Scope of Service

Consumer Directed Supports (Self-Directed Supports) Broker

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

Family Care Partnership: Attachment to Exhibit A to the Long-Term Care Services Agreement
Family Care Only (If applicable): Appendix N to Subcontract Agreement

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

1.0	Definitions
1.1	**Service Definition** **Consumer Directed Supports (Self-Directed Supports) Broker** is an individual who assists an Enrollee in planning, securing, and directing self-directed supports (SDS). The direct assistance provided by the support broker depends on the needs of the member and includes assistance, if needed, with recruiting, hiring, training, managing, and scheduling workers. The extent of the services provided is specified in the member-centered plan (MCP). The services of a support broker are paid for from the Enrollee's self-directed supports budget. Support brokers are subject to criminal background checks and must be independent of any other waiver service provider. A support broker shall be knowledgeable of the local service delivery system and local community-integrated services and resources available to the Enrollee. A support broker shall also be knowledgeable of the typical kinds of needs of persons in the Enrollee's target group. The Enrollee and interdisciplinary team staff (IDT Staff) are responsible to assure that a support broker selected by the Enrollee has the appropriate knowledge.
1.2	Consumer directed supports broker excludes the cost of any direct services authorized and obtained by a consumer through an SDS plan, which is paid for and reported under the appropriate service definition. Consumer directed supports broker excludes the cost of fiscal agent services, which is paid for and reported as financial management services.
1.3	Consumer directed supports broker services are limited to members who self-direct some or all of their waiver services. This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan, including care management services. A provider of this service must have the ability to identify the unique needs/preferences of the member and must have knowledge of the available providers for services in the member's geographic area.

2.0	Service Description/ Requirements

2.1	**Support Broker Services**
	• Meet with Enrollee within seven (7) business days from the date Provider receives referral and as needed on an on-going basis to discuss their self-directed services. Provider agrees to meet with Enrollee at times and locations that are convenient for Enrollee.
	• Assist Enrollee in developing a recruitment strategy and hiring plan that is in line with the Enrollee's budget.
	• Assist Enrollee in coordinating costs associated with the hiring process.
	• Utilize forms and documents that are understandable to the Enrollee.
	• Act as an advocate on behalf of the Enrollee in situations related to self-directed employment and hiring of caregivers or staff.
	• Assist Enrollee with conflict resolution between the Enrollee/employer and the employee.
	• Contact Enrollee's IDT Staff with any information or concerns that Provider may have, which may affect Enrollee's health and/or safety.
	• Support Enrollee in becoming a good employer by assisting them with the following:
	  ○ Advertising and staff recruitment
	  ○ Job Description Development
	  ○ Screening applicants and assisting with interviews
	  ○ Establish training protocols and performance reviews
	  ○ Completing employee paperwork
	  ○ Reviewing/verifying time sheets prior to submission to the fiscal management agency
	  ○ Any other duties that may assist or support Enrollee
	• Communicate with Enrollee's IDT Staff in a timely manner in order to assist the IDT Staff in maintaining a service plan which accurately reflects the current financial needs of the Enrollee.
	• Send weekly progress updates to Enrollee's IDT and MCO SDS staff.
	• The quantity of services provided to Enrollee must be consistent with the care plan developed by the IDT Staff and the service authorization. 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, the Provider will contact the IDT Staff in a timely manner to request such modification. ***i*Care will not pay for services that have not been authorized.**

3.0	**Unit of Service**
3.1	Billable time for Support Broker is face-to-face time with the Enrollee and/or the Enrollee's SDS employees, phone contacts and collateral contacts, within the authorized hours as designated on the Service Referral and Authorization form issued by the care manager or designee. Billable time includes recruiting activities with and/or on behalf of the Enrollee.
3.2	Travel time may be paid to and from the Support Broker's primary site (may be personal residence) and the Enrollee's home or other authorized activity site. This additional cost is evaluated on a case-by-case basis.
3.3	Excludes the cost of any direct services authorized and obtained by an Enrollee through an SDS plan, which is paid for and reported under the appropriate service definition. Excludes the cost of fiscal agent services which is paid for and reported as financial management fees.

