INDEPENDENT CARE HEALTH PLAN

iCare New Provider Education

Reviewed/Revised: June 2021

Living Our Mission

"The Mission of *i*Care is to secure the wellness of persons with complex medical and behavioral conditions, respecting their dignity and the values of caring stakeholders."

iCare Benefit Plans

- Medicare – SNP
  - *i*Care Special Needs Plan
  - Aurora Special Needs Plan
    - Closed Network
- Medicaid – SSI
  - BadgerCare+
- Family Care Partnership

Member Eligibility

- Providers are required to obtain member eligibility information
  - Providers should verify eligibility at every visit
  - Coverage of services should be verified before rendering
- Check iCare eligibility via ForwardHealth portal, iCare Customer Service or our Provider Portal for network specifics
  - Coverage is not guaranteed based on presentation of an insurance card

Members Rights

Members have the right to know the following information:

- Provider's credentials
- Right to medical records
- If applicable, physician incentive plan
- Their rights as members
- Their civil rights as members
- All medically necessary covered services are available and will be provided in the same manner to all members. All persons or organizations connected with *i*Care that refer or recommend members for services shall do so in the same manner for all members

More detailed information can be found in the Provider Reference Manual & FCP Provider Reference Manual: http://www.icarehealthplan.org/

Member Grievance and Appeal Guide

- All Wisconsin Medicaid Health Plans are required to implement and enforce all of the requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F (included in link below).
- This guide provides contractual requirements for member grievance and appeal systems, including notice timing and content requirements, and grievance and appeal resolution timeframes for BadgerCare+ and Medicaid

- This Guide should be reviewed by all providers, which can be found on ForwardHealth's portal:
  - HMO and PHIP Member Grievances and Appeals Guide
    - Under Policy Guides

BadgerCare+/Medicaid Ombuds

- BadgerCare+ and Medicaid members have access to an Ombudsmen via DHS
- Ombuds can:
  - Research and resolve enrollee grievances about the care or services
  - Help enrollees with a grievance (telephonic or written)
    - 1-800-760-0001
    - BC+Medicaid Ombudsmen, PO Box 6470, Madison WI 53716
  - Help enrollees understand their rights
  - Represent enrollees
  - Act as a fair and impartial go-between

Please see our website for complete details:
https://www.icarehealthplan.org/Provider-Documents.htm.

Cultural Competency

- *i*Care encourages and fosters cultural competency among staff and providers
- Quality services to individuals from different cultural backgrounds are based on an understanding of each population's distinct needs
- *i*Care uses known Member cultural information to help determine resources needed for cross-cultural and culturally specific- practices, such as: Community outreach organizations that provide free material or advice based on the cultural needs of the Member
  - Providers and organizations that are able to communicate in the Member's preferred language, if needed

Cultural Competency Provider Expectations

- *i*Care considers its network providers to be full partners in the mission to deliver culturally competent services to Members
- *i*Care contracted providers are contractually required to be sensitive to honoring cultural diversity, differing levels of English proficiency, and diverse cultural and ethnic backgrounds, and to foster in their staff attitudes and interpersonal communication styles which respect the diversity of iCare's members
- Please see our Webinars on our website: icarehealthplan.org / Providers / Provider Resources

