Scope of Service

Day Habilitation

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	**Day habilitation** provides activities and supports to foster the acquisition of generalized skills and opportunities for the member to actively participate in integrated community-based activities that build on the member's interest, preferences, gifts, and strengths. Day habilitation reflects the member's person-centered goals regarding community connections and involvement. This service promotes maximum participation in integrated community life while facilitating meaningful relationships, friendships, and social networks with members of the broader community who share similar interests and goals for community participation. Services are aimed at supporting members to reach the highest level of independence and where possible, reducing or eliminating the need for paid supports to engage in personally meaningful community activities. Services provided must be consistent with the member's member centered plan (MCP). Day habilitation includes: • Development of an inventory to establish baseline levels of skills and independence; • A wide variety of activities focused on the development, retention, and ~~or~~ improvement of self-help, socialization, and adaptive skills • Daily opportunities to engage in community life and interact with members of the community who do not receive HCBS; • Community mapping; • Supports are designed to foster, through experiential and adult learning, the acquisition of positive social skills, interpersonal competence, greater independence, and the ability to communicate personal choices and preferences; • Coordination with needed therapies in the member -centered plan, such as physical, occupational, or speech therapy; • For members with degenerative medical conditions, supports and community involvement opportunities that are designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills; • Retirement activities; • Supports to participate in volunteer opportunities not related to vocational goals; • Skills in arranging and using transportation; and • Completion of six-month day habilitation reports to the MCO.

1.2	This service may be provided in a disability-specific, provider-owned and controlled (facility-based) setting or a non-disability-specific (community based) setting. When this service uses a provider owned and controlled setting for a portion of the service delivery, the service delivery is considered facility based. When this service uses a community setting 100% of the time, the service delivery is considered community based. Community-based service delivery may use a provider owned or controlled setting as a hub or base but cannot provide services in that setting. Day habilitation must be provided separately from the member's residence or other residential living arrangements. When services are provided in community settings, the service is expected to be provided in small groups no larger than three (3).
1.3	Transportation between a member's place of residence and the service setting or site of day where the member starts and ends the service each day may be included as a component of day habilitation activities or under Specialized (Community) Transportation, but not both. Transportation between the service setting and one or more community site is always included in the service. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Personal care/assistance may be a component of day habilitation services as necessary to meet the need of members but may not comprise the entirety of the service. Members who receive day habilitation services may also receive educational, supported employment, and prevocational services, however different types of non-residential habilitation services may not be billed during the same period of the day. Day habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services). This service cannot involve volunteering for the day habilitation provider.
1.4	For facility-based day habilitation providers, the facility must be HCBS compliant per 42 CFR 441.301(c)(4). For community-based providers, service delivery must be 100% community based. All agency provider must meet at least one of the following provider qualifications: • Accreditation by a nationally recognized accreditation agency, or • A minimum of two years of experience working with the target population in providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services. Individual day habilitation providers must have a minimum of two years of experience providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment, or similar services. Additionally, agency and individual providers providing personal care must meet the Training and Documentation Standards for Support Home Care and agencies and individuals providing transportation must meet the provider qualifications for Specialized Transportation- Community Transportation.
2.0	**Service Description/ Requirements**
2.1	All settings and locations must meet all Home and Community-Based Services (HCBS) rules and be determined compliant prior to being eligible to provide services under the Family Care/Family Care Partnership waiver programs. • Compliance is specific to the approved location. Any planned move to another location (address) needs to be prior approved by DHS and determined HCBS compliant. A copy of the

	letter of determination for a new location needs to be provided and the Provider contract needs to be updated to reflect the new location. All nonresidential settings must meet conditions that ensure specific rights of people receiving HCBS in those settings, including the following qualifications: • Is integrated in, and supports full access to, the greater community. • Provides opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources. • • Is selected by the individual from among multiple setting options, including non-disability specific settings. • Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. • Optimizes individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. • Facilitates individual choice regarding services and supports, and who provides them. Exceptions or modifications to an HCBS Settings Rule requirement may be necessary to mitigate risks to a member's health and safety. Exceptions to these requirements can be allowed through the Person-Centered Planning process and must be included as part of the MCP and the provider Individual Service Plan (ISP). CMS refers to these as Modification of Rights (MOR) Plan. Consideration and planning for a modification of rights must include the member, Legal Decision Maker (LDM) when indicated, IDT, and the Provider. For more specific information regarding HCBS requirements use this link: HCBS Settings Rule: Compliance for Nonresidential Services Providers | Wisconsin Department of Health Services
2.2	Day habilitation services for adults includes working with members in a group setting (small or large) with program goals that may include, but are not limited to, activities of daily living and community living. • Day services shall include at least one of the following: ○ Independent living skills ▪ Financial literacy ▪ Safety and situational awareness ▪ Technology training and exploration ○ Mobility and travel training skills ○ Social, emotional, and personal development ▪ Self-awareness and self-advocacy ▪ Problem solving and critical thinking ○ Communication skills ▪ Peer to peer sharing ○ Community access/Integration ▪ Community involvement and volunteering with non-profit organizations as a means to explore interest areas, to become comfortable with working alongside people without disabilities, or to develop general skills helpful for integrated employment ▪ Tours and information gathering at various community venues (civic centers, libraries, recreation facilities, etc.) ○ Introduction to the meaning of work/vocational exposure ▪ Tours and information gathering of area business'