<table>
<tr><td>3.4</td><td>Provider must bill using appropriate procedure codes and modifiers.
<table>
<tr><th>Service Code</th><th>Modifier</th><th>Service Description</th><th>Unit of Service</th></tr>
<tr><td>T2041</td><td></td><td>Support Brokerage, self-directed</td><td>Per 15 minutes</td></tr>
<tr><td>T2041</td><td>U5</td><td>Support Brokerage, self-directed</td><td>Per 15 minutes</td></tr>
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<tr><td>3.5</td><td>Remote Waiver Services and Interactive Telehealth
Provider must include modifier 95 when submitting claims for services that are delivered remotely or through telehealth.</td></tr>
<tr><td>4.0</td><td>Documentation of Service</td></tr>
<tr><td>4.1</td><td>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.</td></tr>
<tr><td>4.2</td><td>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.</td></tr>
<tr><td>4.3</td><td>The Provider must retain copies of the authorization notification.</td></tr>
<tr><td>4.4</td><td>The IDT shall issue a new authorization notification to Provider when the tasks assigned, amount, frequency, or duration of the service changes.</td></tr>
<tr><td>4.5</td><td>The Provider must retain the following documentation and make available for review by iCare 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 MCO.</td></tr>
<tr><td>4.6</td><td>Remote Waiver Services and Interactive Telehealth
Provider may not require members to receive a service via interactive telehealth or remotely if in-person service is an option.

Remote Waiver Services are waiver services delivered using audiovisual communication technology that permits 2-way, real-time, interactive communications between a provider and a member. Remote waiver services do not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail. The IDT cannot require the use of remote services to authorize the service.</td></tr>
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	The IDT must first determine the service is necessary to support an outcome by using the RAD or other Department approved alternative and then determine whether it can be authorized remotely. To authorize a waiver service for remote delivery, the IDT must: • Determine that the service can be delivered remotely with functional equivalence to face to face as the in-person service. Functional equivalence exists when there is no reduction in quality, safety, or effectiveness of the in-person service because it is delivered by using audiovisual telecommunication technology. • Obtain informed consent from the member to receive the service remotely. • Determine that the member has the proper equipment and connectivity to participate in the service remotely. The MCO is not required to provide the proper equipment and connectivity to enable the member to access the service remotely. State Plan Services Via Interactive Telehealth: Interactive telehealth is telehealth delivered using multimedia communication technology that permits 2-way, real-time, interactive communications between a certified provider of Medical Assistance at a distant site and the Medical Assistance recipient or the recipient's provider.
4.7	Information regarding authorization and claims processes are available at: **Family Care:** Providers/Claims and Billing at www.inclusa.org **Family Care Partnership:** Provider/Claims section and Provider/Prior Authorization section at www.icarehealthplan.org
5.0	**Staff Qualifications and Training**
5.1	**Caregiver Background Checks –** Caregiver and Criminal Background checks must be completed in compliance with Wisconsin DHS Admin. Code Chapter 12 and 13. Provider must maintain and make available for review documentation that caregiver and criminal background checks have been completed timely for all staff.
5.2	Provider must comply with all training requirements as outlined in their licensing/certification standards. If training standards are not specified, Provider must ensure that staff are fully trained to complete the assigned tasks.
5.3	Provider must orient and train their staff on the Family Care and Family Care Partnership Programs. Support materials can be found at: **Family Care:** www.inclusa.org **Family Care Partnership:** www.icarehealthplan.org
5.4	Staff must be trained in recognizing abuse and neglect and reporting requirements.

5.5	The Provider must ensure that staff have received training on the following subjects pertaining to the individuals served:
	• Policy, procedures, and expectations may include the following:
	  ○ Enrollee rights and responsibilities
	  ○ Provider rights and responsibilities
	  ○ Record keeping and reporting
	  ○ Arranging backup services if the caregiver is unable to make a scheduled visit
	  ○ Other information deemed necessary and appropriate
	• Information about individuals to be served including information on individual's specific disabilities, abilities, needs, functional deficits, strengths, and preferences. This training

