

Scope of Service

Community Based Residential Facility (CBRF) 9 or more beds

This Scope of Service defines requirements for this service type for the iCare Family Care (branded “Inclusa”) and Family Care Partnership [Cardinal Health at-Home: Catalog Search Results](#) programs

Family Care Partnership: Attachment to Description of Long-Term Care Provider Services and
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	Residential Services are a combination of treatment, supports, supervision, or care above the level of room and board provided to members residing in a community-integrated residential setting that meets HCBS settings requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable member needs. Services assist the member to reside in the most integrated setting appropriate to their needs and typically include supportive home care, personal care, and supervision. Services may also include social and recreational programming, daily living skills training, medication administration, intermittent skilled nursing services, and transportation. Residential services also include coordination with other services and providers, including health care, vocational, or day services. Services may also include the provision of other waiver services as specified in the contract between the MCO and residential provider. Waiver funds may not be used to pay for the cost of room and board, items of comfort or convenience, or costs associated with building maintenance, upkeep, and improvement. Residential services may be authorized only: When members’ long-term care outcomes cannot be cost-effectively supported in the member’s home, or when members’ health and safety cannot be adequately safe-guarded in the member’s home; or When residential services are a cost-effective option for meeting that member’s long-term care needs. Community Based Residential Facility 9 or more beds (CBRF) are residences where five (5) or more adults not related to the operator or administrator of the facility, reside and receive care, treatment, support, supervision and training. An individual with an intellectual disability may only reside in a CBRF that is licensed for eight (8) or fewer residents, unless that person has been determined to require No Active Treatment (NAT) for the person’s intellectual disability. Services may include up to three hours per week of nursing care per resident. A licensed CBRF must comply with Wis. Admin. Code § DHS 83 and must be HCBS compliant per 42 CFR 441.301.
2.0	Service Description/ Requirements

2.1	iCare adheres to and Providers are subject to the requirements and qualifications defined for Community Based Residential Facilities (CBRF) in the Wisconsin Department of Health Services (DHS) Family Care Partnership contract, as well as applicable statutory and regulatory requirements.
2.2	Services and supports covered and included in the Agreement are listed below. Provision of services are dependent on the needs of residents. If a resident you provide support to needs the service, you are required to provide that service. Physical Environment (Room & Board) - Physical Space – sleeping accommodations in compliance with facility regulations including, access to all areas of facility and grounds. - Furnishing – all common area furnishings and bedroom furnishings including all of the following: bed, mattress with pad, pillows, bedspreads, blankets, sheets, pillowcases, towels and washcloths, window coverings, floor coverings. - Equipment – all equipment that becomes a permanent part of the facility, such as grab bars, ramps and other accessibility modifications, door alarms, pull-stations and/or call lights. - Housekeeping services – including laundry services, household cleaning supplies, and bathroom toilet paper and paper towels. - Building Maintenance – including interior and exterior structure integrity and upkeep, pest control, and garbage and refuse disposal - Grounds Maintenance – including lawn, shrub, and plant maintenance, snow and ice removal. - Building Protective Equipment – carpet pads, wall protectors, baseboard protectors, etc. - Building Support Systems – including heating, cooling, water and electrical systems installation, maintenance and utilization costs. - Fire and Safety Systems – including installation, inspection and maintenance costs. - Food – 3 meals plus snacks, including any special dietary accommodations, supplements, thickeners and consideration for individual preferences, cultural or religious customs of the individual resident. If supplements (e.g. Ensure) are above and beyond 3 meals per day plus snacks, they could be covered by iCare if medically necessary per Medicaid requirements. If a supplement is in lieu of meal or snack it is covered by the CBRF. - Meals out or meals ordered in that are planned as one of the three meals provided per day (e.g. entire house going out for fish dinner on Friday) are the responsibility of the Provider. - Enteral (tube) feedings are excluded from this requirement and these costs are covered by iCare. If all nutrition is derived from enteral (tube) feedings, the food portion of room & board must be deducted from Provider reimbursement. - Telephone and Media Access – access to make and receive calls and acquisition of information and news (e.g. television, newspaper, internet) Program Services (Support & Supervision) - Supervision – adequate, qualified staff to meet the scheduled and unscheduled needs of Enrollees and to maintain Enrollee records. - Personal Care, Assistance with Activities of Daily Living and Daily Living Skills Training. - Activities, Socialization and Access to Community Activities – including facility Leisure Activities, Community Activities, information and assistance with accessing, and assistance with socialization with family and other social contacts. - Health Monitoring – including coordination of medical appointments, coordination of transportation, coordination of natural supports or accompanying Enrollees to medical