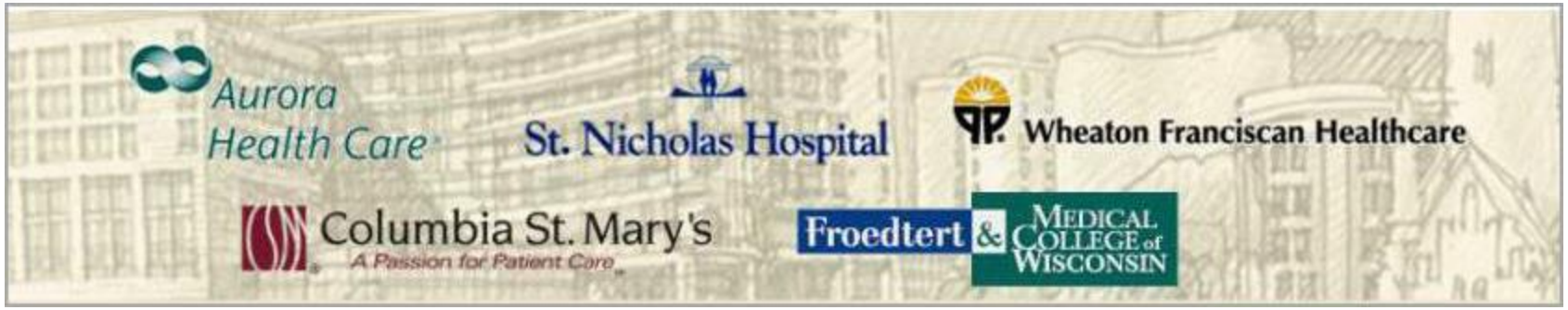
Limited English Proficiency

- *i*Care understands and applies the guidelines and requirements of Limited English Proficiency (LEP) and special needs as outlined in the Civil Rights Compliance Plan required by the State of Wisconsin Department of Workforce Development, the Department of Health Services, and Centers for Medicare and Medicaid Services. *i*Care also complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination of members.
- All primary recipients and sub-recipients of federal funding are obligated to provide oral language interpretation assistance and/or written translation to all LEP individuals requesting or applying for services. (*i*Care receives this federal funding)
- iCare Members have a right to have access to translation/interpretation services and to receive information provided by *i*Care in another language or format upon request
- *i*Care has an obligation to get information to members in a way that works for them
  - Consider literacy levels, physical/cognitive abilities, preferences, etc.
  - Provides free language services to people whose primarily language is not English such as :
    - Qualified interpreters during any covered service
    - Information written in other languages or in other formats
- LEP members are encouraged to ask their Care Manager (CMs) or Care Coordinators (CCs) for language assistance or to discuss discrimination problems.

iCare Member Demographics

- Ethnicity (as reported by the Members)
  - 58% African American
  - 30% Caucasian
  - 8% Hispanic
  - <4% Other

Major Health Care Systems in the iCare Provider Network



Clinical Practice Guidelines Excerpt (CPG)

- *iCare* is dedicated to enriching the quality of clinical care provided to our members by our staff and contracted providers.
- CPG are for the explicit purpose of disseminating peer-reviewed, evidence-based practice recommendations to enhance the quality and consistency of care delivered to all patients, regardless of payor source.
- CPG support providers in treating chronic disease, providing preventative care, and facilitating provider-member interactions
- Information on CPG applies to all providers of care to iCare members
  - CPG are reviewed annually and is updated no less than every two years, or as national guidelines change. Updates to the Clinical Practice Guidelines are reviewed by the Credentials Review Committee

Clinical Practice Guidelines Excerpt (CPG)

- All CPG recommended by *i*Care are based on national medical association and health organization recommendations and are aligned with national STAR initiative metrics for MCOs.
- Electronic-based provider newsletters and other forms of web-based provider information outlets are additional resources that iCare may use at its discretion to inform providers of new or updated policies on an as-needed basis
- **Full guidelines and information regarding CPG and their updates are posted on iCare's provider website**

Statements of Deficiency & Background Checks

Pertains to all Division of Quality Assurance Regulated Providers such as: AFH, Home Health Agencies, Skilled Nursing Facilities, etc

- The Division of Quality Assurance (DQA) is responsible for assuring the safety, welfare and health of persons using health and community care provider services in Wisconsin
  - All deficiencies are posted on the DQA website for public access
    - https://www.dhs.wisconsin.gov/dqa/index.htm
- iCare's Quality Department performs ongoing monitoring of DQA Statements of Deficiency (SOD) for all contracted organizations that are regulated by the DQA
  - *Examples include, but are not limited to: Home health agencies, AFHs, CBRFs, Skilled Nursing Facilities, etc*
- If an organization has recently had an SOD that is deemed to be medium or high risk, they may be required to submit documentation to iCare to show that they are in compliance with any corrective actions

Caregiver Background Checks

- Organizational providers who are not regulated by DQA or the Department of Health Services, and have staff who will be providing 'Direct and Regular Care' to our Members are required to comply with Caregiver Background Checks (CBC)
  - *Examples include, but are not limited to: Respite, Supportive Home Care, Adaptive Aids, etc.*
- *i*Care conducts recredentialing of all contracted organizations every 3 years, at which time the non-regulated providers meeting the description above are required to undergo a re-review of their caregiver background check review process