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Volunteering
Discovery/interest identifying workbooks and/or inventories
Discover local communities thru virtual tours of business and informational interviews of local community members

Provider works with the member and IDT to complete a person-centered assessment and team-based planning process to develop specific individualized goals that assist members with enhancing and/or maintaining their independence.
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Community Based Day Habilitation (CBDH)
There is a distinct difference between Facility-Based and Community-Based Day Habilitation Services (CBDH). The purpose of Community-Based Day Services is to expose members to opportunities within their community that will lead to greater independence and a fuller life in their community.

Goals set for CBDH are to be measurable and consistent with each member's stated interest areas. Activities that contribute to the member's community exploration, community participation, independence, interpersonal competencies, and personal choice are required.

Provider works with the member and IDT to establish specific goals through assessment and personal discovery. Members receive individualized supports to achieve their goals in small groups.
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Day services exclude:

Services provided in a certified adult day care facility.
Pre-vocational services, work training experience, sheltered workshops and production piecework, paid or unpaid.

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<tr><td>2.5</td><td>In facility-based settings, adequate space shall be provided for dining, group and individual activities, rest, and privacy.</td></tr>
<tr><td>2.6</td><td>Fire and disaster plans and procedures shall be posted in a conspicuous place and shall include scheduled quarterly drills for Enrollees and staff.</td></tr>
<tr><td>3.0</td><td>Unit of Service</td></tr>
<tr><td>3.1</td><td>
Provider must bill using appropriate procedure codes and modifiers.
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<tr><th>Service Code</th><th>Modifier</th><th>Modifier</th><th>Service Description</th><th>Unit of Service</th></tr>
<tr><td>T2020</td><td>UA</td><td></td><td>DD/MH Day Service – Community Based</td><td>Per day</td></tr>
<tr><td>T2020</td><td>UB</td><td></td><td>Day Habilitation Services – Facility Based</td><td>Per day</td></tr>
<tr><td>T2020</td><td>UB</td><td>U1</td><td>DD/MH Day Service – Facility Based</td><td>Per day</td></tr>
<tr><td>T2020</td><td>UB</td><td>U2</td><td>DD/MH Day Service – Intensive, 1:1 staffing, Facility Based</td><td>Per day</td></tr>
<tr><td>T2021</td><td>UA</td><td></td><td>DD/MH Day Service – Community Based</td><td>Per 15 minutes</td></tr>
<tr><td>T2021</td><td>UB</td><td></td><td>Day Habilitation Services – Facility Based</td><td>Per 15 minutes</td></tr>
<tr><td>T2021</td><td>UB</td><td>U1</td><td>DD/MH Day Service – Facility Based</td><td>Per 15 minutes</td></tr>
<tr><td>T2021</td><td>UB</td><td>U2</td><td>DD/MH Day Service – Intensive, 1:1 staffing, Facility Based</td><td>Per 15 minutes</td></tr>
<tr><td>T2003</td><td>RI</td><td></td><td>Transportation non-Medical – 1-10 miles</td><td>One way trip</td></tr>
<tr><td>T2003</td><td>RI</td><td>U1</td><td>Transportation non-Medical – 11-20 miles</td><td>One way trip</td></tr>
<tr><td>T2003</td><td>RI</td><td>U2</td><td>Transportation non-Medical – 21-30 miles</td><td>One way trip</td></tr>
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3.2	**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. 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.
4.0	**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 *i*Care 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.
4.6	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	It is desirable that a licensed practical nurse (LPN) or a registered nurse (RN) be available to monitor the health conditions of day care Enrollees.
5.3	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.
5.4	Provider must orient and train their staff on the Family Care and Family Care Partnership Programs. Support materials can be found at: **Family Care:** www.inclusa.org **Family Care Partnership:** www.icarehealthplan.org
5.5	Staff must be trained in recognizing abuse and neglect and reporting requirements.
5.6	Services provided by anyone under the age of 18 shall comply with Child Labor Laws.

5.7	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
6.3	Providers must have an acceptable backup procedure, including notification of member and agency when provider is unable to show for a scheduled visit.
6.4	Supervision of planned activities should be provided by a degreed recreational therapist, occupational therapist, certified occupational therapy assistant, or an individual experienced in working with specialized populations.
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 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*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 representative to identity 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 improve:** approaching a quality concern, trend, or significant 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.