	service when necessary and keeping a record of medical appointments, reports and recommendations. • Medication Management – includes proper storage of medications; preparation of a medication organization or reminder system; assessment of the effectiveness of medications; monitoring for side effects, negative reactions and drug interactions; and delegation and supervision of medication administration. • Behavior Management, including participation with <i>iCare</i> in the development and implementation of Behavioral Treatment Plans and Behavioral Intervention Plans. • Facility Supplies and Equipment – first aid supplies, gauze pads, blood pressure cuffs, stethoscopes, thermometers, cotton balls, medication and specimen cups, gait belts, etc. • Personal Protective Equipment for staff use including gloves, gowns, masks, etc. • OSHA and Infection Control Systems – including hazardous material bags, Sharps disposal containers, disposable and/or reusable wash cloths, wipes, bed pads, air quality - free of unpleasant odors and second-hand smoke etc. • Hoyer or EZ Stand Lifts – <i>iCare</i> will cover the cost of Enrollee-specific slings to utilize with Hoyer lift. If a facility provides Hoyer/EZ stand support the facility will have the needed equipment. If an individual is living in a facility that does not typically cover this support an Enrollee specific conversation will occur to determine if <i>iCare</i> purchasing the equipment on a one-time basis is most cost effective to meet the identified need. • Transportation – Provider will provide all regular and routine transportation for Enrollee. Regular and routine is defined for each Enrollee in their Member Centered Plan. It is to include transportation to all medical appointments, social/recreation activities, religious services, and day service/prevocational training/employment for the Enrollee. Provider should coordinate with natural supports for transportation whenever possible and appropriate to the Enrollee's needs. ○ Transportation for scheduled medical appointments, employment, prevocational and/or day services are excluded from care and supervision rates. Facility and IDT should first look to coordinate transportation through natural supports. If this is not available, transportation could be authorized and reimbursed separately as needed. Facility should work with IDT to coordinate transportation services either through the residential provider or using an Inclusive contracted transportation vendor. ○ Transportation for Multiple Members in One Vehicle - In the event a residential provider is transporting multiple Members, who will be delivered to an end destination, the provider would be expected to split the mileage between the Members who are sharing the ride. Residential providers should not bill for each Member individually in these instances. This expectation would not apply to Members who are in the vehicle due to no supervision at home or if they are in the vehicle for their community outing or any other regular and routine transportation as defined above. Example: Provider transports 2 members, one is going to day services and the other to their place of employment. Total one-way trip is 20 miles. It is 12 miles to the day services and an additional 8 miles to the place of employment. Day services member would have 6 miles of transportation (half of 12 miles), and the employment member would have 14 miles of transportation (half of 12 miles + 8 miles where they are the only member in the vehicle). ○ Wheelchair Accessible Transportation Wheelchair transportation will only be reimbursed if the member requires it. If accessible transportation is needed and provider owns an accessible vehicle, reimbursement would follow requirements as outlined above; however, the reimbursement rate would be higher as outlined
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	within provider subcontract. - Enrollee Funds Management – assistance with personal spending funds, not including representative payee services. The service agreement with the Enrollee must address whether any personal spending funds management is being provided. The following costs are not typically provided by the CBRF and are costs incurred by the individual Enrollee or iCare: - Medication and Medical Care Co-payments. - Personal Hygiene Supplies – including toothpaste, shampoo, soap, feminine care products. - Enrollee Clothing- shirts, pants, underclothes, socks, shoes, coats. - Costs associated with community recreational activities- event fees, movie tickets, other recreational activities of the Enrollee's individual choosing not associated with a Provider sponsored event. - Dietary costs associated with allergies and personal preferences iCare typically pays the following costs in addition to the residential rate: - Personal Incontinence Supplies related to a diagnosis: briefs, pull-ups, catheters, reusable protective pads, etc. - Respiratory Equipment and Oxygen Products · Durable medical equipment and supplies for a specific individual · Sleep apnea related products/equipment - Person-Specific Durable Medical Equipment - Diabetic equipment-Medicare is billed as primary. Safety lancets could increase the safety of a diabetic item which is part of the benefit package. Enrollees are not to be left alone overnight, or at any other time if they are incapable of self-evacuation. An Enrollee specific plan will be in place and mutually agreed upon between Provider, Enrollee/guardian, and iCare in order to have any unsupervised time.										
2.3	Provider agrees to meet the terms of the Agreement and retain licensure or certification in good standing through license or certification with DQA or other certifying body throughout contract period. The Provider must maintain and make available for review documentation demonstrating that certification or licensure is current.										
3.0	Unit of Service										
3.1	Provider must bill using appropriate procedure codes and modifiers. <table><tr><th>Service Code</th><th>Revenue Code</th><th>Modifiers</th><th>Service Description</th><th>Unit of Service</th></tr><tr><td>T2033</td><td>0243</td><td>U1, U2, or U3 as the first modifier U8 as the second modifier U4 as the fourth modifier, if applicable</td><td>9+ bed Care & Supervision</td><td>Per day</td></tr></table>	Service Code	Revenue Code	Modifiers	Service Description	Unit of Service	T2033	0243	U1, U2, or U3 as the first modifier U8 as the second modifier U4 as the fourth modifier, if applicable	9+ bed Care & Supervision	Per day
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3.2	Units of service will be made based on DAYS authorized in the facility. A DAY includes the day of admission, but not the day of discharge. The day of disenrollment of a Family Care member (voluntary or otherwise determined by MCO) is a paid service day. Disenrollment includes death, incarceration, loss of financial/functional eligibility, failure of member to pay cost share, move to an IMD, and/or move out of the MCO service area.										

