INDEPENDENT CARE HEALTH PLAN

*i*Care is a wholly-owned subsidiary of Humana

*i*Care New Provider Education

Reviewed/Revised: September, 2026

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 and Medicaid – Family Care Partnership
- Medicaid – SSI
- Medicaid - BadgerCare+

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 *i*Care eligibility via ForwardHealth portal, *i*Care 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

- In Wisconsin, Medicaid providers are strictly prohibited by state and federal law from balance billing members for covered services, meaning they must accept the Medicaid-allowed amount as payment in full.

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 requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F.
- The link below 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
- 2026_BCP-SSIMA_Contract_withApr.Amend.pdf

Reducing the Number of Missed Appointments-Medicaid SSI and BC+

The following suggestions will reduce missed appointments for all patients, including BadgerCare Plus members. When scheduling appointments, providers should explain to members the importance of keeping appointments and the office rules regarding missed appointments.

- Contact the member by telephone or postcard prior to the appointment and remind the member of the time and place of the appointment and the importance of canceling scheduled appointments in advance.
- Require members to verify their appointment by calling the dental office, using the following procedures:
  - Explain the policy carefully to members when they make appointments.
  - Send postcards to remind members of their appointments, of the office policy regarding confirming their appointments, and of the need to call immediately to confirm the upcoming appointment.
  - If members do not call by a given day before their appointment, give the appointment to another patient.
- If the appointment is made through the HealthCheck screen or targeted case management programs, encourage staff from those programs to ensure that scheduled appointments are kept.

Reducing the Number of Missed Appointments Cont.

- Call the local city/county health department for information about HealthCheck services in the area. Individual dentists may agree only to accept referrals from HealthCheck providers such as the local public health agencies and physicians. Some health departments have outreach staff who may be able to assist members in getting to their dental appointments
- Contact programs and agencies, such as Head Start, sheltered workshops, or human service departments, to develop a referral system. Some of these agencies may assist members in finding transportation and keeping dental appointments.

- Non-emergency medical transportation (NEMT) is available through the DHS NEMT manager. The NEMT manager arranges and pays for rides to covered services for members who have no other way to receive a ride. Non-emergency medical transportation can include rides using:
  - Public transportation, such as a city bus
  - Non-emergency ambulances
  - Specialized medical vehicles
  - Other types of vehicles, depending on a member's medical and ride needs
  - Also, if a members uses their own vehicle for rides to and from your covered health care visits, they may be paid back for miles.
- Schedule rides at least two business days before your visit. You can schedule a routine ride by calling the NEMT manager at 1-866-907-1493 (or TTY 1-800-855-2880), Monday through Friday, from 7:00 a.m. until 6:00 p.m. You may also schedule rides for urgent visits. A ride to an urgent visit will be provided in three hours or less.

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 the DHS Flyer:

https://www.icarehealthplan.org/Files/Resources/PROVIDER-DOCS/OmbudsforBadgerCarePlusandSSIMedicaidHMOMembers82124.pdf

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 *i*Care's members
- Please see our Webinars on our website: https://www.icarehealthplan.org/Education/Resources.htm

iCare Member Demographics

Age Profile of Membership

Age	Number of Members	Percent of total
0-17 years	15,696	30%
18-34 years	14,294	28%
35-64 years	17,913	35%
65+ years	3,746	7%



iCare Member Demographics

(continued)

Race/Ethnicity Profile of Membership

Race/Ethnicity	Number of Members	Percent of total
White	18,528	36%
Black	15,689	30%
Hispanic	7,048	14%
Asian	2,134	4%
Native American/Alaskan Native	231	0.5%
Native Hawaiian/PI	36	0.07%
Other	9	0.02%
Unknown	11	0.02%

Language Profile of Membership

Language	Number of Members	Percent of total
English	35,715	94%
Spanish	1,331	4%
Rohingya	147	0.39%
Burmese	104	0.27%
Hmong	92	0.24%
Arabic	83	0.22%
All other combined	566	1.5%

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)
- *i*Care 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.

Language Trends in Wisconsin

As a provider and a plan, it is important to be aware of language trends. Language barriers lead to a reduction in patient and provider satisfaction and a decrease in quality of care and patient safety (Al Shamsi H, et al., Implications of Language Barriers for Healthcare: A Systematic Review. Oman Med J. 2020 Apr 30;35(2):e122). If we understand the language needs of the communities we serve, we can target resources to reduce language barriers.

In 2024, 9.05% of households in Wisconsin reported a non-English language at home as their primary shared language. The most common non-English language spoken was Spanish (4.94%) followed by Hmong (0.71%) and then German (0.45%). https://datausa.io/profile/geo/wisconsin. Please refer to the table below to see the predominant languages spoken in households in regions around Wisconsin.