5 Star Measure – CMS

- Centers for Medicare & Medicaid Services (CMS) rates health plans like ours on a scale of 1-5 stars
- Star ratings are based on over 50 quality measures mainly from the following:
  - CAHPS (Consumer Assessment of Healthcare Providers & Systems)
  - HOS (Health Outcome Survey)

5 Star Measure *(Continued)*

HEDIS (Health Exchange Data Information Set)

- 1 in 5 Medicare patients are readmitted to a hospital within 30 days of discharge due to:
  - Medication discrepancies
  - Discharge instruction/order confusion
  - Lack of home support
  - Lack of provider follow-up appointments
- To help resolve this and to achieve our measures:
  - Primary Care Physician/MD's should complete a medication reconciliation post-hospitalization discharge (MRP) with all patients
    - Medical record documentation should indicate MRP
  - Post discharge follow up should be completed within 7 days

5 Star Measure *(Continued)*

- Our goal at *i*Care is to keep our members healthy and satisfied
- We are focused on providing quality care with goals of reaching a 5 Star rating through the help of our providers throughout our *i*Care network
  - Working together as partners with our providers and documenting services providers are rendering helps to reach the required quality measures
- Focused on high-need, high impact areas
  - We address multiple measures and also focus on specific target areas

- Our 5 critical measures are:
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Diabetic Retinal Eye Exam
  - Controlling HbA1C
  - Controlling Blood Pressure

Pay 4 Performance - DHS

- Our 4 critical measures are:
  - Breast Cancer Screening
  - Follow-up Visits after an Inpatient Mental Health Stay
  - Controlling HbA1c
  - Pre and Post – natal follow-up visits

Member Incidents

Pertinent to provider specialties such as: LTC, AHF, CBRF, RCAC and SNF

- Providers must report Member Incidents to designated IDT staff no later than 1 business day after the incident or death is discovered
- Once notified, the IDT staff has 30 days to complete the investigation of the incident to establish cause and require the provider to put interventions in place to reduce reoccurrence of another incident
- Certain Member Incidents REQUIRE that iCare immediately report the incident to Department of Health Services (DHS)

- Please see the additional education: Member Incident Training for Providers for further details

Member Incidents (Continued)

- Types of Member Incidents
  - Neglect
  - Self-Neglect
  - Financial Exploitation
  - Abuse
    - Physical
    - Sexual
    - Emotional
    - Treatment without Consent
  - Unreasonable Confinement or Restraint
    - Unplanned or Unapproved Use of Restraints
  - Unplanned or Unapproved Use of Isolation/seclusion
  - Falls
  - Death
  - Missing Person
  - Unplanned or Unapproved Involvement of Law Enforcement and/or Criminal Justice System
  - Medication Errors

Restrictive Measures

- Behavioral Support Plan (BSP) is a plan that supports a Member in building positive behaviors to replace or reduce challenging/dangerous behavior, while attaining their desired quality of life
  - This plan may include techniques for supporting our Members, improving communication with the Member, helping the Member build positive relationships, and intervening in a variety of situations
- Providers are expected to:
  - Use a systematic approach to assess member needs
    - DHS Guideline: https://www.dhs.wisconsin.gov/waivermanual/appndx-r1.pdf
- Providers will work with *i*Care staff to submit the BSP to the State
  - Behavior Support Plans should be reviewed with the IDT minimally every 6 months to ensure effectiveness and track changes

Restrictive Measures *(Continued)*

- Types of Restrictive Measures
  - Restraint
    - Manual Restraint
    - Mechanical Restraint
  - Seclusion
  - Isolation
  - Protective Equipment
  - Mechanical Support
  - Medical Restraint

Cooperation with Investigations

- Providers are required to fully cooperate with any member-related investigation conducted by *i*Care, DHS, Centers for Medicare & Medicaid Services (CMS), Law Enforcement, or any other legally authorized investigative entity

iCare's Interdisciplinary Teams

- Medicare SNP – Care Coordination
  - Consisting of a Care Coordinator and RN
    - Comprehensive assessments, care plans, monitor changes in condition and work to maintain Member wellness
- Medicaid – SSI Care Coordination
  - Consisting of a Care Coordinator, Care Manager and RN
    - Comprehensive assessments, care plans, care coordination and case management services
- BadgerCare+
  - Consisting of a Care Coordinator, Care Manager and RN
    - Initial Health Needs Assessment, care coordination and Member outcome follow-up
- Family Care Partnership
  - Consisting of a Case Manager, RN and Nurse Practitioner
    - Team is focused on Member Centric Goals
    - Help Members maintain their independence within the community setting; work in collaboration with the PCP provider, home and community based LTC services