3.3	<u>Room & Board</u> Each Enrollee is responsible for the room & board portion of the daily rate. However, <i>iCare</i> will collect the room & board payments from each Enrollee and pay the provider the room & board portion of the rate on behalf of the Enrollee. Room & board should be billed using Service Code 0159. The room & board rate will also be indicated on the Member Specific Rate Sheet.
3.4	Planned Termination of Placement: A written 30-day notice is required by <i>iCare</i>/member or residential provider (whoever is initiating the termination) to terminate a placement. Payment will be made up to, but not including the date of the member's move out of the home. Failure by provider/<i>iCare</i> to meet 30-day notice requirement may result in a financial penalty up to, but not exceeding the number of days left in provider/<i>iCare</i>'s 30-day service commitment, unless an earlier date is mutually agreed upon by both parties. Unplanned Termination of Placement: When an unplanned termination is due to reasons involving health and/or safety concerns a 30-day notice may not be required. The residential provider will coordinate an appropriate discharge plan with the IDT. Payment will be made up to, but not including the date of the member's move out of the facility. If the unplanned termination is due to disenrollment of a member, 30-day notice would not be required. Disenrollment includes death, incarceration, loss of financial/function eligibility, failure of member to pay cost share, move to an IMD, and/or move out of <i>iCare</i>'s service area, voluntary or otherwise determined by <i>iCare</i>. Payment would be made up to the last day of enrollment but does not include the date of disenrollment.
3.5	Member absence (Bed Hold) from residential care: For temporary Enrollee absences, the Provider must notify <i>iCare</i> of the Enrollee's absence 24 hours in advance (if known) or within 24 hours for unexpected absences. Failure to notify <i>iCare</i> will result in Provider not receiving bed hold payment. Following notification, the Provider can coordinate with <i>iCare</i> for reimbursement during the absence. The Care & Supervision residential authorization will be ended the day prior to the date of discharge. The Room & Board authorization will remain open through the end of the current month (I.e. if member leaves in March member absence rate authorization will end March 31st). If the member will not be returning to the facility prior to the end of the month, <i>iCare</i> cannot extend the Room & Board authorization. The provider should work with the member or legal decision maker and IDT to determine an amount to be paid directly to the facility by the member or legal decision maker. This would not include visits with family, vacations, or camp attendance that is less than 14 calendar days. Providers would continue to receive the daily total rate for residential services in these situations. Substitute Care (provider respite) cost is the responsibility of the residential provider and is included within the residential service rate.
4.0	Documentation of Service
4.1	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.
4.2	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.
4.3	The Provider must retain copies of the authorization notification.
4.4	The IDT shall issue a new authorization notification to Provider when the tasks assigned, amount, frequency, or duration of the service changes.
4.5	The Provider must retain the following documentation and make available for review by MCO 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 expectation of work rules, work ethics and reporting variances to the program supervisor. • Employee time sheets/visit records which support billing to iCare.
4.6	Direct service for all services must be documented through an entry in the case notes. The case narrative must be contained in the case record maintained by the Provider. The Provider shall maintain an Enrollee record containing the following documents. Enrollee documents must be maintained individually to ensure confidentiality. Enrollees' personally identifiable health care information should never be publicly visible. • Enrollee Information Sheet – including name and date of birth • Guardian name and contact information (if applicable) • POA name and contact information (if applicable) • Emergency contacts and numbers • Medical insurance information • Financial service agreement • Medication log • Enrollee health assessment • Enrollee ISP • Enrollee BSP (if applicable) • Monthly ledger of personal funds • Evidence that Enrollee has been provided personal rights • Grievance procedure • Advanced directives (if applicable)