Most Prevalent Non-English Languages per Wisconsin Region*

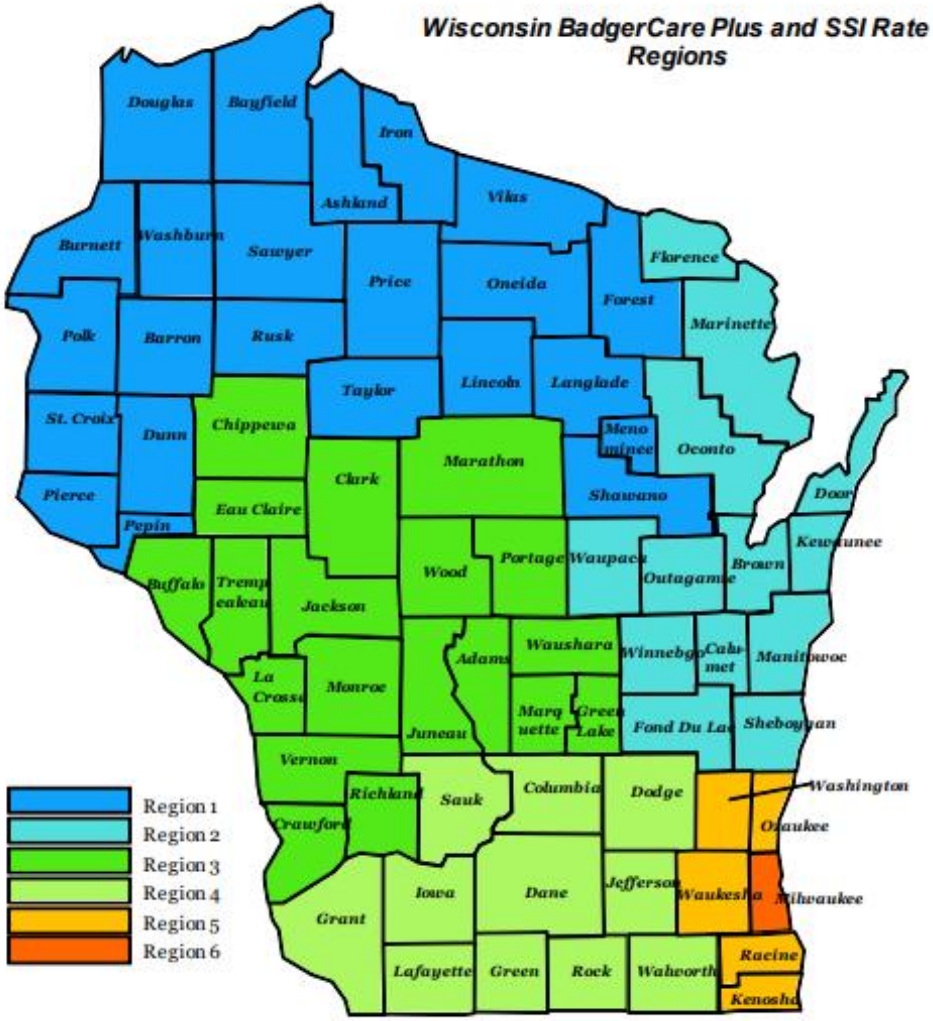
Region	Most Common Language	Second Most Common Language	Third Most Common Language
1	Spanish	Hmong	Somali
2	Spanish	Hmong	Somali
3	Spanish	Hmong	Lao
4	Spanish	Hmong	Arabic
5	Spanish	Mandarin Chinese	Vietnamese
6	Spanish	Hmong	Mandarin Chinese

See Slide 16 for Region Map

* Prevalent Language data calculated for CY 2026

Source: Wisconsin Department of Health Services, Division of Medicaid Services, BadgerCare+ Medicaid SSI Contract. Date: 1/1/2026

Language Trends in Wisconsin *(Continued)*



For language details at the county level, please visit our website
https://www.icarehealthplan.org/Education/Resources.htm#Training___Resources

Provider Support: Individual language data

We will share our member's preferred language for health care on our prior authorization forms. A redacted example is below.



iCare
INDEPENDENT CARE HEALTH PLAN

Prior Authorization Provider Notification

Today's date: 02/17/2023

MEMBER INFORMATION: [redacted] [redacted]

MEMBER PRIMARY LANGUAGE: Spanish

Provider Support: Translated patient education

MedlinePlus brings together authoritative health information from the National Library of Medicine (NLM), the National Institutes of Health (NIH), and other government agencies and health-related organizations.

Printable versions in English & Spanish are available on Medline Plus for the following topics (click on hyperlinks):

- Health Topics - symptoms, causes, treatment and prevention for over 1000 diseases, illnesses, health conditions and wellness issues
- Medical Tests – what the test is, why it is ordered, how it will feel and what results mean
- Healthy Recipes – recipes for healthy meals
- Videos – animated videos to explain health and medicine topics

Materials linked above are produced by the federal government and therefore not copyrighted

MedlinePlus®
Trusted Health Information for You

Provider Support: Translated patient education

Other translation tool available are:



Visit X-Plain Health Encyclopedia for a library of health information and resources.

