tr> <td>S5136</td> <td></td> <td>Companion Care Services</td> <td>Per Day</td> </tr> <tr> <td>S0215</td> <td>RI, U9</td> <td>SHC mileage – with or for member only</td> <td>Per Mile</td> </tr> </tbody> </table>	Service Code	Modifier	Service Description	Unit of Service	S5125		Attendant Care Services	Per 15 min	S5125	U3	Attendant Care, travel time	Per 15 min	S5135		Companion Care Services	Per 15 min	S5135	U3	Companion Care, travel time	Per 15 min	S5126		Attendant Care Services	Per Day	S5136		Companion Care Services	Per Day	S0215	RI, U9	SHC mileage – with or for member only	Per Mile
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3.2	Travel time to and from the member is not routinely reimbursed.																																
3.3	<p>Minimum Referral Units</p> <p>There is no minimum for referral units; however, providers may refuse referrals at their own discretion if they are unable to cover the time frame based on current staffing pattern.</p> <p>Referrals must be made based on member need, and teams should not increase units to meet a provider referral base line.</p> <ul style="list-style-type: none"> • Time must be supported through assessment such as task list, median minutes, or time and task sheet 																																
3.4	<p>The SHC Agency will Only Bill for Authorized and Performed Services</p> <p>The SHC agency will only bill for authorized and performed services using the SPC and procedure codes designated on the referral form. SHC providers are prohibited from billing for services not authorized in the service plan.</p>																																

3.5	<p>Electronic Visit Verification (EVV)</p> <p>Electronic Visit Verification (EVV) is a system that uses technology to verify that authorized services are provided. Through EVV, a worker providing personal care services or applicable supportive home care services sends visit data to an EVV vendor at the beginning and end of each visit using methods such as a mobile application, a home phone (landline or fixed Voice over Internet Protocol [VoIP]), or fixed device.</p> <p>SHC agencies are required to use EVV to report member visits for the designated codes. SHC agencies 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.</p>
3.6	<p>Activity Fees</p> <p>Activity fees for the caregiver who provides accompaniment into the community for integration, socialization, and recreation is included in the hourly reimbursement rate. It is the responsibility of the SHC agency to manage and minimize these costs through coordination with the caregiver, member, and IDT.</p> <p>Any activity fees related to the member's participation in community activities are the responsibility of the member.</p>
3.7	<p>SHC Agency Responsible for Personal Protective Equipment</p> <p>The SHC agency is responsible for providing any Personal Protective Equipment necessary for caregivers to perform their duties under OSHA guidelines. Cost of supplies such as gloves that are used by the worker for personal protection during supportive home care duties are covered within the hourly reimbursement rate.</p> <p>The agency is not responsible for providing supplies for any other caregivers in the home other than their own employees.</p>
3.8	<p>Remote Waiver Services and Interactive Telehealth</p> <p>Provider must include modifier 95 when submitting claims for services that are delivered remotely or through telehealth.</p>
4.0	<p style="text-align: center;">Documentation of Service</p>
4.1	<p>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.</p>
4.2	<p>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.</p>
4.3	<p>The Provider must retain copies of the authorization notification.</p>
4.4	<p>The IDT shall issue a new authorization notification to Provider when the tasks assigned, amount, frequency, or duration of the service changes.</p>
4.5	<p>The Provider must retain the following documentation and make available for review by MCO upon request:</p>

	<ul style="list-style-type: none"> • Proof that Provider meets the required standards for applicable staff qualification, training and programming including training and documentation standards for Supportive Home Care as required by WI DHS. • 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 expectation of work rules, work ethics and reporting variances to the program supervisor. • Employee time sheets/visit records which support billing to MCO. • If hiring family members of LDM, policy and procedures for identifying and reviewing conflict of interest.
4.6	<p>Information regarding authorization and claims processes are available at:</p> <p>Family Care: Providers/Claims and Billing at www.inclusa.org</p> <p>Family Care Partnership: Provider/Claims section and Provider/Prior Authorization section at www.icarehealthplan.org</p>
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	Personal assistance services training shall be completed prior to providing personal assistance services. Provider shall comply with the MCO Training and Documentation Standards for Supportive Home Care and In-Home Respite Care as set forth at: https://www.dhs.wisconsin.gov/publications/p01602.pdf .
5.3	Household/chore service training shall be completed within two (2) months of beginning employment.
5.4	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
5.5	Staff must be trained in recognizing abuse and neglect and reporting requirements.
5.6	Services provided by anyone under the age of 18 shall comply with Child Labor Laws.
5.7	<p>The Provider must ensure that staff have received training on the following subjects pertaining to the individuals served:</p> <ul style="list-style-type: none"> • Policy, procedures and expectations may include the following: <ul style="list-style-type: none"> ○ 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

	<ul style="list-style-type: none"> 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	<p>Provider must ensure:</p> <ul style="list-style-type: none"> 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
6.3	Provider must have an acceptable back up procedure, including notification of member and MCO when provider is unable to show for a scheduled visit.
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	<p>The Provider shall report to the IDT whenever:</p> <ul style="list-style-type: none"> There is a change in service provider There is a change in the Enrollee's needs or abilities The member or provider is not available for scheduled services (within 24 hours unless an alternate date is scheduled between provider and member)
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>iCare will not pay for services that have not been authorized.</i>

7.6	Provider shall follow up with the Enrollee or IDT to determine the reason for an unplanned Enrollee absence.
7.7	<p>Member Incidents: Provider must communicate and report all incidents involving an <i>iCare</i> 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Incident reporting resources and training are available at:</p> <p>Family Care: Providers section of the Inclusa website at www.inclusa.org</p> <p>Family Care Partnership: For Providers/Education/Resources section of the <i>iCare</i> website at www.iCarehealthplan.org.</p>
7.8	<p>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.</p> <p>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.</p>
8.0	Quality Program
8.1	<p><i>iCare</i> 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.</p> <p>It is the responsibility of providers and provider agencies to maintain the regulatory and contractual standards as outlined in this section. <i>iCare</i> will monitor compliance with these standards to ensure the services purchased are of the highest quality.</p>
8.2	<p>Quality Performance Indicators</p> <ul style="list-style-type: none"> • 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-

	<ul style="list-style-type: none"> ○ 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.
8.3	<p>Expectations of Providers and <i>iCare</i> for Quality Assurance Activities</p> <ul style="list-style-type: none"> ● 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. <p><i>iCare</i> 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.</p>