	should be person specific for the people to be served and generally focused. • Recognizing and appropriately responding to all conditions that might adversely affect the Enrollee's health and safety including how to respond to emergencies and Enrollee-related incidents. • Interpersonal and communication skills and appropriate attitudes for working effectively with Enrollees and with IDT. • Confidentiality laws and rules • Practices that honor diverse cultural and ethnic differences Procedures for following Family Care and Family Care Partnership required processes for handling complaints and grievances (see Section 7.3).
6.0	**Supervision and Staff Adequacy**
6.1	The Provider shall maintain adequate staffing to meet the needs of Enrollees referred by MCO and accepted by the Provider for service.
6.2	Provider must ensure: • Staff are supervised and assessed to assure they are working effectively and collaboratively with Enrollees by conducting adequate on-site supervision and review. • Performance issues with staff are addressed promptly and IDT is kept informed about significant issues that affect the Enrollee. • Supervisory staff are involved in assessment, goal planning and tracking, and supervision for Enrollees. • Provider staff are working collaboratively and communicating effectively with MCO staff
7.0	**Communication and Reporting Requirements**
7.1	It is the responsibility of the Provider to ensure the MCO has the most accurate and updated contact information to facilitate accurate and timely communication.
7.2	The Provider shall report to the IDT whenever: • There is a change in service provider • There is a change in the Enrollee's needs or abilities The Enrollee or provider is not available for scheduled services (within 24 hours unless an alternate date is scheduled between provider and Enrollee)
7.3	Provider shall notify IDT of formal complaints or grievances received from Enrollees within 48 hours of receipt. Written notification of completed complaint investigations must be submitted to the IDT.
7.4	Provider must notify the Enrollee and IDT when the contracted service is unable to be rendered such as closing for inclement weather or widespread illness outbreak.
7.5	The IDT must be notified in a timely manner if the Provider, through its experience in providing services to the Enrollee, believes that the Enrollee's needs have changed, and a modification of the service level is indicated. ***i*Care will not pay for services that have not been authorized.**
7.6	Provider shall follow up with the Enrollee or IDT to determine the reason for an unplanned Enrollee absence.

7.7	**Member Incidents** Provider must communicate and report all incidents involving an *i*Care re Enrollee to the IDT– the Care Coach or the Field Care Manager Nurse within **24 hours** via phone, fax, or email. If the reporter is unable to reach someone from the care team, they may leave a message reporting details of an incident that has been resolved and did not result in serious harm or injury to the Enrollee. If the incident is not yet resolved or resulted in serious harm or injury to the Enrollee, the provider must attempt to contact the IDT via phone. **Family Care:** If unable to contact IDT, call 1-877-622-6700 and ask to speak to a Care Management Support Manager to immediately make a report. If a manager is unavailable, the provider will speak with the receptionist to be redirected or leave a message**.** **Family Care Partnership:** If unable to contact IDT, call 1-800-777-4376 and ask to speak to a Care Management Support Manager to immediately make a report. If a manager is unavailable, the provider will speak with the receptionist and ask to be redirected or leave a message. All reported incidents will be entered into the MCO Incident Management System and reported to DHS in accordance with MCO contract requirements. Providers may be asked to provide any additional information or details necessary to complete the investigation of reported incidents. The provider will inform the MCO when notifying their regulatory authority of incidents. A copy of the report may be submitted as a form of notification. Incident reporting resources and training are available at: **Family Care**: Providers section of the Inclusa website at www.inclusa.org **Family Care Partnership**: For Providers/Education/Resources section of the *i*Care website at www.iCarehealthplan.org
7.8	The provider agency shall give at least 30 days' advance notice to the IDT when it is unable to provide authorized services to an individual Enrollee. The provider agency shall be responsible to provide authorized services during this time period. The IDT or designated staff person will notify the provider agency when services are to be discontinued. The IDT will make every effort to notify the provider at least 30 days in advance.
8.0	**Quality Program**
8.1	*i*Care 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*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 MCO for Quality Assurance Activities** • **Collaboration**: working in a goal oriented, professional, and team-based approach with MCO representatives to identify core issues to quality concerns, strategies to improve, and implementing those strategies • **Responsiveness**: actions taken upon request and in a timely manner to resolve and improve identified issues. This may include submitted documents to MCO, responding to calls, emails, or other inquiries, keeping MCO designated staff informed of progress, barriers, and milestones achieved during quality improvement activities • **Systems perspective to improvement**: approaching a quality concern, trend, or significant incident with the purpose of creating overall improvements that will not only resolve the issue at hand, but improve service and operations as a whole • **Enrollee-centered solutions to issues**: relentlessly striving to implement solutions with the focus on keeping services Enrollee-centered and achieving the goals and outcomes identified for persons served *i*Care is committed to interfacing with providers to collaboratively and proactively discuss issues identified with processes and assist with implementing improvements and reviewing the impact of the changes as a partner in the mission to serve Enrollees.