Provider Support: Requesting an Interpreter/Translator from iCare

Independent Care also provides Interpreter/Translator Agency services and coordinates with providers to assure services are available to meet member needs and protect member rights.

If a healthcare provider determines an interpreter is needed, please call 414-231-1029 (or toll free: 1-877-333-6820) and include the following information:

- Name of member
- iCare member ID number
- Date of appointment including length of visit
- Language being requested
- Healthcare provider contact (name, address, suite number and phone number)
- Contact name and phone number of person at the healthcare provider

Once an interpreter is identified for the appointment, the interpreter/translator agency will
provide the name of the interpreter to *i*Care Provider Services . *i*Care will in turn provide confirmation to the healthcare provider including the name and contact information for the agency and interpreter. If an interpreter is not available, notice is provided by phone or e-mail to the requester.

Major Health Care Systems in the iCare Provider Network

Ascension

Aurora Health Care

Froedtert & Medical College of Wisconsin

ProHealth Care

HSHS St. Nicholas Hospital

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 *i*Care 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 *i*Care 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 *i*Care's provider website:** https://www.icarehealthplan.org/Education/Resources.htm

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
- *i*Care'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 *i*Care 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

MEDICAL RECORDS

- Due to the reporting that *i*Care is required to submit to CMS and DHS in support of the quality programs outlined above, providers of covered services are required to provide medical records and documentation validating members received certain healthcare services. Independent Care's contracted providers should reference their contract with *i*Care for more information.
- When *i*Care requests copies of a member's medical records for purposes of determining whether benefits are payable (e.g., prior authorization requests, claims adjudication, utilization management, or Grievances and Appeals), *i*Care does not pay for medical records. Following state guidelines, payment is not required under the law.

Reporting Child Abuse

- Providers who are required by law to report suspected child abuse and neglect must know and understand the laws, identification requirements, and reporting procedures under Wisconsin Statutes s. 48.981.
- For further training on reporting suspected child abuse, refer to the following link: WI Child Welfare Professional Development Mandated Reporter.

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 *i*Care 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/publications/p02572.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

- 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)

- Medicaid SSI, BadgerCare+ and Medicare/Medicaid Family Care Partnership
- Prior Authorization is required for (not an all-inclusive list):
  - Admission to Inpatient or 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 7 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 for Medicaid and 65 days for Medicare

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://products.ssigroup.com/vpsportalregistration/register
    - Does not apply to LTC claims
- EFT and Electronic Remittance (835)
  - InstaMed
  - Online: www.instamed.com/eraeft
  - Phone: 866-467-8263 to speak to a live agent
- Explanation of Payment/Remittance
  - Information found on our provider portal
- Coordination of Benefits

Claims Processing, Cont'd

- **Review/Reopening**
- *Review/Reopening* is the first level request to review a processed claim when the provider does not agree with the outcome and feels the claim warrants an adjustment. In order to avoid processing delays, providers should complete the Review/Reopening form and attach any supporting documentation relevant to the request. Review/Reopening requests can also be made telephonically by calling Customer Service or can be mailed to the address below within 60 days from the date of the EOP:
- *i*Care Health Plan
  Review/Reopen
  P.O. Box 280
  Glen Burnie, MD 21060-0280
- **Reconsideration/Formal Appeal**
- *Reconsideration/Formal Appeal* is a formal process to review a processed claim when the provider does not agree with the outcome and feels the claim warrants an adjustment. The provider must submit this request in writing. Providers are not required to first submit a review/reopening request, but are encouraged to do so for minimal processing errors. Providers should complete the Reconsideration/Formal Appeal form and attach supporting documentation, including the required Waiver of Liability (WOL) form. Request cannot be handled telephonically and should be mailed to *i*Care Appeal Department Address below within 60 days from the date of the EOP or response to the review/reopening request:
- **Reconsideration/Formal Appeal Form Address:**
- *i*Care Health Plan
  Appeal Department
  1555 N. RiverCenter Dr., Suite 206
  Milwaukee, WI 53212

Claims Processing, Cont'd

- If a provider is not satisfied with *i*Care's response to an appeal, or if *i*Care does not respond to the provider within the required timeframe as set forth above, the provider may appeal to DHS. Providers are required to first exhaust all appeal rights with *i*Care before appealing to DHS. All Appeals to DHS must be submitted in writing to DHS within sixty (60) calendar days of *i*Care's final decision or failure to respond to the provider, as follows:
  - BadgerCare Plus and Medicaid SSI Managed Care Unit – Provider Appeal P.O. Box 6470 Madison, WI 53716-0470 Fax Number: 608 224-6318

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 *i*Care contains a Business Associate Agreement which authorizes the sharing of member information between you and *i*Care for purposes of treatment, payment, and health care operations