Authorization of Services

Prior Authorization (PA)

- SNP, Aurora Special Needs Plan, Lakeland Care + Health, SSI, BadgerCare+ and Family Care Partnership
- Prior Authorization is required for (not an all inclusive list):
  - Admission to subacute facility, Home Health Care Services, Therapy Services, Referrals for additional opinions, etc
- Please reference the provider tab on the *i*Care website for complete list of services requiring PA http://www.icarehealthplan.org/Providers/Authorization.aspx
  - PA questions can be directed to *i*Care's customer service department
  - Please see the PA form for required information
- Urgent Prior Authorizations are processed within 72 hours; Standard Requests are processed within 14 calendar days

- Prior Authorization and Service Request does not guarantee coverage or payment for services provided to our Members
- Emergency After Hours contact – 414.223.4847

Authorization of Services *(Continued)*

Service Request (SR)

- Family Care Partnership
  - Members, legal decision makers or providers can request new services or extensions of existing services
  - **ALL** FCP providers must have LTC services **authorized** by the IDT
  - Authorizations depend on the Member's needs and how much time is needed to provide adequate services
- The following is needed for a service request:
  - Member name, description of services to be provided and HCPCS code, units and frequency of service, dates of service, and service location

Claims Processing

- *Detailed information on the following can be found at: www.icarehealthplan.org/providers/claimsprocessing.aspx*

Claim Mailing Addresses

Corrected Claim mailing addresses

- Must be marked as "Corrected Claims"
- If line items are not included in the corrected claim; it is assumed that deletion of the line items is part of the correction

Claim errors: Review/Reopening and Reconsideration/Appeals

- Review / Reopening are an informal process for Medicare/Medicaid
  - **NOTE: Any Medicaid claims related to a Family Care Partnership member may not utilize the review/reopening request. These requests will need to be submitted as a corrected claim or a formal appeal.**
- Reconsideration / Formal Appeal is a formal process for Medicare/Medicaid
- All reviews MUST be received within 60 days of the EOP

Complete and Clean Claims

- See website for clean claim requirements
- Clean claims are processed within 30 days of receipt

Claims Processing, Cont'd

- Claims Filing Limits
  - 120 days from date of service unless otherwise specified in agreement
- Electronic Claims Submission
  - https://products3.ssigroup.com/ProviderRegistration/
  - Does not apply to LTC claims
- Electronic Remittance (835)
  - provideroutreach@icarehealthplan.org
  - Must include entity, contact name, NPI, Tax ID and name of clearing house
- Explanation of Payment/Remittance
  - Information found on our provider portal
- Coordination of Benefits

Sharing of Information under Federal and State Privacy Laws

- Independent Care Health Plan (*i*Care) is a health plan and is a covered entity as defined under the Health Insurance Portability and Accountability Act (HIPAA)
- *i*Care has contracts with DHS and CMS to administer Medicare/Medicaid plans
  - Enrolled members can receive coverage under Medicaid, Medicare, and/or Long Term Care depending on the program(s) in which they are enrolled
  - With some limited exceptions, covered entities such as health care providers and health care plans are allowed to disclose personally identifiable health care information about members/patients they are both serving without informed consent, provided it is for the purposes of treatment, payment, and health care operations

Sharing of Information under Federal and State Privacy Laws *(Continued)*

- Case management and care coordination are included in the definition of health care operations under HIPAA (See 45 CFR § 164.501)
- Wisconsin law also permits access to patient health care records without informed consent of the patient if the releases are for the purposes of treatment, payment, or health care operations as defined by HIPPA (See Wis. Stats. § 146.82(1) and (2)

Sharing of Health Care Information under Federal and State Privacy Laws (Continued)

- If you are a type of service provider that is not included in the definition of health care provider under HIPAA, your provider contract with iCare contains a Business Associate Agreement which authorizes the sharing of member information between you and iCare for purposes of treatment, payment, and health care operations