4.7	Provider must notify iCare of visits from licensing and other regulatory entities within two days of the conclusion of the visit. If Provider is issued a citation, iCare must be provided with a copy of the plan of correction submitted to DQA.
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	CBRF staff must receive department approved training in accordance with Wis Admin DHS 83.20. Approved trainings that must be completed and documented appropriately include: • Standard Precautions – All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. • Fire Safety – to be completed within 90 days of beginning employment • First Aid and Choking – to be completed within 90 days of beginning employment • Medication Administration and Management – to be completed prior to assuming these job duties
5.3	Additional initial training in the areas of health, safety, welfare, rights and treatment of Enrollees must be completed within the first six months of employment. Staff must then receive another 15 hours continuing education in those areas annually thereafter. Providers and staff also must attend the Alzheimer’s Association “Dementia Specialist Training: Best Practices for Direct Care Staff” if there is an Enrollee with signs of dementia or early-stage Alzheimer’s residing in the facility. Additional topics that should be addressed in the training process include: • Residents’ Rights and Responsibilities • Abuse and Neglect • Confidentiality • Communication Skills • Dietary Needs • Documentation • Responding to Challenging Behaviors • Health Monitoring • Activity Programming • Natural Supports • Recognizing and Responding to Emergencies in Health and Safety • Specialized Equipment • Care Plans • Restraint Plans and Restrictive Measures Regulations Staff training and qualifications are a requirement of regularly scheduled staff and any substitute staff. It is the Provider’s responsibility to ensure substitute staff have the training and qualifications required to work in the CBRF. The Provider must maintain and make available for review a training record which documents completed training requirements for all staff
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	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. • Recognizing abuse and neglect and reporting requirements • 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
6.3	All Community Based Residential Facilities must comply with DHS Chapter 83 staffing requirements. The Provider is responsible for ensuring an adequate number of staff present to meet routine and emergency needs of Enrollees and that staff-to-Enrollee ratios are in accordance with licensure and applicable state and federal rules and regulations. In addition, the Provider is responsible for ensuring staff have received adequate training and knowledge to provide competent care to the Enrollees in the CBRF.
6.4	The Provider and staff must be easily accessible to Enrollees. Staff to Enrollee ratios must meet the needs of Enrollees as identified in assessments and individual service plans and must be in accordance with Medicaid waiver standards and state and federal regulations and licensing requirements.

6.5	If a significant need for staffing changes arises, the Provider will work with iCare to revise rates accordingly. Proposals for rate changes will be explored but are not guaranteed. All changes will be in alignment with the change of condition procedure and fee structure.
6.6	The Provider must have a clearly documented backup plan for times when scheduled staff are not available such as vacations or unexpected staff absences. It is the responsibility of Provider to secure and pay for qualified staff coverage for any gaps in coverage.
7.0	Communication and Reporting Requirements
7.1	It is the responsibility of the Provider to ensure iCare 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
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	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. iCare will not pay for services that have not been authorized.
7.5	Member Incidents Provider must communicate and report all incidents involving an iCare 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 Inlusa website at www.inlusa.org • Family Care Partnership: For Providers/Education/Resources section of the iCare website at www.iCarehealthplan.org
8.0	Quality Program

8.1	<i>i</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. It is the responsibility of providers and provider agencies to maintain the regulatory and contractual standards as outlined in this section. <i>i</i>Care will monitor compliance with these standards to ensure the services purchased are of the highest quality.
8.2	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.
8.3	Expectations of Providers and <i>i</i>Care 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>i</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.